Australian Competition & Consumer Commission

Determination

Application for authorisation

lodged by

Rural Doctors Association of Australia Limited

in respect of

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

Date: **14 May 2008**

Commissioners: Samuel
King
Martin
Walker

Authorisation no.: A91078

Public Register no.: C2007/2294

Summary

The ACCC grants authorisation to the Rural Doctors Association of Australia (RDAA) and its constituent state associations to collectively negotiate with state/territory health departments the terms of contracts for general practitioner or rural generalist visiting medical officers (VMOs) in rural areas, particularly with respect to payments for services provided to public patients and for on-call services. Authorisation is granted for five years, until 30 June 2013.

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 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 seek 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. The RDAA does not propose to negotiate on behalf of other medical specialists or with individual hospitals.

Assessment of public benefit and detriment

The ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott conduct limit the potential detriment. In particular, given the voluntary nature of the proposed arrangements the ACCC would expect that a collectively negotiated agreement will only be reached if it is mutually beneficial to both state/territory health departments and RDAA members. Authorisation does not compel the state/territory health departments to negotiate with the RDAA. The state/territory health departments remain free to continue with their existing arrangements for GP VMO contracts.

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 RDAA negotiating with state/territory health departments on behalf of its members in circumstances where state/territory health departments agree to the collective bargaining process.

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

Determination

The ACCC grants authorisation to application A91078 until 30 June 2013. Authorisation does not extend to any collective decision by current or future RDAA members to engage in collective boycott activities. Authorisation does not extend to the RDAA negotiating on behalf of other medical specialists. Authorisation also does not extend to negotiations involving individual hospitals or any group of hospitals.

Contents

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

1.3. 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.

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

1.5. 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.

1.6. 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.

2. The application for authorisation

2.1. On 7 December 2007 the Rural Doctors Association of Australia Limited (RDAA) lodged application for authorisation A91078 with the ACCC.

2.2. The RDAA and its constituent state associations seek authorisation to collectively negotiate with state/territory health departments the terms of contracts for visiting medical officers (VMOs) in rural areas, particularly with respect to payments for services provided to public patients and for on-call services, to apply state-wide. The application concerns RDAA members who are rural generalists and general practitioners (GPs). The RDAA does not propose to negotiate on behalf of other medical specialists.

2.3. In its application, the RDAA advised that a 'rural generalist' is a rural doctor who is eligible for the awarding of a fellowship by the Australian College of Remote and Rural Medicine and has the same status as a general practitioner who has vocational registration recognised by the Commonwealth Government.[1] For the purpose of assessing this application, the ACCC adopts this definition of rural generalist throughout this determination.

2.4. The RDAA seeks authorisation for a period of five years and the application is lodged on behalf of current and future members of the RDAA. The Australian Capital Territory does not have any rural hospitals and is therefore not subject to the application.

2.5. On 15 February 2008 the RDAA provided a submission which clarified the arrangement for which it is seeking authorisation. The RDAA advised that it expects that negotiations will be undertaken with the various state/territory departments or authorities responsible for health and public hospitals, or in some cases, with an agent appointed by the department or authority. The RDAA advised that, alternatively, collective negotiations could take place with a representative of all the public rural hospitals in a state/territory (particularly in Victoria), if a state/territory government wished to proceed in this manner. The RDAA does not propose to negotiate with individual hospitals.

The applicant

2.6. The 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. State/Northern Territory RDAs are autonomous entities which deal with government and other bodies in their own jurisdictions.

2.7. The RDAA works at the national level to provide a variety of services to rural medical practitioners, including:

- lobbying and industrial support - the RDAA lobbies federal government decision-makers and policy–makers on a range of issues important to rural medical practitioners and their communities

[1] The Australian Medical Association submitted that the concept of 'rural generalist' does not have any formal status and that fellows of the Australian College of Rural and Remote Medicine are general practitioners. The NSW Department of Health also submitted that the term 'rural generalist' has no accepted meaning.

- timely and relevant information – the RDAA provides regular information to its members on current rural medical issues through publications, emails and teleconferences
- policy development – the RDAA works with rural medical practitioners and other stakeholders to develop policies on a wide range of rural healthcare and rural medical issues
- research projects – the RDAA undertakes and supports research regarding access to rural healthcare services. This research often forms the basis for Commonwealth health funding decisions
- strategic advice and liaison with other organisations.

2.8. In 1996, in response to demand from rural doctors and trainees, the RDAA created the Australian College of Rural and Remote Medicine, which determines and upholds the standards, training and continuing medical education for rural doctors.

The industry

2.9. The RDAA's application for authorisation concerns rural generalist and GP VMOs in rural areas.

2.10. 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.[2] These services may be provided as in-patient or after-hours services.

2.11. In rural and remote Australia a significant proportion of VMOs are GPs. General practice is the provision of primary, continuing, whole-patient medical care to individuals, families and their communities.[3] General practice 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.[4]

2.12. General practice in Australia operates predominantly through private medical practices.[5] In November 2002 there were 4,074 registered GPs practising in rural and remote locations in Australia. Approximately 60% of doctors providing medical services in rural and regional Australia were GPs.[6]

2.13. GPs operating in rural and remote areas often undertake a broader range of clinical work than their urban counterparts, including emergency care and population health activities. This is often due to geographic and professional isolation and the lack of nearby supporting medical specialists.[7] The Rural Doctors Association of Victoria (RDAV) indicated that the presence of a GP serviced hospital implies isolation and the necessity to supply advanced medical services to the local community by local doctors.[8]

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[2] Australian Institute of Health and Welfare, *Public Hospital Establishments National Minimum Data Set: National Health Dictionary*, Version 12, (2003), http://www.aihw.gov.au/publications/hwi/phe/phe.
[3] Definition of General Practice and General Practitioner, RACGP website, www.racgp.org.au
[4] Ibid.
[5] Australia Medical Association, "General Practice/Rural Medicine Training", June 2005, www.ama.com.au.
[6] *The Review of the Impact of Part IV of the Trade Practices Act 1974 on the recruitment and retention of medical practitioners in rural and regional Australia*, 2002, p. 25.
[7] Australian Medical Workforce Advisory Committee, (AMWAC) "The General Practice Workforce in Australia: supply and requirements to 2013" Report 2005.2 (2005), p 97.
[8] Rural Doctors Association of Victoria, submission to the ACCC, 16 April 2007, p 2.

