Draft Determination

Application for revocation and substitution of authorisation A91376

lodged by

Rural Doctors Association of Australia

in respect of

Collective negotiations with state and territory health departments, Medicare Locals and Local Hospital Networks

Date: 28 August 2013

Authorisation number: A91376

Commissioners: Sims
Rickard
Schaper
Cifuentes
Court
Dimasi
Walker

Summary

The ACCC proposes to revoke authorisation A91078 and grant authorisation A91376 in substitution. The substitute authorisation is for the Rural Doctors Association of Australia and its constituent state associations to collectively negotiate with state and territory health departments, the terms of contracts for general practitioners and generalist visiting medical officers in rural areas.

The ACCC proposes to authorise this conduct for five years.

The ACCC does not propose to extend authorisation to the RDAA to collectively negotiate with Medicare Locals and Local Hospital Networks.

The ACCC now seeks further submissions in relation to this draft determination before making its final decision.

The Rural Doctors Association of Australia and its constituent state associations (collectively referred to as the RDAA) are seeking re-authorisation to allow them to continue collective negotiations with state and territory health departments on behalf of rural doctors.

In addition, the RDAA has sought to extend the scope of the re-authorisation to allow them to collectively negotiate with Medicare Locals and Local Hospital Networks on behalf of rural doctors.

Rural doctors (including general practitioner registrars and locums) provide services in public hospitals and health facilities as visiting medical officers, and primary health care services, including after-hours services.

Australians who live in rural and remote areas are significantly disadvantaged in their access to health care services, which the RDAA believes is due to a depleted rural medical workforce.[1] As such, the RDAA believes that any initiative which facilitates rural workforce recruitment and retention, including by the granting of this authorisation, will in turn improve health outcomes and result in considerable economic and social benefits for rural communities.

The ACCC considers that there are public benefits resulting from the RDAA, on behalf of rural doctors, continuing to collectively negotiate state-wide agreements with state and territory health departments. In particular, collective bargaining enables rural doctors to have greater input into contract terms and conditions than would be the case if they were each to deal with health departments individually. The ACCC notes that there is no evidence of any public detriment under the authorisation that has been in place since 2008.

In contrast, the ACCC considers that collective negotiations with Medicare Locals and Local Hospital Networks are likely to result in limited benefit and may result in some detriment by reducing price competition and the scope to negotiate specifically tailored solutions for each region.

Consequently, the ACCC is proposing to authorise the RDAA to continue to collectively bargain with state and territory health departments over state-wide agreements, but not

[1] RDAA Policy Position Paper 2/2010, *Addressing the Medical Workforce Shortage in Rural and remote Australia*

to extend authorisation to bargaining with Medicare Locals and Local Hospital Networks.

The ACCC notes that Medicare Locals and Local Hospital Networks have only recently been established and based on the information before the ACCC, it is difficult to accurately determine the impact of collective bargaining on these entities. The ACCC would welcome any further information to assist it in making its final determination.

Contents

The application for authorisation

1. On 7 May 2013 the Rural Doctors Association of Australia (the RDAA) lodged an application under section 91C(1) of the *Competition and Consumer Act 2010* (the Act) for revocation of authorisation A91078[2] and substitution with authorisation A91376.

2. The RDAA and its constituent state associations (collectively referred to as the RDAA) are seeking re-authorisation to allow them to continue to collectively negotiate with state and territory health departments the terms of contracts for general practitioners and generalist visiting medical officers (VMOs)[3] in rural areas (collectively referred to as rural doctors), particularly with respect to payments for services provided to public patients and for on-call services.

3. The RDAA is also seeking to extend the arrangements to include collective negotiations between the RDAA and Medicare Locals and the RDAA and Local Hospital Networks (LHNs).

4. Collective negotiations could include payments for services provided to public patients or services provided within the hospital and health care facilities, including payments for on-call and arrangements for rosters and on-call (VMO services) and broader aspects of support and remuneration. The RDAA submits that negotiations may also cover payments for the provision of primary care services, including after-hours services in the general practice or other primary care setting.

5. Broadly, the RDAA submits that authorisation is still relevant and necessary and has facilitated effective negotiations and agreements in a number of states. The RDAA anticipates that these arrangements will continue under any future authorisation.

6. Australians who live in rural and remote areas are significantly disadvantaged in their access to health care services, which the RDAA believes is due to a depleted rural medical workforce.[4] The RDAA submits that many rural hospitals remain in decline because of a lack of rural doctors to staff them properly and there has been a significant decline in procedural services during the past ten years.[5]

7. The RDAA submits that a key purpose of its application is to preserve rural medical networks and to facilitate a working environment for rural general practice across both primary care and acute and procedural services, together with opportunities for a career in rural medicine that is attractive enough to compete with metropolitan practice.

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2 Authorisation A91078 was granted on 14 May 2008 and authorised until 30 June 2013.

3 Visiting medical officers (VMO) are medical practitioners appointed by a hospital to provide medical services for hospital (public) patients. Australian Institute of Health and Welfare, Hospitals A-Z Glossary http://www.aihw.gov.au/ hospitals- glossary/.

4 RDAA Policy Position Paper 2/2010, *Addressing the Medical Workforce Shortage in Rural and remote Australia*

5 *Health Workforce Australia 2025 (3)* reported that proceduralists have declined 50 per cent since 2002, p.118.

