

FILE No:
DOC:
MARS/PRISM:



The General Manager
Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
Canberra ACT 2601

AUSTRALIAN MEDICAL
ASSOCIATION
ABN 37 008 426 793

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42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

5 Sept 2012

Dear Sir or Madam:

RE: Application for authorisation

Please find enclosed an application for authorisation by the Australian Medical Association for an agreement affecting competition, made under Part VII, Division 1 of the *Competition and Consumer Act 2010* (Cth).

Please find enclosed also a cheque in the amount of \$7,500.00 being lodgment fee for the above application.

If you have any queries regarding the application, please contact John Alati, Senior Industrial and Legal Advisor on (02) 6270 5473 or jalati@ama.com.au.

Sincerely,

A handwritten signature in black ink, appearing to read 'Francis Sullivan', with a long horizontal stroke extending to the right.

Francis Sullivan
Secretary General

Encl:
Application for authorization
Lodgment fee by cheque

AUST. COMPETITION &
CONSUMER COMMISSION
CANBERRA

11 SEP 2012

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**Application to the
Australian Competition and
Consumer Commission
on behalf of general practitioners
who are AMA members for the
authorisation of certain intra-
practice price-setting and collective
bargaining arrangements**

List of abbreviations

ACCC	The Australian Competition And Consumer Commission
ACT	Australian Capital Territory
AMA	Austalian Medical Association Limited ABN 37 008 426 793
GP	General Practitioner, registered by the Medical Board of Australia pursuant to the <i>Health Practitioner National Law</i> and its State and Territory equivalents.
LHN	Local Hospital Network
MBS	The Medicare Benefits Schedule
Medicare	Medicare Australia
NSW	New South Wales
The Act	The <i>Competition and Consumer Act 2010</i> (Cth)
VMOs	Visiting Medical Officers

References:

- Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007.
- Authorisation A91088 Australian Medical Association (NSW) Limited in respect of collective negotiations with NSW Health and public health organizations on the terms and conditions (including but not limited to remuneration) of visiting medical officer contracts in the New South Wales public hospital system, 13 August 2008.
- Authorisation A91100, Australian Medical Association Limited in respect of collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas, 10 December 2008.
- Notification no. CB00004, Objection notice in respect of a collective bargaining notification lodged by Australian Medical Association (Vic) Pty Ltd on behalf of a group of doctors at Latrobe Regional Hospital, 19 December 2007.

- Draft Determination, Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 20 June 2002.
- Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 19 December 2002.



Form B

Commonwealth of Australia

Competition and Consumer Act 2010 — subsections 88 (1A) and (1)

AGREEMENTS AFFECTING COMPETITION OR INCORPORATING RELATED CARTEL PROVISIONS: APPLICATION FOR AUTHORISATION

To the Australian Competition and Consumer Commission:

Application is hereby made under subsection(s) 88 (1A)/88 (1) of the *Competition and Consumer Act 2010* for an authorisation:

- to make a contract or arrangement, or arrive at an understanding, a provision of which would be, or might be, a cartel provision within the meaning of Division 1 of Part IV of that Act (other than a provision which would also be, or might also be, an exclusionary provision within the meaning of section 45 of that Act).
- to give effect to a provision of a contract, arrangement or understanding that is, or may be, a cartel provision within the meaning of Division 1 of Part IV of that Act (other than a provision which is also, or may also be, an exclusionary provision within the meaning of section 45 of that Act).
- to make a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would or might have the effect, of substantially lessening competition within the meaning of section 45 of that Act.
- to give effect to a provision of a contract, arrangement or understanding which provision has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of that Act.

(Strike out whichever is not applicable)

PLEASE FOLLOW DIRECTIONS ON BACK OF THIS FORM

1. Applicant

- (a) Name of Applicant:
(Refer to direction 2)

A91334 Austalian Medical Association Limited ABN 37 008 426 793

- (b) Short description of business carried on by applicant:
(Refer to direction 3)

The AMA is the peak health advocacy organisation in Australia, representing more than 27,000 medical practitioners across Australia. The AMA membership includes doctors employed in the public sector as well as private practice. The AMA membership also encompasses a range of craft and special interest groups including salaried doctors, general practitioners, other

specialists, academics, researchers and doctors-in-training. Membership encompasses rural, regional and metropolitan practitioners. Medical students are also eligible for membership.

The AMA is a national body with affiliated organisations in each State and Territory. When doctors join the relevant State or territory organisation, they are granted membership of the Federal AMA. The AMA's aims and objectives are to:

- promote and advance ethical behaviour by the medical profession and protect the integrity and independence of the doctor - patient relationship;
- promote and advance the public health;
- protect the academic, professional and economic independence and the well being of medical practitioners; and
- preserve and protect the political, legal and industrial interests of medical practitioners.

The AMA achieves these aims by:

- fostering and sustaining consultation, co-operation and communication within the medical profession;
- acting as the principal co-ordinating and lobbying body for the medical profession;
- fostering unity amongst medical practitioners by providing a forum for their opinions;
- promoting the achievement and maintenance of high clinical and ethical standards in medical practice; and
- fostering communication between the medical profession and the community.

The AMA has a strong history of patient advocacy and is well known for its advocacy on behalf of disadvantaged groups, such as Indigenous Australians and has a public health care agenda which is constantly being researched and revised in order for the organization to advocate for optimum health care outcomes.

- (c) Address in Australia for service of documents on the applicant:
42 Macquarie Street BARTON ACT 2600
Postal:
PO Box 6090 KINGSTON ACT 2604

2. Contract, arrangement or understanding

- (a) Description of the contract, arrangement or understanding, whether proposed or actual, for which authorisation is sought:
(Refer to direction 4)
- The AMA is seeking Authorisation for members of the AMA who are General Practitioners, including locums, to engage in conduct which might otherwise have the effect of substantially lessening competition within the meaning of section 45 or otherwise contravene Division 1 of Part IV of the *Competition and Consumer Act*¹. The Authorisation is sought for AMA members who operate in medical practices which operate within one of the following structures:

¹ 2010 (Cth)

- A partnership of two or more practitioners where not all partners are natural persons, that is, where at least one is a body corporate or other separate entity.
- An associateship of two or more GPs operating as a team which shares patient records, common facilities, a common trading name and common policies and procedures.
- Any structure with more than one general practitioner operating in a location where the general practitioners operate as separate entities.
- Any of the above which, from time to time, employs GPs on a locum basis.

The AMA seeks authorisation for general practitioners who are AMA members operating in the above structures within a single practice to engage in:

- Intra-practice price setting, which would allow AMA members in a single practice to control, set and maintain fees within that practice, and agree on the fees that any locums they engage either individually or jointly will charge patients for services within their practices
- Collective bargaining in relation to their engagement as Visiting Medical Officers, which would allow Member GPs within a single practice operating within the above business structures to be able to discuss and agree on the fees that they charge as VMOs to a public hospital (hospital agreements).
- Collective bargaining with Medicare Locals in relation to their engagement to provide services to Medicare Locals, which would allow member GPs within a single practice operating within the above business structures to negotiate and agree collectively with Medicare Locals regarding fees that they may charge for the provision medical services organised or coordinated by Medicare Locals including the provision of out of hours medical services.

Importantly, authorisation is only sought for price setting and collective bargaining as between the members of a single practice (organised in one of the structures specified) or locums supplying services to that practice.

Voluntary nature of the arrangement

Any arrangements will be voluntary. No individual GP or group of GPs, or Medicare Local would be bound by the authorisation to take part in collective bargaining arrangements.