2.14. GPs may also develop procedural skills in areas such as anaesthetics, obstetrics and general surgery to compensate for the limited availability of specialist consultants in remote regions. The RDAV indicated that in rural Victoria communities are serviced by generalist medical practitioners with emergency and procedural capabilities working both in local hospitals and in their own general practices.[9] Data from the Australian Medical Workforce Advisory Committee (AMWAC) indicated that in 2003, 22.1% of the rural and remote general practice workforce practised in at least one procedural field.[10]

2.15. Victorian data indicates that in 2006, there were a total of 401 GPs engaged as VMOs, with 80 in metropolitan areas and 321 in rural and regional areas.[11] Information from the RDAV indicates that there are a total of 93 hospitals and 525 medical practitioners in rural locations of Victoria. The ACCC understands that, except in larger locations where a smaller proportion of GPs work in hospitals, most of those GPs will be VMOs.

2.16. NSW Health data from 2004/05 shows that 19% of all VMOs appointed to NSW public hospitals were VMO GPs. In rural NSW Area Health Services, however, they comprised a larger component of the VMO workforce, ranging from 25% to 50% of the total VMO workforce.[12]

GP appointment to public hospitals

2.17. In order to be granted VMO rights, a doctor must be appointed by the Area Health Service, or hospital. The doctor will generally be approved to provide specified medical services at a nominated hospital(s). The services provided by a GP depend on their individual skill mix. These services can include the provision of accident and emergency services, in-patient care and in some instances procedural activities such as anaesthetics, basic surgery or non-complex obstetrics.

2.18. Contracting arrangements for VMO services vary between states and territories, and between hospitals in the same state or territory (this is discussed in more detail in chapter 5). In most states, GPs appointed as VMOs to a hospital are independent contractors. The ACCC understands that in most states/territories standard VMO agreements are set at the state level. In Victoria rural hospitals negotiate directly with GPs regarding their appointment as VMOs. In the Northern Territory, only specialists, rather than GPs, are appointed as VMOs.

Draft determination

2.19. On 6 March 2008 the ACCC issued a draft determination proposing to grant authorisation for a period of five years to the RDAA and its constituent state associations to collectively negotiate with state/territory health departments the terms of contracts for VMOs in rural areas, particularly with respect to payments for services provided to public patients and for on-call services, to apply state-wide. The proposed authorisation was limited to RDAA members who are rural generalists and general practitioners.

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[9] Ibid.
[10] Ibid, p. 32.
[11] Department of Human Services, Victoria, 2006 Annual Report.
[12] NSW Health, Submission to the ACCC, 6 February 2008, p. 2.

2.20. The ACCC noted that the proposed authorisation extended to negotiations between the RDAA and any health department representative, or agent, of all the rural hospitals in a state or territory with respect to a state-wide arrangement for GP VMO contracts.

Conduct not proposed to be authorised

2.21. The proposed authorisation did not extend:

- to any collective decision by current or future RDAA members to engage in collective boycott activities
- to the RDAA negotiating on behalf of other medical specialists
- to negotiations involving individual hospitals or any group of hospitals.

Chronology

2.22. A chronology of significant dates in the consideration of this application is below.

DATE	ACTION
7 December 2007	Application for authorisation lodged with the ACCC.
23 January 2008	Closing date for submissions from interested parties in relation to the application for authorisation.
15 February 2008	Submission received from the RDAA in response to interested party submissions.
6 March 2008	Draft determination issued.
14 April 2008	Final submission received from interested parties in relation to the draft determination.
16 April 2008	Final submission received from RDAA.
14 May 2008	Final determination issued.

3. Submissions received by the ACCC

Prior to the draft determination

3.1. The ACCC sought submissions from 44 interested parties potentially affected by the application, including consumer groups, industry associations and government departments. The ACCC received public submissions from:

- **ACT Health** which submitted that the ACT does not have any hospitals that would be classed as rural, however very generally, ACT Health would support an authorisation that encouraged easier recruitment and retainment of the rural health workforce.

- **Australian Government Department of Health and Ageing** which noted that the employment of doctors to provide VMO services in public hospitals and health facilities is the responsibility of health departments within each state and territory and DOHA 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 a collective negotiation.

- **Australian Society of Anaesthetists Ltd** (ASA) which submitted its support for a centralised professional body to negotiate terms and conditions for Visiting Medical Officers.

- **Department of Health and Community Services (Northern Territory)** (NTDHCS) which submitted that it only negotiates conditions of employment with visiting medical officers who are specialists and consequently, it does not foresee any involvement in the arrangements proposed by the RDAA. DHCS does not have GPs providing visiting medical services in rural areas.

- **Department of Human Services (Victoria)** (VDHS) which submitted that the proposed arrangement would not result in the claimed public benefits in Victoria. VDHS also considers that in Victoria the proposed arrangement will impede competition and result in a less efficient pricing outcome, including an overall increase in price with additional budgetary pressure placed on rural public hospitals which also face the possibility of losing non-specialist VMO providers if collective negotiations fail.

- **Health Complaints Commissioner of Tasmania** (HCCT) which supports the application in principle and particularly endorses the claimed public benefits of improved efficiency and effectiveness in establishing employment arrangements for VMOs in public hospitals with a positive effect on the retention of rural VMOs.

- **NSW Department of Health** (NSWDOH) which considers that there is no public benefit arising from the RDAA's proposed arrangements and for this reason, authorisation should not be granted.