8. The RDAA submits that, subject to authorisation, it will support rural doctors and facilitate their participation in the provision of VMO and other health care services. The RDAA believes that any initiative which facilitates rural workforce recruitment and retention, including by the granting of this authorisation, will in turn promote better workforce retention, the more efficient delivery of health care services, improve health outcomes and result in considerable economic and social benefits for rural communities.

9. The RDAA submits that the arrangements allowing collective negotiations with state and territory health departments have worked well to date with no evidence of public detriment.

Interim Authorisation

10. The RDAA requested interim authorisation to maintain the status quo of its existing arrangements and also for a new arrangement to allow it to negotiate with Medicare Locals for the provision of healthcare services to be provided by rural doctors while the ACCC is considering the substantive application.

11. Interim Authorisation was granted on 13 June 2013, to allow the RDAA to continue to collectively negotiate with state and territory health departments. This interim authorisation does not extend to the RDAA collectively bargaining with Medicare Locals, and interim authorisation was not sought in respect of collective negotiations with LHNs.

12. Interim authorisation will remain in place until the date the ACCC's final determination comes into effect or until the ACCC decides to revoke interim authorisation.

Previous relevant authorisations

Australian Medical Association Authorisation A91334

13. On 21 February 2013, the ACCC granted authorisation A91334 for five years to permit all general practitioners, who practice in defined business structures, to engage in:

    - intra-practice price setting
    - collective bargaining, as single practices, with purchasers of VMO services provided to public hospitals and
    - collective bargaining, as single practices[6], with Medicare Locals, in relation to the provision of Medicare Local services.

14. Authorisation A91334 does not apply to any price agreements or collective bargaining between practices.

[6] Single practices are not represented by organisations such as the AMA or the RDAA in any such collective bargaining.

Australian Medical Association Authorisation A91100

15. On 10 December 2008, the ACCC granted authorisation to the AMA and the AMA state and territory bodies in Victoria, South Australia, Western Australia, Northern Territory, Queensland and Tasmania to collectively negotiate with relevant state and territory health departments, the terms of contracts (including fees) for rural general practitioners providing services as VMOs in public hospitals and health facilities in rural and remote areas of Australia. This authorisation expires on 28 February 2014.

Australian Medical Association (NSW) Ltd Authorisation A91088

16. On 13 August 2008, the ACCC granted authorisation to the AMA (NSW) to collectively negotiate with NSW Health the standard terms and conditions, including rates of remuneration, of contracts for VMOs engaged in the NSW public hospital system.

17. The ACCC also granted authorisation to the AMA (NSW) to collectively negotiate with public health organisations in NSW on issues relevant to the engagement of VMOs by public health organisations but excluding standard VMO contract terms and conditions and rates of remuneration.

18. Authorisation was granted until 31 December 2013.

Background

19. Authorisation is a transparent process where the ACCC may grant protection from legal action for conduct that might otherwise breach the *Competition and Consumer Act 2010* (the Act). The ACCC may 'authorise' businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment. The ACCC conducts a public consultation process when it receives an application for authorisation, inviting interested parties to lodge submissions outlining whether they support the application or not. Before making its final decision on an application for authorisation the ACCC must first issue a draft determination.[7]

Key parties

20. The application seeks authorisation for the RDAA to collectively negotiate on behalf of visiting medical officers and rural general practitioners. Rural doctors are more likely to be able to provide in-hospital care as well as private consulting room care and after-hours services. Rural communities in which there are few doctors to choose from typically expect them to also engage in public health roles such as providing clinical procedures and emergency care. Rural doctors are also more likely to encounter a higher burden of complex or chronic health

[7] Detailed information about the authorisation process is contained in the ACCC's Guide to Authorisation available on the ACCC's website **www.accc.gov.au**.

presentations and larger proportions of Aboriginal or Torres Strait Islander patients in their overall patient load. [8]

21. The extent to which general practitioners will engage in any of these activities and roles, however, depends entirely on the rural or remote context in which they choose to practice, or the range of general practice skills in which they wish to involve themselves. Some rural doctors in smaller rural towns, for instance, are based primarily at the local hospital, but the practice they conduct is still predominantly primary medical care, even though some secondary and, in some cases, tertiary care is also possible due to the hospital facilities.[9]

22. In 2011, there were 87,890 medical practitioners registered in Australia, of whom 33.9 per cent were general practitioners.[10]

23. The RDAA submits that Rural Health Workforce Australia estimates that in 2010 there were 6,467 doctors (or approximately 20 per cent) practising primarily in the general practice setting in areas ranging from inner regional to very remote areas of Australia. Table 1 below provides a breakdown of general practitioners employed in the various remoteness classifications in Australia. The map below illustrates those remoteness classifications.

Table 1 Number of General Practitioners employed in various regions in Australia[11]

	Major Cities	**Inner regional**	**Outer regional**	**Remote/very remote**
2007	16,291	3,968	1,766	523
2011	17,489	4,849	2,117	598

Source: Medical Workforce 2011[12]