Likewise, hospitals will remain free to choose whether or not to enter into collective negotiations with groups of GPs that fall within the scope of the authorisation and GP groups may choose not to negotiate collectively. Individual GPs may choose not to take part in

collective negotiations. The voluntary nature of collective bargaining arrangements was discussed in a previous Authorisation² with the ACCC noting:

‘...given the voluntary nature of the proposed arrangement, a collectively negotiated agreement will only be reached if it is mutually beneficial to both state/territory health departments and AMA members.’³

As with any contract, groups of GPs cannot force hospitals, and there is no intention to seek to compel any counterparties, to enter into collective negotiations with GPs. It is an arrangement which may work in some instances, or may not in others. For the avoidance of doubt, there is no intention that GPs would be authorised to engage in collective boycotts of public hospitals or Medicare Locals.

The ACCC has previously noted the importance of voluntary arrangements, stating:

‘The ACCC will be less concerned with a collective bargaining proposal where the target has a real choice whether to deal with such groups or not.’⁴

The AMA submits that the proposed arrangements will be genuinely voluntary. Medicare Locals will be free to contract with groups of GPs under the proposed arrangement, and in fact various groups of GPs will be able to compete with each other on a practice by practice basis, or individual basis. Again for the avoidance of doubt, no pressure will be placed, directly or indirectly, on GPs to participate in any collective arrangement.

The AMA does acknowledge that in some rural and regional markets there may only be a limited number of suppliers of the relevant services and, in these circumstances, public hospitals and Medicare Locals may have less choice about whether they wish to negotiate on a collective basis.

Coverage issues

- The application does not propose any geographical boundaries, such as those contained in the Rural Doctors’ Application which proposed ‘services within defined local geographic areas that relate to public hospitals and health facilities in rural and remote areas of Australia.’⁵
- The application covers AMA members within single practices only, and does not contemplate more than one practice collaborating to set fees or negotiate with public hospitals or Medicare Locals. To the extent that a practice is comprised of both AMA

² Authorisation A91100, Australian Medical Association Limited in respect of collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas, 10 December 2008.

³ Ibid, par 6.55.

⁴ Authorisation A91088 Australian Medical Association (NSW) Limited in respect of collective negotiations with NSW Health and public health organizations on the terms and conditions (including but not limited to remuneration) of visiting medical officer contracts in the New South Wales public hospital system, 13 August 2008 par 5.26 p 13.

⁵ Rural Doctors Association of Australia Limited (RDAA) application, 5 December 2007.

members and non-members, any authorisation would not extend to price setting or collective bargaining as between those AMA members and non-members.

Boycott activity

In addition to the statements about the voluntary nature of the arrangements above, it must be emphasised that the present application is not intended to restrict the supply such services to any party. If GPs were to agree to restrict or limit the supply of their services in any way, this would be likely to constitute collective boycott. Collective boycotts are prohibited by the *Competition and Consumer Act*.⁶

The AMA does not seek authorisation for collective boycott activity. Accordingly any collective agreement by GPs in one practice, operating in the relevant business structures, not to supply their services to a public hospital or Medicare Local would not be protected by the authorisation. In light of this, the AMA considers that the proposed authorization is unlikely to adversely affect the supply of VMO services or services to Medicare Locals.

Further, the AMA submits that any concerns about adverse affects on the supply of VMOs would be unfounded as no reduction restriction of supply is contemplated. The ACCC has previously noted:

‘... Accordingly any collective agreement by GPs in one practice, operating in the relevant business structures, not to supply their services ... to a public hospital would not be protected from legal action under the Act. In light of the above, the ACCC considers that the proposed arrangements are unlikely to adversely affect the supply of VMO services, including specialty services, by GPs to public hospitals.’⁷

Where not all members of a practice are AMA members

As noted, the application seeks coverage for AMA members only. The AMA serves the interests of its members and seeks to ensure that those interests are advocated for in a range of medical, legal and political forums.

The AMA acknowledges that there may arise situations where not all doctors working in a practice are AMA members, which leaves a potentially anomalous situation where a group of GPs within a practice may seek to collectively set prices or negotiate with a hospital or Medicare Local.

The AMA also acknowledges that the risk of inadvertent contraventions of Part IV of the *Competition and Consumer Act 2010* in such circumstances will need to be carefully managed and that it will be important for both AMA members and non-members to fully understand the types of conduct that are authorized and the types that are not. It will be particularly important to ensure that AMA members understand the authorization would not extend to the inclusion of non-member colleagues in discussions about price or disseminating pricing information to non-member colleagues.

⁶ *Competition and Consumer Act 2010* (Cth), ss 4D, 45D.

⁷ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p45 par 6.104.

In those situations the AMA would advocate for a co-operative problem solving approach, which may involve all doctors in that practice not taking part in collective arrangements. However, the AMA would encourage doctors to act on the terms of the authorization if granted. The AMA intends to provide its members with guidance in relation to what conduct is, and is not, covered by the authorization and in particular in relation to the risks associated with practices comprising both AMA members and non-members.

As an example, if a practice consisted of four GPs, and three of them are AMA members, one is not. Under the terms of the authorization, if the doctors in that practice sought to collectively set fees, the three who are AMA members may negotiate and agree on fees. The one who is not cannot take part in those negotiations. Practically speaking, the one non-AMA member is competing with the collective group of AMA members.

If the same group sought to collectively negotiate with a hospital or Medicare Local, again the three AMA members would be able to do so collectively, the non-AMA member would not be able to.

- (b) Description of those provisions of the contract, arrangement or understanding described at 2 (a) that are, or would or might be, cartel provisions, or that do, or would or might, have the effect of substantially lessening competition:
(Refer to direction 4)

Intra-practice price setting as described in 2(a) above.

Collective bargaining with hospitals as described in 2(a) above.

Collective bargaining with Medicare Locals as described in 2(a) above.

Provisions in any of the above arrangements in relation to price, or other terms and conditions, including but not limited to provisions relating to rostering and on-call arrangements.

- (c) Description of the goods or services to which the contract, arrangement or understanding (whether proposed or actual) relate:

The goods or services relate to the provision of all services available in General Practice, and those services provided by GPs to hospitals and Medicare Locals, including, but not limited to, consultations, emergency services, surgery, obstetrics, anaesthetics, provision of reports and opinions, supply and transfer of medical records, by GPs, Locums, and GPs acting as VMOs in hospitals and GPs providing services to Medicare Locals.

- (d) The term for which authorisation of the contract, arrangement or understanding (whether proposed or actual) is being sought and grounds supporting this period of authorisation:

The AMA draws the ACCC's attention to Authorisation no. A91024⁸ in relation to intra-practice price setting, which was granted for four (4) years.

The AMA also draws the ACCC's attention to Authorisation no. A91100⁹ in relation to collective negotiations for VMOs, which was granted for five (5) years.

The AMA respectfully submits that a period of five (5) years would be appropriate in this context.

3. Parties to the proposed arrangement

- (a) Names, addresses and descriptions of business carried on by other parties or proposed parties to the contract or proposed contract, arrangement or understanding:

GPs and locums who are AMA members, public hospitals which contract with GPs who are the subject of the application for Visiting Medical Officer services, and Medicare Locals which use the services of GPs who are the subject of the application.

- (b) Names, addresses and descriptions of business carried on by parties and other persons on whose behalf this application is made:

(Refer to direction 5)

All current and future general practitioners who are AMA members referred to in 2(b) above.

The business carried on by the parties to the application is General Practice services in general practices, hospitals and Medicare Locals.

4. Public benefit claims

- (a) Arguments in support of authorisation:

(Refer to direction 6)

The AMA seeks the authorisation on the grounds that the public benefit will outweigh public detriment. The AMA acknowledges that the ACCC may only grant authorisation if it is satisfied that, in all the circumstances, the proposed

⁸ Authorisation in relation to an application by the Royal College of General Practitioners in respect of intra-practice price setting.

