FILE No:
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22 JAN 2008

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Ms Isabelle Arnaud
Director, Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
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By fax (02) 6243 1199

Dear Ms Arnaud

Application for authorisation lodged by the Rural Doctors Association of Australia Limited - interested party consultation

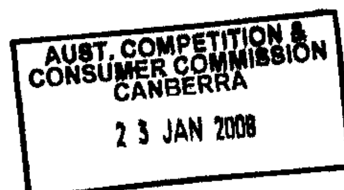
I refer to your letter of 17 December 2007 inviting the Department of Human Services (**DHS**) to make a submission on the application for authorisation lodged by the Rural Doctors Association of Australia Limited (**RDAA**). The authorisation application (**Application**) is to allow the RDAA and its constituent State associations to collectively negotiate, with State and Territory health departments, a set of standard terms of engagement for visiting medical officers (**VMOs**) in rural areas. This would include agreeing payments for services provided to public patients and for on-call services, but would not cover services provided by medical specialists.

For the reasons set out in this submission, DHS considers that the proposed conduct would not result, or would not be likely to result, in a benefit to the public that would outweigh the anti-competitive detriments to the public. DHS therefore submits that the Application should be declined by the Australian Competition & Consumer Commission (**ACCC**).

The Application

The Application is to allow State based agreements setting terms and conditions for contracting of VMOs (excluding medical specialists). The RDAA claims that this:

> '...will build on processes already in place in most States where the State health department unilaterally determines the arrangements for the contracting of doctors in state hospitals and facilities' (p.2 Application).



In the State of Victoria, DHS has no direct involvement with setting contractual terms for VMOs, as this role has been devolved to individual hospitals. DHS is of the view that this devolved approach allows for a greater degree of flexibility and ultimately provides more efficient outcomes for Victoria than the centralised imposition of uniform terms across the State. In particular contracting at the hospital level allows:

- individual hospitals and VMOs to agree terms that reflect supply and demand conditions in that geographic area; and
- promotes a better level of understanding and cooperation between hospital administrators and VMOs.
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DHS is concerned that the Application does not provide any real analysis of the Victorian market, merely categorising each rural Victorian hospital as a 'monopsonistic purchaser' identical to other State's Health Departments. To this extent, the Application is clearly deficient and does not provide any basis for the ACCC to be satisfied that, in Victoria, any benefit to the public stemming from the proposed arrangements will outweigh public detriment. Irrespective of this obvious deficiency, this submission focuses upon the claimed public benefits and detriments to the public in the context of the State of Victoria's current arrangements.

Market Definition

Market definition involves consideration of four different dimensions:

- Product market;
- Geographic market;
- Functional market, and
- Temporal market.

In this instance we submit that the most important dimensions of the market are the product and geographic dimensions. The RDAA envisages the relevant markets to be a large number of markets for VMO services within the catchment area of a particular public hospital or health facility 'in rural or remote areas of Australia' (p.4 Application). The RDAA therefore appears to assert a national market for such services, made up of a number of sub-markets constituted by rural public hospitals and their VMO 'catchment' areas. DHS does not agree that this is the correct approach to defining the geographic dimension of the relevant market.

The accepted starting point for market definition is the product and geographic dimensions of the relevant entities. In this instance the Application is not envisaging a standard national VMO engagement agreement, but rather individual State based agreements that will be entered into by the RDAA, the Rural Doctors Associations in each State and State Health Departments, noting:

> 'These agreements are expected to be made on a State by state basis i.e. it is not expected that a national agreement could or would be put in place.' (p.2 Application)

We therefore consider that the key relevant entities are the State based constituent bodies of the RDAA and State/Territory Health departments. Therefore the geographic markets in which they operate, which are State and Territory based, should be the starting point for any competition assessment.

Further, DHS notes that the ACCC must be satisfied using the 'future with and without' approach as to whether the public benefits of the proposed conduct will outweigh the public detriments. That is to say, the ACCC must compare the position that would or would be likely to exist in the future if the authorisation were granted, with the position if the authorisation were not granted. As the current position differs as between States and therefore the 'future with-out' position will differ State by State, we consider the ACCC must approach its review of the 'future with or without' on a State by State basis.