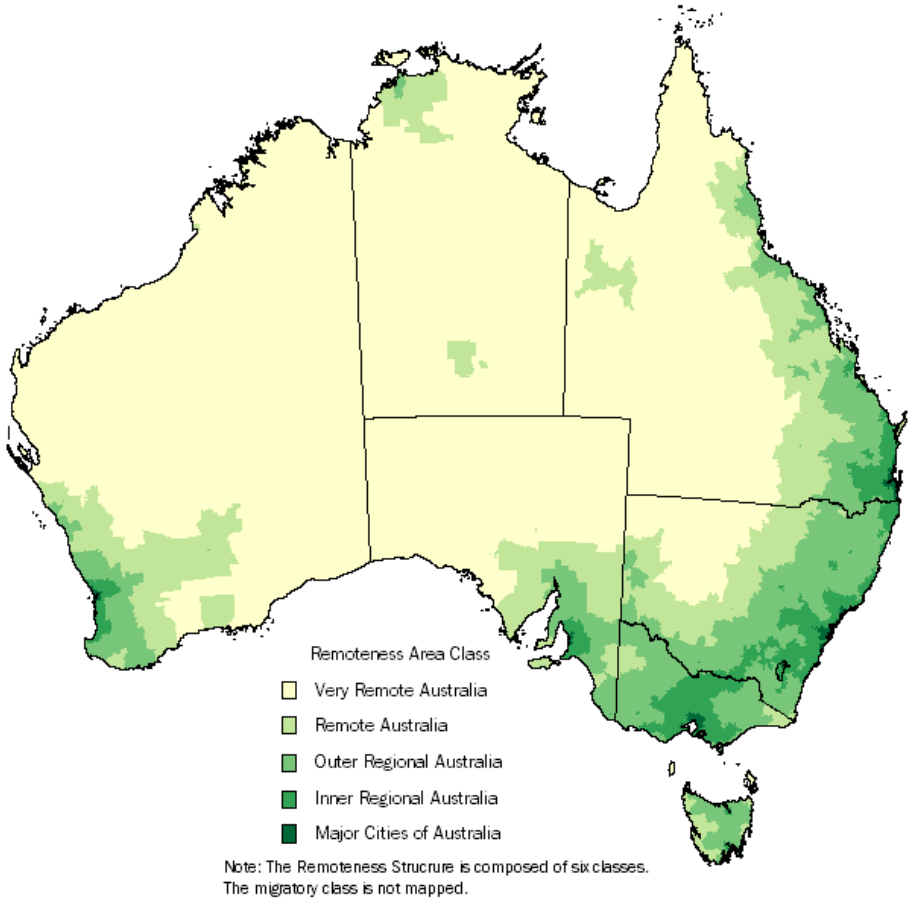
8 **http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-rural-general-practice/**, sourced 6 August 2013

9 **http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-rural-general-practice/**, sourced 6 August 2013

10 *Australian Institute of Health and Welfare 2013, Medical Workforce 2011,* National Health workforce series no.3, Canberra, p.viii

11 The data referred to in the *Medical Workforce 2011* report was broken up into "Remoteness Areas" using the Australian Standard Geographical Classification (ABS 2008).

12 *Australian Institute of Health and Welfare 2013,* op cit



MAP OF AUSTRALIA ILLUSTRATING 2006 REMOTENESS STRUCTURE[13]

24. The supply of general practitioners in rural areas, per head of population, decreased approximately 2 per cent between 2007 and 2011.[14]

25. The RDAA is the peak organisation representing the interests of doctors working in rural medical practice throughout Australia. The RDAA comprises the Rural Doctors Association (RDA) of each state and territory representing rural doctors from around the country. State RDAs are autonomous entities which negotiate with government and other bodies in their own jurisdictions. Members are typically drawn from small rural towns and remote areas.

26. Medicare Locals are primary health care organisations which have been established as a key component of the Australian Government's National Health Reform agenda. Medicare Locals will coordinate the delivery of primary healthcare services and address local health care needs and service gaps. Each Medicare Local has an independent company structure and each receives federal government funding to undertake a number of tasks and achieve outcomes determined by the Government. There are 61 Medicare Locals across Australia, 41 of which the RDAA submits have a significant rural constituency.

[13] The map shows "Remoteness Areas" using the Australian Standard Geographical Classification, sourced from *http://www.abs.gov.au/websitedbs/d3310114.nsf/home/remoteness+structure#Anchor2e*

[14] *Medical Workforce 2011 report,* p.26, para 4.2, the number of GPs decreased from 111.9 to 109.7 FTE per 100,000 population compared to general practitioners in major cities. NB, this data should be treated with some caution due to the changes in classification structures and collection of data.

27. The Australian Medicare Local Alliance (AMLA) advises that Medicare Locals currently deliver and coordinate primary health care services to their local communities. An initial priority for all Medicare Locals, submits AMLA, is to improve access to urgent after hours primary health care services. As of 1 July 2013, Medicare Locals are directly negotiating and entering into contracts with medical practitioners to deliver face to face after-hours services within their region.

28. The RDAA anticipates that the range of services for which Medicare Locals will negotiate will extend beyond the provision of after-hours services in the future.

29. A Local Hospital Network (LHN) is an organisation that provides public hospital services in accordance with the National Health Reform Agreement. An LHN consists of small groups of local hospitals, or an individual hospital, and is usually defined as a business group, geographical area or community. LHNs link services within a region or through specialist networks across a state or territory.

30. There are 136 LHNs across all states and territories. Of these, 123 are geographically based networks and 13 are state or territory-wide specialised networks that will deliver particular hospital services across some jurisdictions.[15] The RDAA advised that LHNs are separate statutory authorities that have only recently been established.

31. The RDAA submits that while the current arrangements for the negotiation of rural doctor fees and conditions will continue at the state level for all states except Victoria[16], this may change in the future such that the role of LHNs may include direct negotiations with organisations such as the RDAA, as well as with individual doctors, regarding the provision of services. As such, the RDAA is seeking authorisation to negotiate with LHNs at some time in the future should their role change.