⁹ Authorisation in relation to collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas.

authorisation is likely to result in a public benefit that will outweigh any public detriment.¹⁰

Intra-practice price- setting:

This section of the application seeks authorization for the relevant GPs to:

- Control, set and maintain fees within their practice, otherwise known as ‘intra-practice price setting’
- Agree on the fees that any locums engaged in their practices may charge their patients.

The AMA submits that the proposed arrangements are likely to generate significant public benefits which will outweigh any limited public detriments. The anticipated benefits include:

- A team approach to increase morale and the culture of safety of general practices
- continuity and consistency of patient care
- reducing the stress of uncertainty which may be present in general practices
- delivering a range of efficiencies and related benefits to doctors and health consumers, including allowing for efficient use of locums.

(b) Facts and evidence relied upon in support of these claims:

Team approach

The ACCC has acknowledged the importance of the team approach in the context of intra-practice price setting, stating:

‘...the ACCC considers that GPs operating in the relevant business structures are likely to benefit ... by being able to discuss all aspects of general practice in a team-based environment.’¹¹

Private practice is still the mainstay of General Practice in Australia, and it is submitted that a majority of health consumers rely on the presence of private practices to address their primary health care needs. It is vital to maintain the viability of those practices.

The AMA considers that the ability of GPs and locums to agree on the prices they charge for their services within a practice location is consistent with the general team approach already adopted by most practices and the collegiality which is characteristic of medical practice in Australia.

The AMA acknowledges that while GPs the subject of the application operate as independent legal entities, in practice they act as one unit sharing patient records, common facilities, a

¹⁰ *Competition and Consumer Act 2010* (Cth) s90(6)

¹¹ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p35.

common trading name, and common policies and procedures. Agreeing on their price structures is consistent with a collegial, stable approach to practice and patient expectations.

A culture of transparency and good teamwork in health care has a range of positive effects, including fewer delays, increased morale, job satisfaction and efficiency, and a benefit in information exchange and identifying and addressing errors. The effects translate into an overall better service being available to patients. In Authorisation A91024 the ACCC noted in relation to team based structures:

‘The ACCC accepts that there are benefits to GPs and consumers (including error management and reduction) from an open, team-based structure in general practice. The ACCC considers that most of these benefits would already be generated by the team structures and policies adopted by the relevant GPs, without authorisation. However, the ACCC accepts that there is some benefit from the proposed arrangement as fee setting will not risk undermining the team approach of the practice’.¹²

The AMA considers that GPs are likely to benefit by being able to discuss all aspects of general practice, in a team-based environment, including with locums, and this will have a flow-on benefit to their patients, such as improved safety and outcomes. In Draft Determination, Authorisation 90795 the ACCC stated:

‘The Commission accepts that a team approach to the provision of health care is likely to improve patient health outcomes.’¹³

A culture of open communication is in the interests of patient safety and removes the concern that doing so may lead practitioners to inadvertently transgress competition legislation.

Continuity and consistency of patient care

The AMA notes that doctors practising within a single legal entity can agree on fees charged without breaching competition law. The AMA submits that members of the public have little or no concern for what business structures or entities exist behind the General Practice setting. Few if any medical consumers would be interested in knowing this.

The AMA considers that consumers will experience some benefit from consistent, predictable pricing among GPs operating within one practice. The ACCC previously noted:

‘The ACCC considers that consumers may experience some benefit from consistent, predictable pricing among GPs operating within one practice.’¹⁴

And further:

¹² Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p36 par 6.39.

¹³ Draft Determination, Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 20 June 2002, Commission Evaluation, p31.

¹⁴ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p 38 par 6.54.

‘The ACCC considers that consistent pricing for GPs services in the one practice may enable those consumers who are price sensitive to continue their care within the one practice, in the event their regular doctor is not available.’¹⁵

Whilst those GPs operate in separate legal entities, they work as a team, sharing patient records, common facilities, a common trading name and common policies and procedures. Generally, to consumers they appear to be ‘a practice’ with little or no concern as to the legal entities behind the practice. Consistency of fees within a practice gives reassurance and security to patients, relieves the burden of making decisions based on cost structures and is consistent with the expectations of members of the public. Consumers generally look to build a long-term relationship with their doctor on the understanding that past medical history is a very significant factor in ongoing medical treatment and for many an intensely personal, sometimes painful, record.

Practitioners will still be encouraged to make their fee structures clear to patients. The ACCC has noted the importance of this. In Draft Determination, Authorisation 90795¹⁶, the ACCC noted:

‘The Commission considers that medical practitioners have an ethical duty to inform their patients about the cost of the services before they acquire them.’

Indeed, the Medical Board of Australia’s *Good Medical Practice: A Code of Conduct for Doctors in Australia* obliges doctors to do this.¹⁷ This is facilitated and simplified by consistent fee structures.

Patients generally prefer to see another doctor in the same practice if their regular doctor is unavailable, rather than attend another practice, and any bar to a common fee structure could create a situation where attending on a particular day may mean different prices are in place due to different practitioners being on duty. Patients are unlikely in such situations to pay much regard to the complex legal reasoning behind the situation.

Commonality of structures in place within general practices enables the patient to be treated by another GP at the same rate. This provides the patient with continuity of care. The AMA submits that this approach is consistent with better patient outcomes and satisfaction.

The AMA submits that there is a clear public benefit in patients being able to have certainty, clarity and predictability around the price of seeking healthcare.

These arrangements would also facilitate flexible working hours for GPs, as they will be able to take reasonable leave knowing that their patients can receive continuity of care and responsive, consistent service. This will enhance the efficient use of locums when required,

¹⁵ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra- practice price setting arrangements and hospital agreements, 23 May 2007, p38 par 6.55.

¹⁶ Draft Determination, Authorisation 90795¹⁶, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 20 June 2002, p30.

¹⁷ Clause 3.5. The Code is issued under s 39 of the Health Practitioner Regulation National Law Act 2009 (the National Law).

and allow locums the certainty of knowing what fees they may charge, and what their earnings are likely to be.

The proposed authorisation contemplates allowing locums employed by the relevant practices to agree to their fees set in the same context as the doctors who employ them. The ACCC has previously commented on this situation:

‘...when GPs in the specified structures agree on the fee they will charge, they are also agreeing that this will be the fee that locums or independent contractors will charge. Locums as employees or independent contractors of the practice provide services on behalf of the entity that engages them and therefore can be directed by the entity on what fees to charge for their services.’¹⁸

The AMA submits that this situation remains unchanged since the time that statement was made, and that the ability to employ locums is an important part of the general practice structure. It allows doctors to fill vacancies when they are ill or on leave or to increase service delivery when needed. The use of locums also has flow-on benefits to patients by facilitating continuity of care even in circumstances where their regular doctor is not available.

Effectively, patients should see the practice as an entity, not individual doctors as privateers, seeking to undercut each other. It is clearly in the best interests of medical consumers to provide predictable, consistent billing arrangements within a general practice. In this context, it is important that fees are consistent within practices to ensure that patients who may see a different GP do not experience arbitrary changes in fee.

Reducing the stress of uncertainty for GPs

The AMA submits that the proposed collective arrangements are likely to benefit GPs by reducing the stress of uncertainty in general practice. General practice is a stressful context in which to work. Demanding patients, difficult situations, concerns over patient care, long hours, few opportunities for meaningful leave, fear of litigation and administrative burdens all characterize life as a GP. Work life balance is difficult to achieve under these circumstances. The capacity to employ locums on clear, predictable terms could alleviate these problems to a significant extent, thereby also diminishing the potential adverse affects upon patient care that may arise as a result of such stresses and uncertainties.