- **Queensland Health** (QH) which submitted that it does not oppose the RDAA's application for authorisation but noted that should authorisation be granted, it would be necessary for the RDAA to apply for recognition as an agent for rural VMOs and if successful to participate as co-agents with the Queensland Branch of the Australian Medical Association.

- **Rural Doctors Association of Victoria** (RDAV) which submitted its support for the RDAA's application for authorisation.

- **South Australia Department of Health** (SADOH) which expressed concern that the arrangement proposed by the RDAA will undermine the current collaborative arrangements that are in place in Country Health SA (CHSA).

- **Victorian Healthcare Association** (VHA) which noted that within Victoria, arrangements are negotiated directly between the legal entity (hospital) and the medical practice providing the service. In general, the VHA submitted that it does not consider that the public benefits claimed by the RDAA are likely to arise in the Victorian context. The VHA expressed significant concern that the arrangement proposed by the RDAA will drive costs up to the detriment of the public.

- **Victorian Hospital Industrial Association** (VHIA) which submitted that the public detriments generated by the RDAA's proposed arrangement will far outweigh any public benefit generated by the arrangement. The VHIA noted that a common fee schedule is at odds with the manner in which health services are operated in Victoria. It considers that the arrangement proposed by the RDAA will result in a substantial increase in the cost of medical services in Victoria.

- **Western Australia Department of Health** (WADOH) which considers that the proposed collective bargaining arrangement will not produce any public benefit and will generate a number of detriments including a less efficient payment structure which is unlikely to increase the supply of medical practitioners in areas of short supply.

3.2. In addition to the information provided in its application for authorisation, on 15 February 2008 the RDAA provided a submission addressing the issues raised by interested parties. In particular, the RDAA submitted that:

- Authorisation is sought to remove any legal risk possibly associated with dealings between the state and territory health departments and the RDAA on behalf of its members with respect to GP VMO contracts.
- If authorisation is granted it would not compel the Victorian Government to enter into an arrangement across the state. Rather, it would facilitate such an arrangement if the state government agreed that it should proceed.
- It is not the intention of the RDAA to enter into any negotiations with individual hospitals in Victoria. The RDAA would proceed with negotiations with a representative of rural hospitals in Victoria if the state government wished to proceed in this manner. The RDAA requested that any authorisation granted by the ACCC allow for this possibility.

Following the draft determination

3.3. In response to the draft determination, the ACCC received public submissions from:

- **Australian Government Department of Health and Ageing** (DOHA) which acknowledged the role of general practitioners in providing visitor medical officer services in rural areas. DOHA recognised the importance of doctors successfully negotiating VMO contracts, especially in rural and regional Australia.

- **Australian Medical Association** (AMA) which noted its role in representing rural practitioners and providing them with advice and assistance. The AMA considers that in the majority of states, VMOs do have the ability to vary their terms and conditions of

employment, 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. The AMA submitted that the concept of 'rural generalist' does not have any formal status.

- **Benalla & District Memorial Hospital** (Benalla Hospital) which submitted its support for a determination that will allow the RDAA to collectively negotiate VMO contracts with the Department of Human Services. Benalla Hospital noted that its largest general practitioner clinic had advised that it will negotiate a new contract at the expiration of the current contract as local negotiations are 'stressful and unpleasant'. Benalla Hospital raised concerns that the proposed authorisation would enable the Department of Human Services to refuse to negotiate.

- **Consumers Health Forum** (CHF) which submitted that consumers expect that the medical workforce will be able to meet community needs, be nationally consistent and coordinated and negotiations to achieve this will look to system solutions rather than individual benefits.

- **Department of Human Services (Victoria)** (VDHS) which considers that it will be subject to some pressure to negotiate with the RDAA even though the proposed arrangements are voluntary. This pressure is likely to be in the form of GP VMOs withdrawing or threatening to withdraw their VMO services. This is an issue for VDHS because it has to ensure that services are provided. In the current environment, a state-wide arrangement will set a price floor and remuneration arrangements will increase. VDHS advised that it currently has regular contact with the RDAV on a range of issues excluding price. VDHS noted that if authorisation is granted, it will deal with any proposed changes as required.

- **Mansfield District Hospital** (Mansfield Hospital) which submitted its support for a determination that will allow the RDAA to collectively negotiate VMO contracts with the Department of Human Services. Mansfield Hospital raised concerns that the proposed authorisation would enable the Department of Human Services to refuse to negotiate.

- **NSW Department of Health** (NSWDOH) which considers that the present arrangement for the representation of GP VMOs, as reflected in NSW Health policy and legislation, should continue. It submits that given its long-standing and ongoing relationship with the RDAA in respect of the Rural Doctors Settlement Package, it cannot 'walk away' from dealing with the RDAA. NSWDOH noted that GP VMOs may relinquish their VMO appointments and work exclusively in their private practices which are generally their principal place of practice and income. In these circumstances, GP VMOs possess considerable bargaining power.

- **Queensland Health** (QH) which submitted that it does not oppose the draft determination.

- **South Australia Department of Health** (SADOH) which advised that it accepts the draft determination.

- **The Kilmore & District Hospital** (Kilmore Hospital) which submitted its strong support for a determination that will allow the RDAA to collectively negotiate VMO contracts with the VDHS. Kilmore Hospital suggested that the determination be open-ended but subject to annual review. Kilmore Hospital is concerned VDHS should agree to any collectively negotiated outcome being full funded.

- **Victorian Healthcare Association Ltd** (VHA) which considers that the proposed authorisation is acceptable. Its only concern is that any agreement negotiated by the VDHS be adequately funded.

- **Victorian Hospitals' Industrial Association** (VHIA) which submitted that the proposed authorisation will result in an increase in medical services costs (for both GP VMOs and specialists), a deterioration in the recruitment and retention of GP VMOs and an adverse impact on clinical governance. The VHIA considers that the RDAA has the ability to bring sufficient pressure on the VDHS to negotiate. Rural doctors are in a powerful position because the rural sector is a very sensitive area for government. The VHIA advised that currently, negotiations for VMO contracts generally focus on the fee schedule to the contract, rather than the contract itself. The VHIA suggests that the ACCC considers excluding Victoria from the proposed authorisation.