Submissions received by the ACCC

32. The ACCC tests the claims made by the applicant in support of an application for authorisation through an open and transparent public consultation process.

33. The ACCC sought submissions from over 100 interested parties potentially affected by the application, including state and territory government departments, industry associations, consumer organisations and Medicare Locals. A summary of the public submissions received from interested parties follows.

34. The Australian Medicare Local Alliance (AMLA) submits that it is concerned that if the full breadth of the authorisation, as outlined by the RDAA in its application, were to be applied, it could impact on health services for rural communities and on Medicare Local functions.

[15] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/lochospnetwork

[16] In Victoria, the arrangements for the provision of health care services are negotiated directly between medical practitioners and practices and LHN Boards in rural areas.

35. The Consumers Health Forum of Australia (CHF) submits that it would expect to see evidence of the RDAA's claims that its collective negotiations with state and territory health authorities have been effective. In particular, CHF states that it would like to see evidence that collective bargaining has not resulted in the negative effects usually associated with anti-competitive behaviour, such as an increase in the price of medical services supplied by VMOs, and reductions in service availability, quality and choice.

36. The Northern Territory Department of Health (NTDoH) submits that it does not have any objection to the RDAA's application for authorisation at this time. The NTDoH submits that the Northern Territory Medicare Local is a partnership between it, the Aboriginal Medical Services Alliance Northern Territory, and the former General Practice Network Northern Territory.

37. NTDoH submits that supply and demand for the provision of health care services will significantly impact both the supplier and provider [ie hospitals]. The NTDoH submits that for many years the supply of medical officers has not met demand and therefore individual medical officers have been in a strong bargaining position.

38. NTDoH submits that it is currently close to being fully medically staffed for the first time in many years and in the future it is likely that the NT will not struggle with a significant undersupply of doctors and this should be taken into account in the ACCC's consideration of the competitive situation.

39. NTDoH also notes that it negotiates with the Australian Salaried Medical Officers Federation and the AMA and while the RDAA is not a registered body, it may represent individuals in enterprise negotiations under s.176 of the *Fair Work (Registered Organisation) Act 2009.*

40. Australian College of Rural & Remote Medicine (the College) submits that it supports the RDAA in its application so that it can continue to support rural doctors, promote efficient delivery of health care services, and continue to improve better workforce recruitment and retention and the improved health outcomes for rural and regional communities.

41. The College submits that it considers the conduct currently authorised to be relevant, beneficial and necessary to facilitate collective negotiations between the RDAA and state and territory health departments. Moreover, the College submits that extending the scope of the arrangements to include Medicare Locals and LHNs is therefore necessary to allow the RDAA to continue to appropriately support doctors.

42. The views of the RDAA and interested parties are considered in the evaluation section of this draft determination. Copies of public submissions may be obtained from the ACCC's website **www.accc.gov.au/authorisationsregister.**

ACCC evaluation

43. In its evaluation of this application, the ACCC has taken into account:

    a. Information received from the RDAA and interested party submissions.

b. Information available to the ACCC regarding the RDAA's 2008 authorisation application A91078 and similar authorisations.

c. The likely future without the conduct which is the subject of the authorisation.

d. The relevant areas of competition likely to be affected by the various collective bargaining arrangements.

e. The five year authorisation period requested.

44. The ACCC's evaluation of the proposed conduct is in accordance with the relevant net public benefit tests[17] contained in the Act. While there is some variation in the language of the tests, in broad terms, the ACCC is required to identify and assess the likely public benefits and detriments, including those constituted by any lessening of competition and weigh the two. The ACCC may grant authorisation if it is satisfied that the benefit to the public would outweigh the public detriments.

45. In order to assess the effect of the proposed conduct and the public benefits and detriments likely to result, the ACCC identifies the relevant areas of competition and the likely future without the conduct.

The relevant areas of competition

46. The RDAA submits the relevant areas of competition are:

a. the provision of VMO services by rural doctors to rural hospitals and health care facilities within a defined geographic area, and usually in the community in which the practitioner is located. There may be some instances where these services are provided to hospitals and health care facilities in nearby towns

b. the provision of health care services by rural doctors to Medicare Locals within a defined geographic area and usually restricted to the community in which the practitioner is located.

47. As it has previously concluded, the ACCC considers that public hospitals are likely to seek VMO services from doctors practising in a localised geographic radius from the hospital, predominantly in rural Australia. The size of these regions is likely to differ depending on the remoteness of the area. These regions are the relevant areas of competition for the purposes of this assessment.

The future with and without

48. To assist in its assessment of the conduct against the authorisation tests, the ACCC compares the public benefits and detriments likely to arise in the future where the conduct occurs against the future in which the conduct does not occur.

[17] Subsections 90(6), 90(7), 90(5A) and 90(5B). The relevant tests are set out in Attachment A.

49. The RDAA's submission did not address the issue of the future without the conduct.

50. The ACCC considers that in the future without collective negotiations the RDAA could continue to play a consultative role but higher transaction costs from individual negotiations would mean individual rural doctors would be likely to accept standard form contracts with limited ability to negotiate the terms and conditions of their agreements with state and territory health departments.

51. Given that Medicare Locals and LHNs are smaller entities than state and territory health departments and that they have been established to coordinate tailored solutions for the delivery of health care services in geographically defined areas, there may be more opportunity for individual rural doctors to have effective input into contract negotiations in the future without the conduct.