In a recent article by Shrestha and Joyce published as part of the MABEL (Medicine in Australia: Balancing Employment and Life) study, it was noted:

‘Difficulty in taking time off when wanted and having to work unpredictable hours (both reflecting poor control over work hours and work-time inflexibility) were significantly associated with poor WLB [work life balance] of GPs.’¹⁹

The same article noted:

¹⁸ Ibid, p 36.

¹⁹ Shrestha D, Joyce C. Aspects of work-life balance of Australian GPs: Determinants and possible consequences. *Australian Journal of Primary Health*. 17:40-47, p44.

‘If half of the GPs who reported poor WLB reduced their work hours, a considerably large amount of full-time equivalent GPs would be lost. This could result in adding more workload and inflexibility to the remaining workforce ... Thus a self-perpetuating circle of inflexibility and shortage may result. It is highly advisable therefore to improve the work-time flexibility of GPs ...’²⁰

The AMA believes that the proposed authorisation would provide an unequivocal ruling that provides certainty to GPs to work collaboratively and the extent to which they can discuss fees without falling foul of the *Competition and Consumer Act*²¹.

The AMA submits that the proposed authorization would reduce the number of commercial and other disputes in practices, with partners and associates able to clearly determine costs and profit sharing arrangements. The concept of an associateship is currently without legal definition in Australia, although the ACCC has previously defined associateship as:

‘A group of GPs who co-locate to share facilities, equipment and staff while maintaining their own status as independent businesses. The level of integration within an associateship may vary considerably. Some associateships may simply share rent and staffing costs while running relatively independent practices while other associateships may be highly integrated commercial and medical entities.’²²

It is clear that an associateship involves a contractual business relationship between associates, bound up in a variety of professional and legal obligations. The concept of a company²³, a trust²⁴ and a partnership²⁵ are all more easily defined legally, although no less fraught with challenges.

Where partners or associates are forced to compete with each other, this presents a situation clearly at odds with the normal legal notion of a ‘partnership’, or the broader definition of an ‘associateship’. Smooth running practices without internal disputes are better for the public image of the profession, promote stability and trust in patients, and lead to lower turnover of practitioners within a practice. They are also less likely to incur the costs of litigation and other dispute management requirements.

Further, the partnership model itself is supported by the proposed authorisation in that the ability to agree on prices is consistent with the general concept of a partnership. The ACCC has stated its support for the partnership model as ‘the most efficient business structure available’.²⁶ The AMA supports this and submits that a solid partnership model is beneficial for doctors and their patients.

²⁰ Ibid, p 46.

²¹ *Competition and Consumer Act 2010* (Cth).

²² Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 19 December 2002.

²³ *Corporations Act 2001* (Cth), s9.

²⁴ See for example *Trustee Act 1925* (NSW).

²⁵ See for example *Partnership Act 1892* (NSW) s1.

²⁶ Draft Determination, Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 20 June 2002, p35.

The authorisation may assist doctors to choose the business structure that best suit their needs. This is likely to provide long term benefits, as the issue of which business structure to engage is often a difficult one to address for those seeking to enter into practice, particularly those new to private practice. It is likely to lead to a commitment from doctors to enter into long term arrangements to practice, bringing benefits to their communities.

Efficiencies

The AMA submits that GPs operating in relevant business structures are likely to experience efficiency savings in administrative functions from agreeing on one price structure, as opposed to pricing their services individually.

The proposed authorization will result in several efficiencies, including reduced transaction time and costs in relation to day-to-day general practice and will allow for an expedient, viable process for the employment of locums to take the pressure off general practitioners when they require assistance at the clinical level.

Further, the costs of running a general practice, both fixed and variable, are more easily controlled and can be shared equally where price structures, and therefore turnover, are predictable and consistent and can be shared equally. The ACCC has referred to this, albeit with limited benefit, in Draft Determination, Authorisation 90795, noting:

‘The Commission accepts that there are efficiency gains from individual GPs sharing costs like rent, a reception, and the maintenance of medical records.’²⁷

Such efficiency gains may result in lower overheads to practices, and therefore lower costs to patients.

Counterfactual – Intra-practice price setting

If intra-practice price setting is not authorized, it is likely to add a great deal of stress to the current GP cohort. Uncertainty over the extent to which they can discuss and agree on their fee structures is likely to increase stress and decrease efficiency. Stress, uncertainty and decreased efficiency within the profession are also likely to affect the overall quality of care patients receive, for example, by reducing GP retention rates and continuity of care.

Different fee structures are likely to create barriers to patient care for those patients who are marginalised. The ACCC has acknowledged this factor in a previous decision on intra-practice price setting, particularly in relation to the underprivileged, the elderly and frail, rural residents, people from culturally and linguistically diverse communities, Indigenous Australians and those with disabilities.²⁸

Uncertainty and embarrassment would be likely to ensue, as consumers grapple with decisions based on cost and balance their health needs with cost in an environment not

²⁷ Draft Determination, Authorisation 90795, The Royal Australian College of General Practitioners, In relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees, 20 June 2002, p33.

²⁸ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p36.

usually given to such processes. This may have the greatest effect on patients who are marginalized, disadvantaged or who have complex needs.

Collective bargaining with hospitals

This part of the application seeks authorization to allow the GPs the subject of the application to:

- Negotiate and agree collectively on the fees that they may charge as Visiting Medical Officers to public hospitals. This applies only to members within a single practice, who would negotiate collectively with hospitals on the terms of their engagement as VMOs.

Structures already in place

Some jurisdictions already have structured negotiation processes for VMOs. The AMA submits that these would not be displaced by the proposed authorisation. Rather, the proposed authorisation would fill any gaps which may arise where members are not subject to existing negotiation arrangements.

Agreements are expected to be made on a state by state basis. Due to the jurisdictional characteristics of the hospital system, it is not expected that a national agreement could or would be put in place. The agreements will build on the 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.

The ACCC has acknowledged that:

‘...with or without the proposed collective arrangements GP VMOs will continue to be individually appointed by public hospitals... the terms and conditions of individual VMO appointments differ depending on the skill mix of the practitioner ...in most states/territories (excluding Victoria) VMO contracts contain standard terms and conditions which are set at the state level by the relevant departments of health.’²⁹

The AMA acknowledges this view and would add that the capacity for individuals to enter into particular arrangements where possible and appropriate would not be affected by the proposed authorization.

By way of background, the AMA understands that the current systems already in place are as follows:

New South Wales

The AMA notes that in NSW, particular statutory arrangements are in place, which the proposed authorization would not displace. Section 88 of the *Health Services Act* ³⁰ mandates the use of standard service contracts where they are in place:

²⁹ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p48 par 6.121.

³⁰ 1997 (NSW)

(1) A service contract of a class for which there is a standard service contract must not be entered into unless it contains the set of conditions contained in the relevant standard service contract.

(2) A service contract entered into in contravention of this section is void.

The AMA understands that in NSW standard terms and conditions for fee-for-service and sessional service contracts are established by NSW Health and are applicable to all VMOs appointed on this basis, per the above section.³¹ Hence it would appear that where standard contracts are available, NSW public hospitals are compelled to appoint VMOs on the terms and conditions contained therein, regardless of collective arrangements.

The AMA understands that VMOs may have a choice to be remunerated on a sessional or fee-for-service, or other rate, depending upon the hospital/s at which they are contracted to provide services.

The AMA notes that Authorisation A91088 authorises The Australian Medical Association (NSW) to collectively negotiate with:

- NSW Health the terms and conditions (including but not limited to remuneration) of visiting medical officer (VMO) contracts in the New South Wales public hospital system
- public health organisations (PHOs) in New South Wales on issues relevant to the engagement of VMOs by PHOs but excluding standard VMO contract terms and conditions and rates of remuneration until 31 December 2013.