- **Western Australia Department of Health** (WADOH) which submitted that although it would not be compelled by the proposed authorisation to negotiate with the RDAA, the practical effect would be that the RDAA would be able to create substantial pressure to negotiate.

3.4. The RDAA provided two submissions addressing the issues raised by interested parties following the draft determination. In particular, the RDAA submitted that:

- While most VMO contracts include the ability to manage rosters etc, the essential terms and conditions of contracts have little, if any flexibility. It noted that even in Victoria, where individual hospitals may negotiate contracts, there is a high degree of similarity between contracts.
- In Victoria, negotiation between hospitals and doctors is problematic and harms vital relationships between doctors and health services.
- The provision of an authorisation will not mandate collective negotiations but will simply remove an obstacle to such negotiation occurring if both parties consider such negotiations appropriate.
- The RDAA is not able to take any industrial action and finds it difficult to understand how the granting of authorisation will lead to such pressure on state health departments that they have no option but to negotiate with the RDAA.

3.5. The views of the RDAA and interested parties are outlined further in the ACCC's evaluation of the proposed collective negotiation arrangement in Chapter 5 of this 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.

4. The net public benefit test

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

Application A91078

4.2. The RDAA lodged application for authorisation A91078 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.

4.3. 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

4.4. 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.[13]

4.5. 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.[14]

4.6. 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.

Definition of public benefit and public detriment

4.7. 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:

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[13] *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.

[14] 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.

…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.[15]

4.8. 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.[16]

Future with-and-without test

4.9. 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.[17]

4.10. 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 and conditions

4.11. The ACCC can grant authorisation for a limited period of time.[18] The Act also allows the ACCC to grant authorisation subject to conditions.[19]

Future and other parties

4.12. 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:

- persons who become party to the contract, arrangement or understanding at some time in the future[20]
- persons named in the authorisation as being a party or a proposed party to the contract, arrangement or understanding.[21]

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15 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.
16 Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.
17 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.
18 Section 91(1).
19 Section 91(3).
20 Section 88(10).
21 Section 88(6).

5. ACCC evaluation

5.1. The ACCC's evaluation of the proposed collective bargaining arrangement is in accordance with the net public benefit test outlined in Chapter 4 of this 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 bargaining arrangement.

The market

5.2. 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.

5.3. The RDAA's application for authorisation concerns the provision by GP VMOs of medical services to public hospitals throughout Australia.

5.4. The RDAA submits the relevant area of competition is the market for the provision of VMO services within defined local geographic areas that relate to public hospitals and health facilities in rural and remote areas of Australia.

5.5. The VDHS considers that the relevant geographic markets are state and territory based, given that the proposed arrangement concerns the state-based constituent bodies of the RDAA and state/territory health departments. The VDHS submits that the relevant market is that for the supply of non specialist medical services by private practitioners to public patients in public hospitals in each state or territory of Australia by reference to regional/rural markets that extend to the area of VMO competition around each rural public hospital.

5.6. The ACCC has previously noted that public hospitals are likely to seek VMO services from doctors practicing in a localised geographic radius from the hospital.[22] The breadth of this region is likely to differ depending on the remoteness of the area.

5.7. The ACCC understands that GP VMOs operate predominantly in rural areas. GPs operating in metropolitan areas do not generally provide VMO services to hospitals.

5.8. The ACCC considers that localised geographic markets, predominantly in rural Australia, are likely to be relevant areas of competition for this assessment. The ACCC understands that rural public hospitals may recruit GPs from outside their local area but to settle in the local area. As noted by the VDHS, GPs who provide services in regional and rural areas generally reside within the community in which they work and, particularly in smaller more remote areas, are relied upon to provide a core service to local hospitals.

5.9. The ACCC notes that under the RDAA's proposed collective bargaining arrangement, negotiations will occur at the state/territory level with the relevant health department.

5.10. 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.

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[22] ACCC Determination, Application for revocation and substitution of authorisation A90795 lodged by the Royal Australian College of General Practitioners, 23 May 2007.

The counterfactual

5.11. As noted in Chapter 4 of this 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'.

5.12. The RDAA did not address the issue of the counterfactual. The VDHS submitted that the ACCC must approach assessing the counterfactual on a state by state basis.

5.13. The ACCC considers that in the absence of authorisation, it appears unlikely that the RDAA would represent GP VMOs in collective negotiations, particularly with respect to payments for services provided to public patients and for on-call services, with state/territory health departments and authorities.

Public detriment

5.14. 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.

5.15. 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.

Submissions

5.16. The RDAA submitted that the proposed collective bargaining arrangement may impact on the costs of labour in rural hospitals. It considers that the purchasing arrangements practiced by state/territory health departments and authorities may have had the distorting effect of reducing prices for GP VMO services. The RDAA does not expect that any cost increases will be significant.

5.17. In response to the ACCC's draft determination, the following interested parties made submissions continuing to oppose the proposed collective bargaining arrangement:

- The NSWDOH advised that it does not support the RDAA's application for authorisation. It considers that the present arrangement for the representation of GP VMOs, as reflected in NSW Health policy and legislation, should continue. It submits that given its long-standing and ongoing relationship with the RDAA in respect of the Rural Doctors Settlement Package, it cannot 'walk away' from dealing with the RDAA.[23]
- The VHIA considers that the primary effect of the proposed arrangement will be an increase in the price of medical services supplied by VMOs (GP and specialist). If price should increase, then services could be reduced, with some services removed from local areas and concentrated in regional locations, with the potential effect of deskilling rural GPs. The VHIA considers that a common fee agreement will remove flexibility, competition and

[23] The Rural Doctors Settlement Package establishes rates of remuneration for GP VMOs for their work in NSW public hospitals.

diversity from the industry and result in a loss of the existing direct relationship between hospitals and GP VMOs. The VHIA considers that the proposed arrangement may lead to rural and remote hospitals finding it difficult to recruit and retain GPs. The VHIA suggested that the ACCC consider excluding Victoria from the proposed authorisation.