52. Alternatively, rural doctors may consider entering into collective bargaining arrangements consistent with those already operating in the profession under an ACCC authorisation (see paragraph 13). For example, authorisation A91334[18] enables general practitioners that operate within a shared practice, to collectively negotiate with Medicare Locals, without being represented by an organisation such as the AMA or the RDAA in those negotiations.

Public benefit

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

> …anything of value to the community generally, any contribution to the aims pursued by society including as one of its principle elements … the achievement of the economic goals of efficiency and progress.[19]

54. The RDAA submits the proposed conduct will deliver public benefits, including:

- continuing to facilitate effective negotiations and agreements with health departments in a number of states
- promoting more efficient delivery of health care services, better workforce retention and improved health outcomes for rural and regional communities by supporting and facilitating rural doctors' participation in the provision of VMO and other services.

[18] In 2013, the ACCC granted authorisation A91334 for five years, to allow medical practices within a defined team based practice structure, to collectively negotiate the terms and conditions of the supply of medical services, with health departments, local area networks and hospitals and the provision of medical services to Medicare Locals..

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

Collective bargaining with state and territory health departments

Transaction cost savings

55. Generally there are transaction costs associated with contracting. These transaction costs can be lower where a single negotiating process is employed, such as in a collective bargaining arrangement, relative to a situation where multiple negotiation processes are necessary.

56. Except for Victoria, it appears that rural doctors have little scope to vary the terms and conditions of their contracts, however, there may still be costs associated with entering such contracts, such as the costs associated with obtaining professional advice or obtaining the necessary information to make an informed decision.

57. The ACCC considers that collective bargaining allows parties to share these costs and that such cost savings constitute a public benefit to the extent they arise. Sharing these costs also enables more effective representation of rural doctors in negotiations with state and territory health departments and hence potentially greater attraction and retention of doctors in rural areas.

Effective representation of rural doctors and retention of rural doctors

58. The RDAA submits that the nature of negotiations for the provision of VMO and other hospital-based services varies from State to State, as does the level of RDAA involvement in these negotiations. For example, the RDAA submits that in NSW a series of state-wide agreements have been made between the NSW Department of Health and the RDAA and/or the AMA (NSW). These agreements define the terms and conditions of individual VMO service contracts.

59. In South Australia (SA), the SA Department of Health, through the SA Local Hospital Network, operates as a single agency covering all health units in country SA. The RDAA submits that the SA Government has worked collaboratively with it in developing the SA Rural Medical Engagement Schedule and the SA Medical Schedule of Fees resulting in an official contract for rural doctors who provide services to SA rural hospitals. The RDAA submits that this has resulted in doctors in rural SA having access to a contractual package which did not previously exist and has provided certainty for rural doctors and improved the delivery of health care services in SA rural communities.

60. The RDAA submits that being able to be involved in these negotiations has provided greater certainty for rural doctors, which in turn increases the possibility of doctors participating in VMO rosters in rural areas.

61. The RDAA also notes that while Victorian hospital boards negotiate VMO fees and conditions directly with doctors, the RDAA wishes to continue negotiations toward developing state-wide arrangements.

62. The ACCC notes that it has previously accepted that collective bargaining may result in more effective representation of rural doctors in dealing with state and territory health departments. To the extent that this occurs, this outcome may provide rural doctors with greater confidence with respect to the stability and development of health care services in rural areas, which in turn may have a positive influence on the recruitment and retention of rural doctors.

63. Improving the recruitment and retention of doctors in rural areas is likely to improve access to health services in rural communities and also constitutes a public benefit.

Collective bargaining with Local Hospital Networks and Medicare Locals

64. The RDAA submits that rural doctors are responsible for community, pre-hospital and hospital care as well as advanced medical care in the home. The RDAA submits that this work spans the public and private sectors, primary and acute care, and state and federal jurisdictions. The RDAA submits that it is important that the policies and decisions pursued by Medicare Locals take this into account, in the public interest. Accordingly, the RDAA claims it is desirable that it be in a position to assist such doctors and groups of doctors to negotiate with their Medicare Locals and LHNs in the interests of fully integrated best patient care, to preserve and foster such care.

65. The RDAA submits that it is only likely to provide support to members in negotiations with Medicare Locals at the request of a member. The RDAA considers that by supporting its members in negotiations it may potentially contribute to the retention of primary health care services in rural and remote areas as its members are more likely to enter into agreements with Medicare Locals knowing that they can call on the support of the RDAA if they feel that it is necessary. In this regard the RDAA submits that there have already been instances where members have contacted the RDAA regarding draft contracts with Medicare Locals. The RDAA submits that the very general information, advice and support which the RDAA was able to provide has resulted in some of those doctors re-entering discussions with their Medicare Local and signing agreements for the provision of services. The RDAA considers that this situation would be enhanced under the proposed arrangements.

66. The ACCC accepts there may be some benefit where the RDAA can assist rural doctors to better participate in the negotiation process such that it results in a more efficient outcome, particularly where that leads to a greater retention of rural doctors or the increased provision of medical services in rural and remote areas that are currently under-supplied.

67. However, the ACCC considers this benefit is likely to be small because transaction cost savings and efficiencies are likely to be lower in negotiating with Medicare Locals and LHNs, or unlikely to occur to the same extent compared to a state-wide agreement. As noted by the RDAA, it can and does support its members without authorisation and it can continue to do so without the conduct, albeit without providing pricing information to its members.