ACT

In the ACT, VMOs contracted by ACT Health are subject to a standard form agreement³² which is negotiated on a regular basis and used when 50 or more AMA members agree to it.

Queensland

In Queensland, VMOs are employed under contract³³ and are subject to an agreement known as the *Terms and Conditions of Employment, Queensland Government Visiting Medical Officers 2011* (2011 VMO Agreement).³⁴ This agreement contains terms and conditions on remuneration. AMAQ does not participate in the process of establishing conditions for VMOs engaged as independent contractors, nor has it had involvement with drafting the pro-forma VMO independent contractor agreement. Such arrangements are set by Queensland Health.

Victoria

In Victoria, the Department of Human Services has no direct involvement in setting contractual terms for VMOs as this role has been devolved to individual hospitals.

³¹ The NSW Health Policy Directive, Visiting Medical Officer (VMO) Model Service Contracts Document Number PD2009_052 and model contract can be accessed at:
http://www.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_052.pdf

³² Available at: <http://health.act.gov.au/professionals/medical/vmo-contracts-information>

³³ Available at: <http://www.health.qld.gov.au/vmo/docs/er0506.pdf>

³⁴ Available at: http://www.health.qld.gov.au/vmo/docs/vmo_agreement.pdf

GPs have flexibility in negotiating at the local level on the terms and conditions of VMO contracts. The proposed collective arrangements are not likely to significantly alter this position, so differences and inefficiencies are likely to already exist. This situation can only improve with collective bargaining arrangements.

Western Australia

The arrangement would apply to Visiting Medical Practitioner (VMP) arrangements where GPs and other specialists who are accredited and contracted to provide services to public patients on a fee for service basis.

Traditionally AMAWA negotiated Visiting Medical Practitioner (VMP) contracts. AMAWA has lobbied extensively over VMP contract and indemnity issues and related legislation. AMAWA surveys members regularly on the issue of VMP services and lobbies Government.

In addition AMAWA has made annual submissions and lobbied the WA State Government on adjustments and appropriate indexation to the State Government's Fees Schedule it uses to pay VMPs. The WA State Government has generally accepted these submissions.

AMA Western Australia has reported that the State Government has essentially established template independent contractor Medical Services Agreement with uniform terms and payments based on a uniform WA Public Hospitals Fees schedule. This is subject to Rural loadings according to how WA Country Health Service rates the locality.

The AMA understands that the scope for negotiation by the individual or small groups such as GP groups is very limited in this context.

South Australia

The AMA understands that most VMOs are engaged under the SA Health Visiting Medical Specialists Enterprise Agreement 2009.³⁵

Tasmania

In Tasmania VMOs are employed under *Tasmanian Visiting Medical Practitioners (Public Sector) Agreement 2002* and the *Rural Medical Practitioners (Public Sector) Agreement 2003*.

Potential impact of the proposed authorization upon these arrangements

The ACCC has previously noted that in jurisdictions where GPs have a greater ability to negotiate at the local level on the terms and conditions of VMO contracts:

‘it is likely that inconsistent terms and conditions already exist. The proposed collective arrangements are not likely to alter this position. Therefore, any inefficiencies associated with inconsistent terms and conditions in VMO contracts in

³⁵ Available at: <http://www.industrialcourt.sa.gov.au/index.cfm?objectid=8605E1D0-E7F2-2F96-30BB2AA550F5AD71>

those states is not likely to be a detriment arising from the collective arrangements the subject of this application.³⁶

The AMA supports this view and adds that in practical terms most GP VMOs are likely to enter into existing arrangements, however the capacity to negotiate collectively to alter those contracts and agreements where appropriate would be of benefit to them.

It is difficult to assess the extent to which previous authorizations for negotiations have been utilised, but anecdotal accounts suggest that rural and regional doctors tend to negotiate more at the local level than metropolitan doctors. This supports the view that an option to negotiate on a practice by practice basis is likely to assist in the retention of rural doctors.

The proposed authorization may be seen as a fallback arrangement in the event that an opportunity or need arises for GP groups to negotiate collectively with public hospitals.

The potential impact of Local Hospital Networks

Responsibility for hospital management is being devolved to Local Hospital Networks (LHNs) made up of small groups of local hospitals that collaborate to deliver patient care, manage their own budget and are held directly accountable for their performance.

Local Hospital Networks will be separate state statutory authorities. They will comprise between one and four hospitals in most networks, with regional networks potentially including more small hospitals. These networks will typically be built around principal referral hospitals and specialist hospitals.

LHNs will be established by State Governments as separate legal entities under State legislation, in order to devolve operational management for public hospitals, and accountability for local delivery, to the local level. They will directly manage single or small groups of public hospital services and their budgets, and will be held directly accountable for hospital performance under the Performance and Accountability Framework.³⁷

Local Hospital Networks will be obliged to work with local primary health care providers, such as GPs. They will have a Governing Council and a Chief Executive Officer responsible for delivering agreed services and performance standards. Increasing local accountability will mean that management is empowered to make day-to-day operational decisions that would have otherwise been made by centralized authorities.

The decentralisation of hospital management may impact on the way GPs contract with hospitals to provide VMO services. It is not yet clear precisely what the impact of the LHNs will be on the contracting of VMO services, however the AMA submits that it is likely to change, even if not completely, the way GPs contract with hospitals. It may be that the devolution of authority to the LHNs will mean that there are more opportunities for individual or small collective negotiated arrangements. It is likely that some of the previous

³⁶ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p45 par 6.97.

³⁷ National Health and Hospitals Network Agreement, p 5, available at:
http://www.federalfinancialrelations.gov.au/content/other_related_agreements/NHHN_Agreement.pdf

uniformity of approach that has been seen in particular States may be broken down by the introduction of the LHNs and that this in turn may result in greater scope for efficiency benefits resulting from collective bargaining.

Should this occur, the AMA submits that it would be beneficial to have the proposed authority in place to allow for situations where an existing standard form agreement is not available or is negotiable.

The AMA stresses that such arrangements would contemplate groups of AMA member GPs operating in a single practice negotiating as a group with a hospital. In practical terms, this may mean that group is negotiating with a LHN acting on behalf of a hospital. It would not mean separate practices collaborating to negotiate collectively with a hospital or LHN, nor does it contemplate boycott activity.

The AMA submits that the authorization would have the potential following benefits:

- gains in efficiency
- improvement in the working relationships and teamwork, and reduction of stress in negotiations with other entities
- assisting with the recruitment and retention of GPs by enabling relevant practices to offer clear, predictable, negotiated packages to prospective GPs.

Efficiency

The ACCC has previously noted:

‘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 outcomes’³⁸

The AMA submits that more efficient outcomes for hospitals and health authorities would be a likely result of the proposed authorisation. The negotiation of fair and equitable fees and other contractual conditions by public hospitals, is assisted by a negotiating framework which utilises efficiencies and minimizes the need for agreements to negotiated individually, potentially adding to administrative and legal costs, and disagreements.

A collective approach also puts GPs in a more equitable bargaining position, as they negotiate with hospitals and provide them with an opportunity to have meaningful input into contract discussions. The ACCC has previously supported this position, stating:

‘Enhanced input into contracts by providing doctors with a clear voice in negotiations may also contribute to efficiencies... as hospitals will be able to negotiate with practice doctors, as a group, for the provision of VMO services, which will ensure that coordinated and efficient arrangements are put in place.’³⁹

³⁸ Authorisation A91088 Australian Medical Association (NSW) Limited in respect of collective negotiations with NSW Health and public health organizations on the terms and conditions (including but not limited to remuneration) of visiting medical officer contracts in the New South Wales public hospital system, 13 August 2008, par 5.58 p17.