- The VDHS submitted that in Victoria, the prevailing prices for VMO services are competitive and it does not accept the RDAA's claim that there may have been an artificial lowering of VMO service prices. The VDHS considers that an agreement by all rural providers of non-specialist medical services (in this case most rurally based doctors) would leave the purchasers of these services (rural based public hospitals) with no choice but to take the terms (including price) offered, with significant anti-competitive effect. The VDHS considers that as it is unlikely that any doctors will be looking to lower their current remuneration, such an agreement is likely to increase the floor price to the upper level of current remuneration, that is, the terms and price currently offered by hospitals in the least desirable locations. The VDHS considers that in Victoria, the proposed arrangement will impede competition and result in a less efficient pricing outcome which does not reflect doctors' circumstances and local supply and demand conditions, and may impose additional budgetary pressures on hospitals that may compromise the level of service they are able to provide.

  The VDHS notes that it will not be required to enter into an agreement with the RDAA in the event that authorisation is granted however, it may not be able to decline such a request if it is supported by rural VMOs. VDHS noted that if authorisation is granted, it will deal with any proposed changes as required.

- The WADOH considers that the imposition of a standardised fee structure on a state-wide basis risks escalating prices in locations where GP VMOs are more readily available without providing any incentive in those locations where recruitment is difficult. The WADOH submitted that the RDAA will be able to create substantial pressure to negotiate, particularly in an environment of medical shortage.

5.18. The VHA and the Kilmore Hospital submitted a concern that any collectively negotiated agreement should be fully-funded by the state health department.

ACCC view

5.19. 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 four features are present:

- 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
- there are restrictions on the coverage and composition of the bargaining group
- participation in the collective bargaining arrangements is voluntary
- there is no boycott activity.

Current level of negotiations between individual members of the RDAA and the state/territory health departments

5.20. 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.

5.21. The RDAA submitted that the state health departments unilaterally determine the arrangements for the contracting of doctors in state hospitals and facilities, with the exception of Victoria where fees are negotiated by individual hospitals and health services. The RDAA notes that in some states, the health department may consult with organisations such as the RDAA in setting VMO arrangements.

5.22. The ACCC received submissions from a number of state/territory health departments describing existing practices for establishing employment conditions for GP VMOs, as set out below.

- In New South Wales, individual doctors and practices do not currently negotiate rates and conditions. Rather, these are established by the NSWDOH after consultation with the AMA (NSW) and RDA (NSW) as appropriate.
- In the Northern Territory (NT), only specialists provide visiting medical services in rural areas in the NT. When negotiating conditions of employment with specialist VMOs, the Department of Health and Community Services deals with the Australian Salaried Medical Officers Federation and the AMA.
- In South Australia (SA), the SADOH, through Country Health SA (CHSA), operates as a single agency covering all health units in country SA. The South Australian government, through CHSA, has adopted a collaborative model in negotiating the South Australian Rural Medical Engagement Schedule and the South Australian Medical Schedule of Fees. The process is coordinated by the CHSA Rural Doctors Liaison Forum and involves the AMA, RDASA, the Rural Doctors Workforce Association, the Royal College of General Practitioners and the Australian College of Rural & Remote Medicine. The SADOH submitted that while this 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.
- In Queensland, the state government (acting through QH, the Department of Corrective Services and the Department of Communities) negotiates an agreement with the Queensland Branch of the Australian Medical Association concerning the supply of VMO services. In Queensland, 'VMO' refers to Visiting Senior Specialists, Visiting Specialists and Visiting Medical Officers (GPs including Rural GPs/Rural Generalists).
- In Victoria, VDHS has no direct involvement with setting contractual terms for VMOs as this role has been devolved to individual hospitals. The VHIA advised that currently, negotiations for VMO contracts generally focus on the fee schedule to the contract.
- In Western Australia, most country doctors in the southern half of the state provide services to their local hospitals under contract. Visiting medical practitioners are engaged on the basis of a medical service agreement (MSA). The terms and conditions component of the MSA is largely non-negotiable. The content of the schedules is negotiated individually (with doctors or their agents), taking into account the skills of the doctor concerned, the service requirements of the hospital(s), the volume of service anticipated to be purchased and the payment models preferred by both parties.

5.23. The ACCC understands that in Tasmania VMOs operate predominantly under arrangements set by the state government.[24]

5.24. The AMA submitted that in the majority of states, VMOs do have the ability to vary their terms and conditions of employment, 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.

5.25. On the basis of this information, the extent to which contracts between individual members of the RDAA and the state and territory health departments are currently negotiated, particularly with respect to payments for services provided to public patients and for on-call services, appears to be low. In New South Wales, South Australia and Queensland the state health departments consult with a range of organisations and not individual doctors when establishing arrangements, including fees, for the supply of GP VMO services. A similar process appears to be in place in Tasmania. In Western Australia, there is some negotiation on some aspects of MSAs. In Victoria, there is no negotiation between the VDHS and individual doctors, instead, doctors negotiate directly with hospitals.

5.26. Given the current level of negotiation between individual doctors and the state/territory departments of health is low, the difference in the level of competition amongst doctors with or without collective bargaining is likely to be small in most states.

5.27. The ACCC notes that in Victoria and to some extent Western Australia, the level of competition under the proposed collective bargaining arrangement may be less than it is currently.

Coverage or composition of the bargaining groups

5.28. 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.

5.29. Under the RDAA's proposal, negotiations will be conducted by the RDA in each state/territory with that state or territory's health department.