ACCC conclusion on public benefits

68. The ACCC accepts that the proposed collective bargaining arrangements with state and territory health departments are likely to result in cost savings and enable rural doctors to have more effective input into contracts resulting in more efficient outcomes. However, when negotiating tailored solutions at the local level with Medicare Locals and LHNs, transaction cost savings are likely to be lower compared to state-wide negotiations, and rural doctors negotiating at the

local level already have a greater input into the terms and conditions of their agreements.

Public detriment

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

> …any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.[20]

70. The RDAA submits that the existing arrangements for state-wide negotiations of VMO agreements have worked well to date, without any evidence of public detriment. The RDAA submits that, with the exception of Victoria, the vast majority of rural doctors will have no choice but to accept the VMO fees and conditions which have been negotiated on a state-wide basis.

71. Moreover, the RDAA submits that there would be no compulsion associated with the proposed arrangements and that all parties can avail themselves of other arrangements.

72. The ACCC considers that agreements between competitors which influence the pricing decisions of market participants have the potential to result in allocative inefficiencies. That is, they can move prices away from levels that would otherwise be set in a competitive market. In this case, public detriment may arise if the fees negotiated were artificially higher or lower than they otherwise would be in the absence of collective agreements.

73. However the ACCC has previously identified that the anti-competitive effect of collective bargaining arrangements constituted by lost efficiencies is likely to be more limited where the following features are present:

- the current level of negotiations between individual members of the group and the proposed counterparties is low
- there are restrictions on the coverage and composition of the bargaining group
- participation is voluntary and
- there is no collective boycott.

74. The ACCC's assessment of the likely public detriment from the proposed conduct follows.

Collective bargaining with state and territory health departments

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

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

small. The ACCC considers that while the average composition of the proposed bargaining groups is extensive, in most cases, the arrangements for providing health care services to public hospitals are made at the state level. Moreover, the RDAA submits that it is generally accepted that all state health departments have a very strong negotiating position relative to rural doctors.

76. The ACCC considers that the voluntary nature of the arrangements and the absence of collective boycott conduct limit the potential detriment. In particular, the ACCC considers that agreements will only be reached when it is in the interests of both negotiating parties.

77. The ACCC considers that the RDAA in each state is not in a position to compel state or territory health departments to negotiate with it. The state and territory health departments remain free to continue with existing arrangements for the provision of VMO service contracts.

78. As a result, the ACCC considers there is likely to be little or no detriment in the RDAA negotiating with state and territory health departments on behalf of rural doctors.

Collective bargaining with Medicare Locals

79. AMLA submits that it is concerned that if the full breadth of the authorisation, as outlined by the RDAA in its application, were to be applied, it could impact on health services for rural communities and on Medicare Local functions and consequently:

    - potentially increase the costs for the delivery of health care facilities in rural and regional areas thereby making the delivery of these services unsustainable

    - make it difficult to retain a competitive local negotiating environment

    - add delays to negotiations and consequently delay the delivery of health care services and

    - adversely affect the direct relationship between Medicare Locals and rural/regional general practitioners and practices.

80. In particular, AMLA is concerned that allowing the RDAA to collectively bargain may impact local negotiations. AMLA submits that a key factor in the establishment of Medicare Locals is their ability to deliver national initiatives through locally tailored solutions. AMLA argues that retaining a competitive negotiating environment is critical to achieving this. AMLA submits that while it appears that negotiations with Medicare Locals would take place at the local level and it is not envisaged that state or national agreements for the provision of health care services to Medicare Locals would be put in place, it remains concerned that collective negotiations may reduce Medicare Locals' capacity to fund services and may not allow for the varying operating cost structures for the provision of health care services in line with the differing needs and priorities of rural communities.

Level of individual negotiations

81. AMLA submits that a direct relationship between Medicare Locals and medical practitioners is important to gain support from medical practitioners to facilitate improved access to such services for rural communities. Accordingly, AMLA is concerned that introducing a third party into the negotiation process may impact the direct relationship between Medicare Locals and rural doctors, add more complexity to the negotiating process and unnecessarily distance parties and thus inadvertently impact the sustainability of the delivery of health care services in Australia.

82. The RDAA provided the following response to AMLA's concerns:

    a. the RDAA would only become involved in negotiations at the request of a member, and this is unlikely to occur where the relationship between the Medicare Local and the rural doctor or practice is strong. However, there may be circumstances where the RDAA's involvement can facilitate the best outcomes for the community, especially if it means that agreements can be reached regarding the provision of primary health care services when it might otherwise not have been possible to do so and

    b. the potential for cost increases as a result of the authorisation would be minimal and would be offset by the potential benefit. Moreover, the RDAA responded that any negotiations would take place under the constraints of health budgets, which will provide a consistent and limited cost framework for any negotiations.

83. The ACCC notes that Medicare Locals are smaller entities than state and territory health departments and they have been established to coordinate tailored solutions for the delivery of health care services in geographically defined areas. In particular, the ACCC notes that some Medicare Locals may only have a relatively small number of rural doctors in their area with whom they may be able to negotiate to provide health care services in that area.

84. The ACCC also notes AMLA's concerns that the proposed arrangements could lead to higher prices for the provision of health care services to rural and regional areas and potentially impact the relationship between Medicare Locals and rural doctors. Moreover, that the proposed arrangements may impact the ability of Medicare Locals to negotiate tailored solutions for particular areas.

85. Based on the information before it, the ACCC considers that where there are a limited number of rural doctors within a particular area and a high proportion are members of the RDAA, collective negotiations have the potential to result in some detriment by reducing the scope for negotiating specifically tailored solutions for those areas.