DHS therefore submits that the relevant markets for the purposes of consideration of this Application are:

- The supply of non specialist medical services by private practitioners to public patients in public hospitals (Product market); and
- The supply of these services 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 (Geographic Market).

As noted above, this submission addresses only the competition effects of the Application in the Victorian State market.

Public Benefits

The RDAA claims two areas of public benefit in the Application. These are:

1. State health departments (in other States) and individual hospitals or health services (in Victoria) 'effectively act as monopsonistic purchasers in that they are the only purchaser of hospital based medical services in most rural towns' (p.3 Application). As monopsony is a form of market power, it appears that the RDAA is claiming that a significant inequality of bargaining power between purchasers and suppliers of medical services in rural areas exists and that this has resulted in market failure thereby 'distorting effect of reducing prices for VMO services' (p.5 Application).
2. Improved access to and retention of VMOs due to reduced 'red tape' and transaction costs.

Monopsony Claim

'Monopsony' is where there is a single purchaser of goods or services. It can be contrasted with a 'monopoly', which is where there is a single supplier of goods or services. Monopsony power is derived from a monopsonist's ability (discretion) to reduce demand in order to hold down cost per unit of supply. In theory, one way of mitigating monopsony power is a legal price floor which removes this power over price and eliminates any incentive to restrict the quantity of product purchased. However if the price floor is too high the monopsonist will reduce its purchases, just as competitive buyer would do in response to a price floor and inefficiency would occur..[1]

Attempts to estimate monopsony exploitation in American labour markets suggest that, unless the provider is legally restrained from selling their services elsewhere (such as professional athletes subject to a reserve clause), the estimated rates of monopsonistic exploitation are very low. For example for American teachers and nurses the effect has been shown to be nearly zero.[2] DHS considers that doctors, who have a greater degree of bargaining power, are even less likely to suffer from monopsonistic exploitation.

DHS is of the view that Victorian rural public hospitals do not have monopsony power. As noted above, to have such power the monopsonist must have the discretionary ability to reduce demand in order to depress price. Rural public hospitals, to a greater or lesser degree, suffer from a systemic shortage of supply of VMOs and demand conditions that are largely outside their control. The shortfall of VMO services in rural areas is acknowledged by the RDAA, both in the Application (p. 3) and on its website where it notes:

> 'At least 1000 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush.'[3]

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[1] Monopsony in American labour markets' William M. Boal and Michael R. Ransome

[2] Hirsch Barry T. and Edward Schumacher. 'Monopsony power and relative wages in the labour market for nurses.' Journal of Health Economics 14, no 4 (1995): 443-476.

[3] RDAA 'Rural Health – the facts at a glance'

Clearly where there is an acknowledged shortage of supply there is little scope for individual hospitals to reduce their demand for such services, below what is already a shortfall position, in order to depress price. Further, public hospitals have little discretionary control over their demand for VMO services rather, as public institutions, they are required to provide (non-specialist) medical services to the extent possible, subject primarily to resourcing and budgetary constraints. They therefore lack the degree of discretionary power necessary for them to have monopsony power.

Contrary to the RDAA claim, DHS submits that there is a competitive market for rural VMO services and no significant disparity in bargaining power between public rural hospitals and VMOs. The competitiveness of this market is based upon the difficulty many rural based hospitals have in attracting VMO services and the fact that, for many general practitioners, VMO rights are not essential to their practice. Indeed DHS is aware of some rurally based practitioners who have decided not to offer their services to local hospitals in favour of focussing on their private practices. Conversely, particularly for smaller more remote services, general practitioners who reside within those communities provide an essential core service to the local public hospitals.