5.30. The coverage and composition of the bargaining groups under the RDAA's proposal is extensive. The pool of medical practitioners available to individual state/territory health departments as GP VMOs outside the bargaining groups is likely to be limited. However, the ACCC notes that in many states arrangements for GP VMOs are already generally made at the state level. It also notes that the proposed collective bargaining arrangement is limited to GP VMOs and does not include specialists. While GP VMOs would, as a group, have a stronger bargaining position when dealing with a small rural hospital, their position would be different when negotiating with the state/territory health department. The ACCC notes that negotiations with individual hospitals and groups of hospitals are not included in the proposed arrangements.

Voluntary participation in the collective bargaining arrangements

5.31. The proposed arrangement is voluntary for RDAA members and the state/territory health departments. The RDAA submitted that while the provision of authorisation removes a legal

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[24] Rural Doctors Association of Victoria, submission to the ACCC with respect to the application for revocation and substitution lodged by The Royal College of General Practitioners (A91024), 9 April 2007.

barrier to the proposed collective negotiations taking place, it does not mandate them. The RDAA also submitted that authorisation of the RDAA's proposed collective bargaining arrangement would not preclude state/territory health departments from consulting or negotiating with other parties.

5.32. The ACCC notes interested parties' concerns that the proposed collective bargaining arrangement could lead to higher prices paid by state/territory health departments for GP VMO services with a possible associated reduction in the services provided by GP VMOs at some hospitals. Interested parties have also expressed concern that, particularly in Victoria, the proposed arrangement does not allow sufficient flexibility to address local supply and demand conditions.

5.33. In response to the draft determination, VDHS, NSWDOH and WADOH submitted that they will be subject to some pressure to negotiate with the RDAA even though the proposed arrangements are voluntary. This pressure is likely to be in the form of GP VMOs withdrawing, or threatening to withdraw, their VMO services to focus on their private practices. This is an issue for state/territory health departments because they must ensure that services are provided. The VHIA agrees that the RDAA has the ability to exert pressure on the VDHS to negotiate, particularly because the rural sector is a sensitive area for government.

5.34. The ACCC understands that there are recent examples of local GPs, or GP practices, ceasing to supply VMO services in Victorian locations including Wonthaggi and Portland which have created opportunities for alternative suppliers of VMO services to operate in these locations. The ACCC also understands that in some Victorian locations, such as Benalla and Mansfield, some general practices are currently threatening to withdraw VMO services.

5.35. In contrast to the submissions from VDHS, NSWDOH, WADOH and VHIA, the Benalla, Mansfield and Kilmore hospitals support the application and raised concerns that the draft determination did not compel the VDHS to engage in collective negotiations with the RDAA in Victoria. The ACCC also notes advice from the VDHS that the majority of small hospitals in Victoria have expressed satisfaction with the current arrangements in that state.

5.36. The extent to which the proposed collective bargaining arrangement is genuinely voluntary for all parties is critical to the ACCC's assessment of the RDAA's application for authorisation. The ACCC accepts the submissions from VDHS, NSWDOH and WADOH that GP VMOs have the ability to exert pressure on state/territory health departments by individually withdrawing, or threatening to withdraw, VMO services. However, this possibility exists with or without authorisation, as illustrated by recent events in Wonthaggi and Portland.

5.37. 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 service 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. The issue of collective boycott is addressed at paragraphs 5.43 and 5.44.

5.38. On balance, the ACCC remains of the view that the 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 the negotiations at any time. Further, the state/territory health departments are not compelled to agree to terms, including price, they do not consider are

acceptable. State/territory health departments are able to set parameters on the scope or coverage of any agreement they may wish to negotiate with the RDAA. Importantly, state/territory health departments are free to continue with their existing arrangements.

5.39. The ACCC recognises that this could be different if RDAA members were to negotiate with individual hospitals. The ACCC considers that state/territory health departments do not face the same pressure to negotiate as individual hospitals. The ACCC notes that negotiations with individual hospitals and groups of hospitals are specifically excluded from the RDAA's application for authorisation.

5.40. The ACCC notes the submission from NSWDOH that given its long-standing and ongoing relationship with the RDAA in relation to the Rural Doctors Settlement Package, it cannot 'walk away' from dealing with the RDAA. The ACCC does not consider that a choice by the NSWDOH to continue with its existing arrangements is equivalent to ceasing all dealings with the RDAA. Indeed, by continuing with its current arrangements the NSWDOH would continue to deal with the RDAA in relation to the Rural Doctors Settlement Package.

5.41. With respect to the issue of flexibility, the ACCC notes the RDAA's submission that in order to secure services at some hospitals, a collectively negotiated agreement could contain appropriate provisions or inducements over and above any 'base' agreement.

5.42. The ACCC considers that the proposed collective bargaining arrangement will only lead to agreement between relevant parties if it is mutually beneficial to both state/territory health departments and RDAA members.

Boycott activity

5.43. The ACCC notes the concerns raised by the NSWDOH about the potential for collective boycott activity.

5.44. The RDAA 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

5.45. 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 considers that the coverage and composition of the proposed bargaining groups is extensive however, it notes that arrangements for GP VMOs are already generally made at the state level.

5.46. With regard to the other states, and particularly 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. In particular, given the voluntary nature of the proposed arrangement the ACCC would expect that a collectively negotiated agreement will only be reached if it is mutually beneficial to both state/territory health departments and RDAA members. The ACCC considers that the RDA in each state is not in a position to compel state/territory health departments to negotiate with them. The state/territory health departments remain free to continue with their existing arrangements for GP VMO contracts.

5.47. 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 RDAA's application for authorisation.

Public benefit

5.48. The RDAA submits that the proposed collective bargaining arrangement will deliver the following public benefits:

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

5.49. An assessment of the public benefits claimed by the RDAA follows.

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

Submissions

5.50. The RDAA submitted that currently, state governments may consult with organisations such as the RDAA in establishing VMO arrangements but this gives rise to the possibility of trade practices issues. The RDAA considers that authorisation of its proposed collective bargaining arrangements would enable it to effectively represent the views of its members to state/territory health authorities and agree to a set of arrangements for the employment of GP VMOs in rural public hospitals.