Collective discussion and negotiations regarding VMO contracts among doctors in a practice will assist to determine the most reasonable terms on which to negotiate with hospitals, making the process clearer and fairer.

Negotiating contracts and workplace agreements can be very time consuming and can be a daunting task, particularly for those unaccustomed to it. The proposed authorization would allow for more efficient use of general practitioners' valuable time for the benefit of consumers, by providing primary health care and freeing GPs from the need to spend time negotiating individual contracts.

Hospitals will be able to negotiate with GPs from a practice as a group, which will ensure that coordinated, efficient arrangements are put in place, which will assist hospitals with rostering and administrative processes.

Teamwork and reducing stress.

The AMA submits that there would be considerable benefit to the working relationships of doctors and the culture of team work from the ability to collectively negotiate with public hospitals.

The proposed arrangements will allow GPs to discuss all aspects of the delivery of primary care services within their group practice and to discuss the terms and conditions of their arrangements with hospitals.

It is important for doctors to work harmoniously and be able to discuss common terms, conditions and issues regarding VMO contracts and to put a common voice on those issues, promoting camaraderie and open communications.

As noted above, certainty with respect to their legal position is very important for GPs. Having their collective bargaining activities legally endorsed is likely to remove some stress from them. Free exchange of information, ability to collectively negotiate is likely to allow doctors to better serve the interests of their patients.

Commonality of interest underscores the teamwork approach. The AMA refers the ACCC to Notification no. CB00004,⁴⁰ in which it was noted:

‘The presence of doctors from different craft groups, and therefore less commonality of interests, further reduces the public interest justification.’⁴¹

The AMA respectfully submits that the fact that the proposed authorization includes only General Practitioners, supports the commonality of interest that is naturally part of a teamwork approach to medical practice. A common approach to matters such as quality assurance, rostering, and resource allocation are consistent with better patient outcomes.

³⁹ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p49 par 6.125.

⁴⁰ Objection notice in respect of a collective bargaining notification lodged by Australian Medical Association (Vic) Pty Ltd on behalf of a group of doctors at Latrobe Regional Hospital, 19 December 2007.

⁴¹ Ibid, p 2.

Further, the negotiation process would not be encumbered by the presence of practitioners from different craft groups. The ACCC has previously observed in this context that:

‘... differences between craft groups, and possible individual issues, are likely to make the collective bargaining process more complex and less timely, which would reduce to some extent the benefits from transaction cost savings.’⁴²

Recruitment and retention of the GP workforce

The AMA submits that arrangements which would assist with the recruitment and retention of GPs will generate significant public benefits. The proposed authorisation will allow general practices, operating under the relevant business structures, to offer a pre-negotiated package to prospective GPs, which in turn may assist with recruitment and retention. This is likely to have a beneficial effect on the health of relevant communities, particularly rural and remote communities.

This is particularly valuable in the context of medical workforce shortages and issues associated with recruitment and retention of GPs. Whilst there are initiatives in place to combat shortages, many areas in Australia still face medical workforce shortages.

On Monday 19 March 2012, the Standing Committee on Health and Ageing tabled its report entitled *Lost in the Labyrinth: Report on the inquiry into registration process and support for overseas trained doctors*.⁴³ The report deals mainly with International Medical Graduates, but also makes some general observations about the current state of the medical workforce in Australia. For example, it notes:

‘Currently, although there are some suggestions that there are no shortages of medical practitioners in Australia, ... the more widely held view is that there are still too few medical practitioners to meet Australia’s needs.’⁴⁴

A research report released in 2006 by the Productivity Commission entitled: *Australia’s Health Workforce* observes:

‘...there is evidence that there are shortages in overall numbers across a range of the medical, nursing, dental and allied health professions.’⁴⁵

The report further notes that:

‘Though precise quantification is difficult, there are evident shortages in workforce supply — particularly in general practice...’⁴⁶

⁴² Objection notice in respect of a collective bargaining notification lodged by Australian Medical Association (Vic) Pty Ltd on behalf of a group of doctors at Latrobe Regional Hospital, 19 December 2007, p 26 par 3.129.

⁴³ Available at:

http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm

⁴⁴ Ibid, p 14.

⁴⁵ Productivity Commission 2005, *Australia’s Health Workforce*, Research Report, Canberra, p. 11.

⁴⁶ Ibid, overview, p XVI.

The AMA submits that the proposed authorization would positively impact on GP shortages by underpinning morale, and subsequently the retention of GPs, by reducing administration, bolstering certainty and saving on time and transaction costs.

The proposed arrangements will assist to prevent or reduce the risks of health disparities among marginalised Australians, many of whom live in regional and remote areas.

The proposed authorisation would result in public benefits as it is likely that more doctors would be inclined to take up roles as VMOs, if they can have some certainty and consistency as to terms and conditions.

Young doctors in particular are seeking all-inclusive arrangements without the added stresses of negotiating individually with hospitals. The proposed authorisation would allow practices to collectively negotiate terms and conditions with hospitals and offer those conditions to prospective doctors as part of a package. This would allow them to make informed decisions about whether to join a practice, which is especially important when young doctors are considering re-locating, particularly with a young family.

Individual negotiations between doctors and hospitals can be stressful, costly and can cause conflict in some instances. Doctors may feel the need to obtain legal advice on proposed contracts. A collective bargaining process obviates the need for this.

Counterfactual – collective bargaining with hospitals and health authorities

Should the authorisation not be granted, it is submitted that health authorities and hospitals would in some instances have to negotiate individually with each practitioner they engage. In other areas where standard form contracts are used, doctors will lose bargaining power as they are confronted with the significant resources of state and territory governments and very little room to negotiate.

Teamwork and solidarity will diminish, as individual contracts are likely to lead to a less open and transparent approach between colleagues in an attempt to maintain the confidential nature of the individual agreements. The flow on effect of this will be reduced openness and communication.

Collective bargaining with Medicare Locals

This part of the application seeks authorization to allow the applicants to:

- Be able to negotiate and agree collectively with Medicare locals regarding fees that they may charge for the provision of after hours medical services.

It is submitted that the proposed authorisation will generate a range of public benefits, including:

- Increased efficiency and assisting Medicare Locals, particularly as they start operations

- Assisting accountability of expenditure in Medicare Locals
- Upholding ethical standards and avoiding conflict of interest

Background:

Medicare Locals

According to the Commonwealth Government, Medicare Locals are a key feature of the *National Health Reform*, and are made up of localised health care entities designed to coordinate primary health care delivery, address local health care priorities, support health professionals and improve access to primary care. It is anticipated that there will be a network of 62 Medicare Locals by the end of 2012.⁴⁷

Funding

It is expected that Medicare Locals will receive significant Commonwealth funding, particularly in the initial stages of development. Figures published by the Department of Health and Ageing suggest that a total of \$477 million over four years will be provided to establish the network of Medicare Locals across Australia. Once all Medicare Locals are established, the total annual core funding for the network will be approximately \$171 million. Medicare Locals will also be provided with funding to support their establishment.⁴⁸

One of their key roles will be to co-ordinate the provision of after hours GP services to allow patients to receive face-to-face GP services outside normal operational hours. Medicare Locals will have a specific role in coordinating local face-to-face after hours GP services, working with local GPs to ensure that these services are available in local communities. For this it is anticipated that they will need to engage the services of local GPs from time to time on a range of contractual bases.

They will be independent legal entities managed by Boards. According to the Commonwealth Government, the Medicare Local model seeks to strike a balance between national consistency and local flexibility in governance arrangements to enable them to respond to local needs. Governance arrangements will be tailored for specific communities and population groups. The Department of Health and Ageing has stated:

‘Medicare Locals across the country will, to a degree, have different approaches to governance that are tailored to the needs of their community’.⁴⁹

It is anticipated that even though the Medicare Local model is based on a National Health Reform strategy, the highly localized nature of each Medicare Local will mean that each may have different engagement mechanisms. This creates challenges for local GPs who may not

⁴⁷ Australian Government, Department of Health and Ageing website:
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/medilocprofiles#.T8hkl7C_HSs.