In this regard we note that the ACCC has, in recent draft decisions on collective bargaining notifications lodged by the Australian Medical Association on behalf of specialist doctors at the La Trobe and Werribee Mercy public hospitals, concluded that there is not a significant disparity of bargaining power between these hospitals and VMOs. Similarly DHS submits that there is not a significant degree of disparity in bargaining power between Victorian rural public hospitals generally and general practitioners, so as to justify rural doctors being able to collectively negotiate terms and conditions, including price. In all rural areas, but particularly in smaller more remote areas where there are few if any specialists, general practitioners are sought after and have a high degree of bargaining power.

Improved Access/Retention Claim

DHS does not agree that 'the burden of negotiation' and 'red tape' is a significant factor in either attracting or retaining rural based VMOs. Attracting and retaining doctors in regional and rural areas is a major ongoing challenge throughout Australia. Australian research into factors influencing decisions by medical practitioners to reside in rural areas suggests that professional satisfaction is the main reason for doctors staying in or leaving medical practice in rural and regional areas. The key workforce problem is inability to get time away for recreational leave and family considerations and for emergency relief and relief to complete CME programs.[4] [5]

There have been similar findings internationally. A review of job satisfaction, intentions to quit and the retention of GPs in England and Scotland in 2001/2002 concluded that:

- Pressures at work relating to workload, conflict within the general practice, increased demands from patients and out of hours responsibility caused GPs to be dissatisfied with their job and voice an intention of quitting; and
- Policies aimed at creating more flexible working hours, expanding the range of contractual arrangements and employment opportunities, and establishing more realistic expectations of the role of GPs by patients are likely to promote recruitment and retention of GPs.

The fact that many doctors prefer a metropolitan lifestyle and practice is not an issue that will be affected by the RDAA being able to collectively negotiate terms on behalf of rural doctors. Rather, DHS is of the view that flexibility and the ability to tailor contractual arrangements is a

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[4] Mildenhall D, Humphreys J. *Viable Models of Rural and Remote Practice*. Kingston, ACT: Rural Doctors Association of Australia; 2003.

[5] Humphreys John S et. al. Workforce retention in rural and remote Australia: determining the factors that influence length of practice

key factor in attracting and retaining rural VMOs and that this flexibility would be substantially lost under the proposed state based contracting system.
Further, the amount of VMO time involved in settling individual terms is not great. In relation to the recent collective bargaining notification lodged by the Australian Medical Association on behalf of a group of doctors at Werribee Mercy Hospital, the hospital stated that the process was to write to each doctor and invite them to enter into discussions. Negotiations were typically through a few telephone calls and possibly a further letter, with negotiations typically being finalised by a quick 15 minute to 45 minute meeting.[6] DHS submits that this level of negotiation would be typical of rural public hospitals. This amount of 'red tape' is not particularly burdensome and is likely to be no greater than would be required by any collective negotiation process run by the RDAA.

DHS therefore submits that the claimed public benefits are illusory in Victoria as:

- Rural public hospitals do not have monopsony power such that VMO remuneration has been artificially depressed. Rather there is a competitive market and no significant disparity in bargaining power between Victorian rural public hospitals and non-specialist VMOs.
- The 'red tape' and transaction costs of individual negotiation are neither significant or a major factor behind the shortfall of VMOs in rural areas.

Public Detriments

Approximately 60% of the doctors who provide services in regional and rural Australia are general practitioners. The remainder are specialists (26%), hospital non-specialists (7%), specialists in training (3 %) and non-clinicians (4%).[7] These figures do not, however, include specialists who provide services to rural areas, but whose principal place of practice is elsewhere.
General practitioners 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. Even when a hospital has recruited an overseas trained doctor they usually need to be supervised by an Australian registered doctor as a condition of their own registration. This role will almost inevitably be performed by a local general practitioner, which makes them even more central to a hospital's operation.
Competing providers agreeing to price fix is deemed by section 45A *Trade Practices Act 1974* to substantially lessen competition and is strictly prohibited. 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. This is the significant anti competitive effect of the Application being granted and also a major public detriment.