5.51. In response, the VHA submitted that while this may provide a benefit to the rural doctors, it was unable to identify evidence within the Victorian context to support the notion that this would also provide a public benefit.

ACCC view

5.52. In many cases, the ACCC has identified that individually, businesses have a limited degree of input into their contracts being offered take it or leave it terms and conditions. These circumstances do not always lead to the most efficient contract. The ACCC has often 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.

5.53. In this case, the ACCC understands that currently, in those states in which the department of health establishes the terms and conditions, including price, of GP VMO contracts, it is not uncommon for the department of health to consult with organisations that represent doctors.

5.54. To some extent, representation of GP VMOs through consultation may not differ significantly to representation of GP VMOs through negotiation. However, the ACCC acknowledges that the proposed collective bargaining arrangement will include negotiation and agreement on matters such as price, while current processes are limited to consultation for fear of raising trade practices concerns. It is also possible that a negotiation process will enable GP VMOs, through their RDA state association, to provide greater input into contract terms and conditions than a consultation process allows. The ACCC also notes that the RDAA is an organisation which only

represents rural and regional doctors and this may assist in more effective representation of rural GPs in dealings with state and territory health departments.

5.55. To the extent that the proposed collective bargaining arrangement results in effective representation of rural doctors in dealings with state and territory health departments, it gives rise to some public benefit. Authorisation will remove the legal risk associated with the RDAA negotiating with state/territory health departments on behalf of its members in circumstances where the state/territory health departments agree to the collective bargaining process.

Reduced transaction times and costs associated with the contracting of GP VMOs, including for individual doctors and practices

Submissions

5.56. The RDAA submits that the proposed collective bargaining arrangement will streamline the process of the contracting of GP VMOs, reduce 'red tape' and transaction times and costs, and remove the burden of negotiation from individual doctors and practices.

5.57. A number of interested parties made submissions on this claimed public benefit as set out below.

- HCCT supported the RDAA's claim that the proposed collective bargaining arrangement would reduce the burden on individual doctors and practices.

- NSWDOH considers that the benefit will not arise in New South Wales as individual doctors and practices do not currently negotiate rates and conditions in that state. Rather, these are established by the NSWDOH after consultation with the AMA (NSW) and RDA (NSW) as appropriate.

- QH submitted that in Queensland, the state government (acting through the Department of Health, the Department of Corrective Services and the Department of Communities) negotiates an agreement for VMOs with the Queensland Branch of the AMA, which acts as an agent for VMOs in that state.[25] As such, QH considers that VMOs are not burdened with responsibility for negotiations in Queensland.

- RDAV submitted that in Victoria, the current system of individual negotiation is to the detriment of the rural public and is an impediment to the recruitment, preservation and retention of the required workforce.

- VDHS submitted that it has no direct involvement with setting contractual terms for VMOs as this role has been devolved to individual hospitals. It also submitted that 'red tape' and transactions costs of individual negotiation are neither significant nor a major factor behind the shortfall of VMOs in rural areas. In submitting this view, the VDHS cited the results of several studies which found that professional satisfaction is the main reason for doctors staying or leaving medical practice in rural and regional areas. The VDHS considers that flexibility and the ability to tailor contractual arrangements is a key factor in attracting and retaining rural VMOs and that this flexibility would be substantially lost under the arrangement proposed by the RDAA.

[25] In Queensland, VMOs include Visiting Senior Specialists, Visiting Specialists and Visiting Medical Officers (General Practitioners including Rural General Practitioners/Rural Generalists).

VDHS also submitted that the amount of VMO time involved in settling individual terms is not great. It noted that in relation to the recent collective bargaining notification lodged by the AMA on behalf of a group of doctors at Werribee Mercy Hospital, negotiations were conducted via correspondence and telephone calls and finalised in a 15-45 minute meeting. The VDHS considers that this amount of 'red tape' is not particularly burdensome and is likely to be not greater than required by any collective negotiation process run by the RDAA.

- WADOH submitted that there is no evidence to suggest that there are significant transaction costs associated with medical practitioners undertaking individual negotiations rather than collective negotiations. WADOH also noted that allowing one group of medical practitioners to collectively negotiate risks complicating existing arrangements and increasing administrative costs.

- The VHA submitted that it is not convinced that any reduction in 'red tape' would be significant as some form of document would still need to be reviewed and agreed.

ACCC view

5.58. Generally, there are transaction costs associated with contracting. These transaction costs can be lower where a single negotiating process is employed, such as in a collective bargaining arrangement, relative to a situation where multiple negotiation processes are necessary. The ACCC considers that to the extent that these transaction cost savings do arise they are likely to constitute a public benefit.

5.59. The information available to the ACCC suggests that other than in Victoria, individual rural GP VMOs generally have little scope to vary the terms and conditions of their contracts. However, there may still exist costs associated with entering into such contracts in the form of professional advice or obtaining the information necessary to make an informed choice. A collective may be able to consolidate and share such costs.

5.60. In Victoria, individual doctors do negotiate with hospitals with respect to the supply of GP VMO services and the ACCC would expect that any transaction cost savings generated by the proposed collective bargaining arrangements would be greater in this environment. The ACCC notes that the VDHS has indicated that it is not contemplating changing current arrangements where doctors negotiate directly with individual hospitals. As such, the likelihood of potential transaction cost savings eventuating in Victoria appears limited.

5.61. The ACCC notes that transaction cost savings are more likely in a situation where the collective is a homogeneous group of participants.

5.62. The ACCC considers that if transaction cost savings did arise from the proposed collective bargaining arrangements, they would generally be small.