Coverage and composition of the bargaining group

86. The RDAA submits that the total number of financial members of the RDAA is approximately 1200 (or 20 per cent of rural medical practitioners) including rural doctors practising in specialist areas other than general practice, and doctors working entirely in the public sector, with both categories not being relevant to this application. The RDAA submits that on this basis, this application covers

less than 20 per cent of rural doctors who might be involved in negotiations with Medicare Locals.

87. In addition, in relation to the provision of health care services to Medicare Locals, the RDAA advised that it is only likely to become involved in negotiations at the request of its members.

88. The ACCC considers that while the number of general practitioners represented by the RDAA may appear to be a small proportion of the total number of general practitioners when considering negotiations at a state level, this could differ significantly when negotiating at a local level in rural areas with Medicare Locals.

89. The establishment of Medicare Locals is relatively recent and there is little evidence as to the impact collective bargaining may have on direct negotiations between individual rural doctors and/or medical practices with Medicare Locals.

90. Unlike state and territory health departments, Medicare Locals are not negotiating state-wide, single fee arrangements. Medicare Locals are much smaller entities established to coordinate tailored solutions for the delivery of health care services in geographically defined areas. Particular Medicare Locals may only have a relatively small number of rural doctors in their area who may all be members of the RDAA; in these circumstances, sharing price information amongst those practitioners could reduce the level of price competition in the provision of services to Medicare Locals and reduce the scope to negotiate specifically tailored solutions for each region. Based on the information before it, the ACCC considers that allowing the RDAA to negotiate with Medicare Locals, or provide remuneration advice to its members, particularly information about the fees offered by Medicare Locals to other rural doctors or practices, or the fees ultimately negotiated, has the potential to result in some detriment.

Voluntary participation in the collective bargaining

91. AMLA raised concerns that although the arrangements are voluntary it may create delays to the negotiation process if it refuses to collectively negotiate with the RDAA.

92. It is possible that Medicare Locals would experience a sense of compulsion to negotiate and reach agreement with the RDAA. Even in circumstances where a Medicare Local chose not to collectively bargain and negotiated individually with rural doctors, each doctor could potentially have an understanding through the RDAA of what other doctors in the area are willing to accept or are offering or have been offered which in effect may reduce price competition for the provision of those services.

Collective bargaining with Local Hospital Networks

93. The ACCC did not receive any submissions specifically raising concerns about the RDAA collectively bargaining with LHNs.

94. As noted above, LHNs have only recently been established and they currently do not have a role in negotiating directly with rural doctors for the provision of VMO services in public hospitals. Therefore, the RDAA is seeking authorisation to collectively bargain with LHNs at some future time should the role of LHNs change to include direct negotiations with rural doctors.

95. It appears that each LHN may vary significantly in geographic scope depending on the state or territory. For example, the ACT has one LHN, Tasmania has three, Victoria has 86 and Sydney has 18 LHNs.[21]

96. To the extent that an LHN is state or territory wide, it may be more akin to the RDAA negotiating with a state or territory health department. However, the relative bargaining power of the parties may depend on circumstances specific to that area, such as the degree of remoteness, the population and available facilities.

97. Nevertheless, the ACCC considers that the smaller and more localised the LHN, the more concerns are likely to arise similar to those discussed in relation to Medicare Locals. That is, the majority of LHNs would not be negotiating state-wide, single fee agreements.

98. Similar to Medicare Locals, most LHNs are relatively small entities compared to state health departments, and they have been established to provide coordinated hospital services tailored to a geographically defined area.

99. Particular LHNs may only have a relatively small number of rural doctors in their area who may all be members of the RDAA. In these circumstances, sharing price information amongst those practitioners could substantially lessen competition in the provision of health care services within a region. Collective bargaining is also likely to reduce the scope of negotiations for specifically tailored solutions.

ACCC conclusion on public detriments

100. The ACCC considers that in respect of the RDAA collectively bargaining with state and territory health departments, the difference in the level of competition amongst doctors with or without collective bargaining is likely to be small. Moreover, while the coverage and composition of the proposed bargaining groups is extensive, the ACCC notes that the arrangements are already generally made at the state level. Further, the voluntary nature of the proposed arrangements in these circumstances, and the absence of collective boycott conduct limit any potential detriment. As noted, the ACCC would expect that a collectively negotiated agreement will only be reached if it is in the interests of both parties to do so.

101. However, there is the potential for some detriment to result from collective bargaining with Medicare Locals. In addition, depending on the specific circumstances, there is the potential for some detriment to arise from collective bargaining with LHNs.

Balance of public benefit and detriment

102. In general, the ACCC may grant authorisation if it is satisfied that, in all the circumstances, the proposed conduct is likely to result in a public benefit, and that public benefit will outweigh any likely public detriment, including any lessening of competition.

[21] http://www.publichospitalfunding.gov.au/directory

103. In the context of applying the net public benefit test in subsection 90(8)[22] of the Act, the Tribunal commented that:

> … something more than a negligible benefit is required before the power to grant authorisation can be exercised.[23]

104. For the reasons outlined in this draft determination, the ACCC considers that the proposed conduct is likely to result in public benefit, particularly with respect to the RDAA collectively bargaining with state and territory health departments over state-wide arrangements. However, the ACCC considers there is the potential for some detriment to arise from collective bargaining arrangements with Medicare Locals, and to a lesser extent, LHNs.