⁴⁸ Australian Government, Department of Health and Ageing, Guidelines for the establishment and initial operation of Medicare Locals & Information for applicants wishing to apply for funding to establish a Medicare Local, 2011, p8.

⁴⁹ Australian Government, Department of Health and Ageing, Guidelines for the establishment and initial operation of Medicare Locals & Information for applicants wishing to apply for funding to establish a Medicare Local, 2011, p11.

feel they are in a position to negotiate with Medicare Locals, or may feel they are in an inferior bargaining position with them.

In an environment of significant government funding with localized management, accountability and efficiency will be core expectations which will need to be met for the ongoing management and funding of each Medicare Local.

Public benefits

Efficiently assisting Medicare Locals, particularly as they start operations

One of the key stated objectives for Medicare Locals is to: 'Be efficient and accountable with strong governance and effective management.'⁵⁰

As a new system, with little or no corporate memory, the potential process of negotiating individual contracts with every GP with whom they engage will pose a significant burden on Medicare Locals. The capacity to negotiate with a representative of a group of GPs will make the process much more efficient and is likely to facilitate the smooth introduction of the Medicare Local model into local communities.

The current application proposes that Medicare Locals have the capacity to negotiate with GPs from a practice as a group, which will ensure that coordinated, efficient arrangements are put in place, and will assist with planning, rostering and administrative processes for the provision of after hours GP services.

The proposed authorisation would be likely to result in more doctors being inclined to take up roles in local General Practices and support the emerging Medicare Local system, if they can have some certainty and consistency as to terms and conditions which a collectively negotiated agreement would provide.

The ACCC has previously stated:

'The ACCC generally considers that transaction costs may be lower in implementing a collective bargaining agreement for a single negotiating process, as opposed to the situation where the target must negotiate and implement many agreements'⁵¹

The AMA submits that collective negotiations will reduce transaction costs for Medicare Locals, which will be beneficial in terms of efficiency and cost saving.

⁵⁰ Australian Government, Department of Health and Ageing, Guidelines for the establishment and initial operation of Medicare Locals & Information for applicants wishing to apply for funding to establish a Medicare Local, 2011, p7.

⁵¹ Authorisation A91100, Australian Medical Association Limited in respect of collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas, 10 December 2008, par 6.82 p 30.

Accountability

The very fact that Medicare Locals are a new phenomenon creates challenges for GPs. It is unknown how the Medicare Local model will affect GPs at the practical level and what form their agreements will take.

They will need to be accountable to the Department of Health and Ageing. Even though they are not government entities, they will be funded by government and will need to be accountable for spending. The Department of Health and Ageing has stated that:

‘The Medicare Locals will operate within an environment in which they are accountable to both the Commonwealth and their local community.’⁵²

Collectively negotiated contracts with GPs will provide a level of consistency and transparency which will assist with accountability in this area.

Counterfactual

If GPs are not able to negotiate collectively with Medicare Locals, it may lead to a situation where an indeterminate range of contracts with varying payment structures and other terms will have to be negotiated. This will make accountability more difficult to establish and will be an administrative burden, as Medicare Local boards will have to account for why different practitioners are given different contracts and possibly different rates of pay. A collective approach to bargaining on the part of GPs is likely to facilitate the standardisation of contracts, or the use of fewer different contracts, for use by Medicare Locals, saving time and promoting efficiency.

Overall conclusion on public benefit

In brief, it is the AMA’s submission that the proposed authorization would, overall, deliver a range of benefits which would outweigh any concomitant detriment, including:

- a positive effect on the retention of GPs and VMOs, as their fee structures will be secured.
- the promotion of efficiency and team work
- allowing for an expedient, viable process for the employment of locums to take the pressure off general practitioners when they require assistance at the clinical level.
- allowing doctors to practice in a financially viable setting, reducing the risk to the viability of practices, and more broadly, the presence of private general practices.
- Efficiency gains
- Assisting and supporting the emerging Medicare Local system
- Promoting ethical behaviour

5. Market definition

Provide a description of the market(s) in which the goods or services described at 2 (c) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any

⁵² Ibid, p 11.

restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):
(Refer to direction 7)

The relevant markets for the purposes of the application are localised geographic markets for:

- the provision of primary medical services to the public;
- the provision of VMO services to public hospitals; and
- the provision of GP medical services to Medicare Locals.

6. Public detriments

- (a) Detriments to the public resulting or likely to result from the authorisation, in particular the likely effect of the contract, arrangement or understanding, on the prices of the goods or services described at 2 (c) and the prices of goods or services in other affected markets:
(Refer to direction 8)

The AMA acknowledges that there are potential detriments to the proposed authorization may have some detrimental effects, including:

- Intra practice price setting: reduced competition and increased cost to health consumers
- Collective bargaining with hospitals and health authorities: increased cost to public hospitals
- Collective bargaining with Medicare Locals: increased cost to Medicare Locals

However, the AMA submits that such detriments are likely to have limited effect, if at all, as noted below:

- (b) Facts and evidence relevant to these detriments:

Intra practice price setting: reduced competition and increased cost to health consumers

The AMA acknowledges the risk that setting fees within practices could lead to decreased competition and increased costs to health consumers. However, the AMA notes that the proposed authorization does not contemplate various practices setting prices among themselves. It only contemplates price setting within individual practices. Hence, practices which are not part of the same entity will be, as usual, free to compete with each other, which may assist consumers in making choices based on cost if this is what they seek.

Further, other types of practices which operate as a single entity can already agree on the fees they charge. This has been previously acknowledged by the ACCC in the context of intra-practice price setting.⁵³

Australian health consumers benefit from the Medicare system, with the majority of GP services being bulk-billed. Bulk billing provides an economic constraint on medical fees. In the March quarter of 2012, 81.2% of GP services in Australia were bulk-billed.⁵⁴

Agreements to bulk-bill do not generally attract prosecution. The ACCC has publicly stated:

‘The ACCC considers that an agreement between doctors to bulk bill all patients would be unlikely to result in any harm to patients, as the bulk billed rate is the lowest fee that a doctor is likely to charge for their services.

The ACCC would therefore not take action against agreements to bulk bill.’⁵⁵

Hence in reality a minority of health consumers are affected by price setting outside of the bulk-billed rate.

Collective bargaining with hospitals and health authorities: increased cost to public hospitals

The AMA acknowledges that the authorization regarding collective bargaining arrangements could have the potential detriment of increasing costs to public hospitals, however the AMA submits that this is unlikely to eventuate.

The AMA submits that any increase in costs from the proposed arrangements is likely to be limited. As noted above, the collective bargaining arrangements would be voluntary in the sense that a hospital would not be obliged to agree to negotiate with a practice collectively. In addition, the bargaining group remains small and in many cases will not represent all the GPs supplying VMO services to a particular hospital. However, the AMA acknowledges that in some rural and regional markets, there may only be one practice that is able to supply VMO services.

The AMA submits that any potential detriment from the proposed arrangements is likely to be confined by the fact that public hospitals operate within the constraints of health budgets, which will provide a consistent and limited cost framework in which the negotiating parties will have to operate. Cost over-run is unlikely in a carefully controlled fiscal environment.

Again, the AMA submits that efficiency demands a collective approach, and that the need to negotiate individually with VMOs would in fact create a greater administrative burden for hospitals, health authorities, and GPs alike. The more efficient approach to bargaining

⁵³ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p34.