The RDAA notes that:

> '...it is possible that the granting of an authorisation may impact on the costs of labour in rural hospitals as the monopsonistic purchasing arrangements practiced by State Health Departments and Authorities may have had a distorting effect of reducing prices for VMO services.'(p.5 Application)

DHS in response submits that there has been no artificial lowering of VMO service prices and that the prevailing prices for VMO services are competitive. As the Application is intended to allow collective bargaining of terms and conditions including price, it is highly likely that there will be a pricing impact from the proposed conduct and this will be to introduce an artificially high floor price for such services.

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[6] ACCC Draft Objection Notice, 8 November 2007, para. 3.118.

[7] AIHW (Australian Institute of Health and Welfare) 2000, *Medical Labour Force 1998*, AIHW, Canberra.

Currently in Victoria individual hospitals are able to negotiate terms and conditions with individual doctors. Hospitals in desirable areas (that offer lifestyle attractions) typically have a larger pool of VMO suppliers and the terms and conditions they negotiate are able to reflect this. Other hospitals in less desirable rural areas have a smaller pool of providers and the terms and remuneration they offer is likely to be higher in order to attract doctors to the area and to retain their services.

VMO remuneration is generally based upon a negotiated percentage of fees in the Commonwealth Medicare Benefits Schedule (**CMBS**), which acts as an effective floor price for VMO services. Some hospitals use their own fee schedules which are based on a past CMBS, indexed for inflation, and also provide after-hours loadings and/or on-call arrangements in addition to CMBS payments. There are, however, significant differences in CMBS rates paid for the same specialty in different hospitals/health services and for different specialties within the same hospitals/health services. Generally however, VMOs in rural Victoria receive remuneration (including on-call payments and loadings) that is greater than 100% of CMBS.
In addition to fee-for-service payments, as the VMO workforce has become more mobile and less permanent, it has become necessary for hospitals to offer infrastructure support to enable 'easy entry/gracious exit' from practices, as well as a range of other benefits. Hospitals/health services are under increasing pressure to provide such benefits to non- specialist VMOs.
A further benefit of negotiation at the hospital level is that it allows potential productivity gains through changes to staff structure and work practices that may not be achievable at a national level. Locally based negotiation also allows the medical practitioner and hospitals to recognise their mutual dependency and work more cooperatively.

Any State based collectively negotiated agreement is however likely to use CMBS/existing terms and conditions as a starting point. DHS submits 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. It would therefore create a new and increased floor price for services, with doctors likely to expect no less that the terms specified in any such centrally negotiated agreement. In addition such a system lessens the scope for cooperation between a hospital / health service and local doctors. This loss of a mutual cooperative commitment to the provision of health services, developed through localised contract negotiations, can only be detrimental to the level and quality of healthcare provided in rural areas.

While DHS understands that any authorisation that is granted by the ACCC will not require that it enter into such an agreement with the RDAA, the fact that the RDAA can collectively negotiate is likely to create a significant pressure that they in fact do so and DHS may not be able to decline such a request if it is supported by rural VMOs.

DHS therefore submits that centralised arrangements will impede competition and result in a less efficient pricing outcome. A key benefit to current decentralised Victorian bargaining is that individual hospitals can negotiate contracts with individual doctors that reflect both the doctor's circumstances and local supply and demand conditions.

The public detriments that will result from granting the Application are therefore as follows:

- A decrease in competition between VMO providers;
- VMO terms no longer being as reflective of local market conditions;
- an overall increase in price, to a level above competitive pricing;
- rural based public hospitals facing additional budgetary pressures that may compromise the level of service they are able to provide to the community; and
- rural hospitals being faced with the potential to lose, at the same time, all of the non specialist VMO providers, if collective negotiations fail. Hospitals do not face this risk under the current system where VMO agreements are negotiated individually with the Hospital.

Conclusion

DHS is firmly of the view that the public detriments from the Application being granted would substantially outweigh any public benefit and therefore it should be rejected by the ACCC. Please contact me if you wish to discuss these issues further.

Yours sincerely

FRAN THORN
Secretary