Positive influence on the retention of rural GP VMOs

Submissions

5.63. The RDAA submitted that without authorisation, it could reasonably be expected that an increasing number of GP VMOs will find the process of negotiation too time consuming or the arrangements imposed by state health authorities do not recognise their needs. The

RDAA considers that it is likely that, over time, these doctors may withdraw or reduce the services they provide to rural hospitals, or may withdraw from rural practice altogether. The RDAA considers that by reducing the burden on individual doctors, its proposed collective bargaining arrangement may result in a small increase in the number of GP VMOs providing services to public patients in rural hospitals as well as assisting in retaining current GP VMOs.

5.64. In response, the VHA submitted that it is unable to identify any evidence in the Victorian context to support that notion that the current process of negotiating VMO contracts represents a retention issue. The VHA also noted that the current arrangements in Victoria provide a sense of partnership between GPs and the local hospital, resulting from the interface in negotiating contractual arrangements. The VHA considers that any centralised approach may remove this sense of partnership and create further retention concerns. The VHA also noted that if the proposed collective bargaining arrangement did assist in the retention of GP VMOs then this would be considered a benefit to the public.

5.65. The WADOH noted that current contractual arrangements in Western Australia have not been a barrier to recruitment, with the number of doctors working in rural Western Australia steadily increasing over the past five years.

ACCC view

5.66. The ACCC appreciates that medical workforce shortages in rural areas are important issues. The ACCC considers that arrangements which assist in the retention of medical practitioners in rural areas, and particularly those areas designated 'area of workforce shortage', can generate public benefit.

5.67. As noted above, the ACCC does accept that the proposed collective bargaining arrangement may, to some extent, enhance the effective representation of rural doctors in dealings with state and territory health departments. This outcome in itself may provide rural GP VMOs with greater confidence with respect to the stability and development of medical services in rural areas which may have a positive influence on the retention of rural GP VMOs.

ACCC conclusion on public benefits

5.68. 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 RDAA negotiating with state/territory health departments on behalf of its members in circumstances where state/territory health departments agree to the collecting bargaining process.

Balance of public benefit and detriment

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

5.70. In the context of applying the net public benefit test at section 90(8)[26] of the Act, the Tribunal commented that:

> … something more than a negligible benefit is required before the power to grant authorisation can be exercised.[27]

5.71. The ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott conduct limit the potential detriment. In particular, given the voluntary nature of the proposed arrangements the ACCC would expect that a collectively negotiated agreement will only be reached if it is mutually beneficial to both state/territory health departments and RDAA members. Authorisation does not compel the state/territory health departments to negotiate with the RDAA. The state/territory health departments remain free to continue with their existing arrangements for GP VMO contracts.

5.72. 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 RDAA negotiating with state/territory health departments on behalf of its members in circumstances where state/territory health departments agree to the collective bargaining process.

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

Other issues

The meaning of 'rural'

5.74. NSWDOH is concerned that the term 'rural' is not defined and this potentially gives the RDAA a role in some hospitals in NSW in which it currently has no role, such as base hospitals.

5.75. In response to this concern, the ACCC notes that authorisation is limited to RDAA members. The ACCC understands that RDAA members are typically drawn from small rural towns and remote areas in categories 4 - 7 of the Rural, Remote and Metropolitan Areas classification system.[28]

5.76. The ACCC considers that the meaning of 'rural' could be the subject of negotiation between a state/territory health department and the RDAA. For example, a state/territory health department may wish to exclude particular hospitals from any negotiated agreement.

5.77. The ACCC does not consider it necessary to prescribe a definition of rural in this determination. The ACCC's intention is that authorisation does not extend to any agreement negotiated by the RDAA to apply to GP VMOs in metropolitan hospitals.

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[26] 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.

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

[28] RDAA website, viewed 24 April 2008, <http://www.rdaa.com.au>.

5.78. It is noted that GP VMOs are not common in metropolitan hospitals. Should it become apparent in the future that agreements negotiated pursuant to this authorisation are extending to GP VMOs in metropolitan hospitals, it is open to the ACCC to review and possibly revoke the authorisation.

Other similar applications

5.79. NSWDOH has suggested that other groups which represent doctors may wish to apply for authorisation of similar collective bargaining arrangements.

5.80. In response, the ACCC notes that any application for authorisation will be considered on its merits, according to the net public benefit test.

Length of authorisation

5.81. 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.

5.82. In this instance, the RDAA seeks authorisation for five years. The VHIA submitted that a period of five years is inappropriate as all contracts in Victoria are of three years duration. It also noted that the any period of authorisation should allow for credentialing processes. The VHIA considers that a three year period is appropriate.

5.83. 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 grants authorisation to the proposed collective bargaining arrangement for five years until 30 June 2013.

6. Determination

The application

6.1. On 7 December 2007 the Rural Doctors Association of Australia Limited (RDAA) lodged application for authorisation A91078 with the Australian Competition and Consumer Commission (the ACCC).

6.2. Application A91078 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, of substantially lessening competition within the meaning of section 45 of the Act.

6.3. In particular, the RDAA and its constituent state associations seek authorisation to collectively negotiate with state/territory health departments the terms of contracts for general practitioner and rural generalist visiting medical officers (VMOs) in rural areas, particularly with respect to payments for services provided to public patients and for on-call services, to apply state-wide. The RDAA does not propose to negotiate on behalf of other medical specialists.

The net public benefit test

6.4. For the reasons outlined in Chapter 5 of this determination, the ACCC considers that in all the circumstances the arrangement for which authorisation is sought is 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.

6.5. The ACCC therefore **grants** authorisation to application A91078.

Conduct for which the ACCC grants authorisation

6.6. The ACCC grants authorisation until 30 June 2013 to the RDAA and its constituent state associations to collectively negotiate with state/territory health departments the terms of contracts for VMOs in rural areas, particularly with respect to payments for services provided to public patients and for on-call services, to apply state-wide. Authorisation is limited to RDAA members who are rural generalists and general practitioners.

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

6.8. This determination is made on 14 May 2008.

Conduct not proposed to be authorised

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

Date authorisation comes into effect

6.10. If no application for review of the determination is made to the Australian Competition Tribunal, it will come into force on 5 June 2008.