105. Based on the information currently before it, the ACCC cannot be satisfied that public benefits arising from the conduct in its entirety would outweigh the detriment to the public including the detriment constituted by any lessening of competition that would be likely to result. The ACCC considers that limiting the proposed conduct to collective bargaining with state and territory health departments over state-wide arrangements is likely to result in benefits that would outweigh any detriments.

106. In considering whether to limit the scope of the authorisation, the ACCC has considered whether it would be feasible for the RDAA to collectively bargain with state and territory health departments over state-wide agreements, without also collectively bargaining with Medicare Locals and LHNs. Based on the information before it, and, in particular the fact that the RDAA has engaged in collective bargaining in relation to such state-wide agreements under authorisation A91078, the ACCC considers that the limited authorisation set out below is appropriate.

107. The ACCC welcomes any further information to assist it in making its final determination. In particular, the ACCC is seeking submissions about the nature and extent of benefits and detriments likely to result from the proposed collective negotiations with Medicare Locals and LHNs.

Length of authorisation

108. The Act allows the ACCC to grant authorisation for a limited period of time.[24] This allows the ACCC to be in a position to be satisfied that the likely public benefits will outweigh the detriment for the period of authorisation. It also enables the ACCC to review the authorisation, and the public benefits and detriments that have resulted, after an appropriate period.

109. In this instance, the RDAA seeks authorisation for five years and the ACCC considers five years to be an appropriate period for authorisation.

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

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

24 Subsection 91(1).

Draft determination

The application

110. On 7 May 2013 the Rural Doctors Association of Australia (the RDAA) lodged an application under section 91C(1) of the *Competition and Consumer Act 2010* (the Act) for revocation of authorisation A91078[25] and substitution with authorisation A91376 (re-authorisation).

111. The RDAA and its constituent state associations (collectively referred to as the RDAA) are seeking re-authorisation to allow it to continue to collectively negotiate with state and territory health departments the terms of contracts for general practitioners or rural generalist visiting medical officers (VMOs) in rural areas (collectively referred to as rural doctors), particularly with respect to payments for services provided to public patients and for on-call services.

112. The RDAA is also seeking to extend the arrangements to include collective negotiations between the RDAA and Medicare Locals and the RDAA and Local Hospital Networks (LHNs).

113. Collective negotiations could include payments for services provided to public patients or services provided within the hospital/facility, including payments for on-call and arrangements for rosters and on-call (VMO services) and broader aspects of support and remuneration. The RDAA submits that negotiations may also cover payments for the provision of primary care services, including after-hours services in the general practice or other primary care setting.

114. In order for the ACCC to re-authorise the arrangements the ACCC must consider the application for re-authorisation under the same statutory tests as if it was a new application for authorisation under section 88 of the Act. The relevant sections are:

    - section 88(1) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding, a provision of which would have the purpose, or would have or might have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

    - section 88(1A) of the Act to make and give effect to a contract or arrangement, or arrive at an understanding a provision of which would be, or might be, a cartel provision (other than a provision which would also be, or might also be, an exclusionary provision within the meaning of section 45 of that Act).

Draft determination

115. For the reasons set out in this draft determination, the ACCC is not satisfied that the tests in sections 90(5A), 90(5B), 90(6), 90(7) and 91C(7) of the Act are met with respect to the full scope of the conduct for which authorisation is sought.

[25] Authorisation A91078 was granted on 14 May 2008 and authorised until 30 June 2013.

However, the ACCC is satisfied that these tests are met with respect to collective bargaining with state and territory health departments only. [26]

116. Accordingly, the ACCC proposes to revoke authorisation A91078 and grant a new authorisation A91376 in substitution. The proposed substitute authorisation is to enable the RDAA and its constituent state associations to collectively negotiate with state and territory health departments the terms of contracts for general practitioners or rural generalist visiting medical officers in rural areas, particularly with respect to payments for services provided to public patients and for on-call services.

117. The ACCC proposes to grant the substitute authorisation for five years.

118. This draft determination is made on 28 August 2013.

Conduct not proposed to be authorised

119. For the reasons set out in this draft determination, the ACCC proposes not to extend authorisation to the RDAA and its constituent state associations to collectively negotiate with Medicare Locals and Local Hospital Networks the terms of contracts for general practitioners or rural generalist visiting medical officers in rural areas particularly with respect to payments for services provided to public patients and for on-call services.

Further submissions

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

[26] See Attachment A.

Attachment A - Summary of relevant statutory tests

Subsections 90(5A) and 90(5B) provide that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding that is or may be a cartel provision, unless it is satisfied in all the circumstances that:

- the provision, in the case of subsection 90(5A) would result, or be likely to result, or in the case of subsection 90(5B) has resulted or is likely to result, in a benefit to the public; and

- that benefit, in the case of subsection 90(5A) would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result, if the proposed contract or arrangement were made or given effect to, or in the case of subsection 90(5B) outweighs or would outweigh the detriment to the public constituted by any lessening of competition that has resulted or is likely to result from giving effect to the provision.

Subsections 90(6) and 90(7) state that the ACCC shall not authorise a provision of a proposed contract, arrangement or understanding, other than an exclusionary provision, unless it is satisfied in all the circumstances that:

- the provision of the proposed contract, arrangement or understanding in the case of subsection 90(6) would result, or be likely to result, or in the case of subsection 90(7) has resulted or is likely to result, in a benefit to the public; and

- that benefit, in the case of subsection 90(6) would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result, if the proposed contract or arrangement was made and the provision was given effect to, or in the case of subsection 90(7) has resulted or is likely to result from giving effect to the provision.