⁵⁴ Media Release from the Office of the Honourable Tanya Plibersek MP, 24 May 2012. Available at: [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/AFB80B1A51B5B2EBCA257A07007D410B/\\$File/TP048.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/AFB80B1A51B5B2EBCA257A07007D410B/$File/TP048.pdf).

⁵⁵ <http://www.accc.gov.au/content/index.phtml/itemId/575152>, accessed on 09.05.12

outweighs the possible detriment which may result from a reduction in competition. It is highly likely that any increase in costs would be fully offset by efficiency gains particularly in the area of administration. This may free up time and resources in hospitals which may be better directed towards patient care.

Further, the AMA submits that no inefficiencies will arise under the proposed collective arrangements in the remuneration of GP VMOs, particularly where standard form contracts are in place. The ACCC has previously noted in relation to NSW VMO arrangements that this outcome is unlikely to result⁵⁶ and the AMA submits that this applies to all jurisdictions where standard form agreements are used in the engagement of VMOs.

Limited coverage

Further, the proposed authorisation will have limited coverage. Practices which supply VMO services to public hospitals may be structured in a variety of ways. The collective arrangements will only apply to AMA member GPs operating in practices that are structured as noted above.

The AMA notes that in many circumstances a single bargaining group will not cover all the GPs supplying VMO services to a particular hospital or a Medicare Local. Further, there will be situations where not all GPs from a single practice are appointed to a hospital or work for a Medicare Local. Only a limited group of GPs would be involved in the proposed arrangements. Further, as set out below, many VMOs are already be subject to structured agreements.

Decreased competition and increased cost to Medicare Locals

It is possible that collectively negotiated contracts between certain groups of GPs and Medicare Locals may have the effect of lessening competition among GPs. A decrease in competition may lead to an increase in cost to Medicare Locals. However, the AMA notes that the effect of this are likely to be minor and have little or no impact on the conduct of the Medicare Local model or provision of care to patients.

Medicare Locals will run as separate entities, answerable to a board of management, and subject to external funding and auditing arrangements. Any detriment is likely to be incidental and greatly outweighed by the benefits noted above.

Conclusion on public detriment:

The AMA submits that the proposed arrangements are unlikely to impact negatively on consumers, hospitals, or Medicare Locals in any significant way.

The AMA respectfully refers the ACCC to a previous finding that:

‘...the anti-competitive effect of collective bargaining arrangements constituted by lost efficiencies is likely to be more limited where the following features are present:

⁵⁶ Authorisation A91024 The Royal Australian College of General Practitioners in respect of intra-practice price setting arrangements and hospital agreements, 23 May 2007, p 44 par 6.94.

- the current level of negotiations between individual members of the group and the proposed counterparty(s) on the matters to be negotiated is low
- participation in the collective bargaining arrangement is voluntary
- there are restrictions on the coverage and composition of the bargaining group
- there is no boycott activity⁵⁷

The AMA submits that all of the above features are clearly present in the current application. The proposed collective arrangements are limited to GPs operating in one practice, in particular business structures and limited to AMA members only. Further efficiencies gained will offset any perceived detriments.

The proposed authorisation in summary

In summary, the proposed authorisation would allow for AMA members to discuss and negotiate their fees and contracts with hospitals and Medicare Locals with each other, if they are within the same practice but operating as separate entities.

Where a GP within a practice is not an AMA member and feels exposed, he or she may choose to join the AMA. The AMA has several options for membership, including concessional rates for part time doctors. There are no barriers to membership as long as a person is a registered medical practitioner.

The AMA undertakes to communicate clearly to its members the terms of any authorisation granted to avoid confusion. The AMA is also able to advise members over the phone if enquiries about such matters are made.

7. Contract, arrangements or understandings in similar terms

This application for authorisation may also be expressed to be made in relation to other contracts, arrangements or understandings or proposed contracts, arrangements or understandings, that are or will be in similar terms to the abovementioned contract, arrangement or understanding.

- (a) Is this application to be so expressed?

.....

- (b) If so, the following information is to be furnished:

- (i) description of any variations between the contract, arrangement or understanding for which authorisation is sought and those contracts, arrangements or understandings that are stated to be in similar terms:

(Refer to direction 9)

.....

.....

⁵⁷ Authorisation A91100, Australian Medical Association Limited in respect of collective negotiations with relevant state/territory health departments concerning contracts for visiting medical officers in rural and remote areas, 10 December 2008, p21.

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-
- (ii) Where the parties to the similar term contract(s) are known — names, addresses and descriptions of business carried on by those other parties:

-
-
-
-
- (iii) Where the parties to the similar term contract(s) are not known — description of the class of business carried on by those possible parties:

.....

.....

.....

.....

8. Joint Ventures

- (a) Does this application deal with a matter relating to a joint venture (See section 4J of the *Competition and Consumer Act 2010*)?

-
- (b) If so, are any other applications being made simultaneously with this application in relation to that joint venture?

-
-
-
-
- (c) If so, by whom or on whose behalf are those other applications being made?

.....

.....

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9. Further information

- (a) Name and address of person authorised by the applicant to provide additional information in relation to this application:

John Alati

Senior Industrial and Legal Advisor

Australian Medical Association Limited


PO Box 6090

KINGSTON ACT 2604

Email: jalati@ama.com.au

Dated X 6/9/2012

Signed by/on behalf of the applicant

X
(Signature) 

Francis Sullivan
(Full Name)

Secretary General
(Position in Organisation)

DIRECTIONS

1. Use Form A if the contract, arrangement or understanding includes a provision which is, or might be, a cartel provision and which is also, or might also be, an exclusionary provision. Use Form B if the contract, arrangement or understanding includes a provision which is, or might be, a cartel provision or a provision which would have the purpose, or would or might have the effect, of substantially lessening competition. It may be necessary to use both forms for the same contract, arrangement or understanding.

In lodging this form, applicants must include all information, including supporting evidence, that they wish the Commission to take into account in assessing the application for authorisation.

Where there is insufficient space on this form to furnish the required information, the information is to be shown on separate sheets, numbered consecutively and signed by or on behalf of the applicant.

2. Where the application is made by or on behalf of a corporation, the name of the corporation is to be inserted in item 1 (a), not the name of the person signing the application and the application is to be signed by a person authorised by the corporation to do so.
3. Describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding in respect of which the application is made.
4. Provide details of the contract, arrangement or understanding (whether proposed or actual) in respect of which the authorisation is sought. Provide details of those provisions of the contract, arrangement or understanding that are, or would or might be, cartel provisions. Provide details of those provisions of the contract, arrangement or understanding that do, or would or might, substantially lessen competition.

In providing these details:

- (a) to the extent that any of the details have been reduced to writing, provide a true copy of the writing; and
 - (b) to the extent that any of the details have not been reduced to writing, provide a full and correct description of the particulars that have not been reduced to writing.
5. Where authorisation is sought on behalf of other parties provide details of each of those parties including names, addresses, descriptions of the business activities engaged in relating to the subject matter of the authorisation, and evidence of the party's consent to authorisation being sought on their behalf.
 6. Provide details of those public benefits claimed to result or to be likely to result from the proposed contract, arrangement or understanding including quantification of those benefits where possible.

7. Provide details of the market(s) likely to be effected by the contract, arrangement or understanding, in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the authorisation.
8. Provide details of the detriments to the public which may result from the proposed contract, arrangement or understanding including quantification of those detriments where possible.
9. Where the application is made also in respect of other contracts, arrangements or understandings, which are or will be in similar terms to the contract, arrangement or understanding referred to in item 2, furnish with the application details of the manner in which those contracts, arrangements or understandings vary in their terms from the contract, arrangements or understanding referred to in item 2.

