Determination

Application for authorisation

lodged by

Australian Medical Association Limited

in respect of

intra-practice prices setting and collective bargaining

Date: 21 February 2013

Authorisation number: A91334

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Summary

The Australian Competition and Consumer Commission (ACCC) has decided to grant authorisation for five years to general practitioners who operate within certain team based practice structures to engage in intra-practice price setting and collective bargaining with VMO Service Purchasers and Medicare Locals.

The ACCC grants authorisation until 15 March 2018.

1. The application for authorisation

1. On 11 September 2012, the Australian Medical Association Limited (**AMA**) lodged an application for authorisation (A91334) with the ACCC pursuant to sections 88(1) and 88(1A) of the *Competition and Consumer Act 2010* (the **Act**). On 13 November 2012 the AMA amended its application for authorisation to extend the scope of the participants covered by the application. On 5 December 2012, the AMA further amended its amended application, seeking to extend the scope of the authorisation to cover all GPs within defined practice structures.

2. The AMA has sought authorisation to permit general practitioners[1] (**GP**s) (that practise in the defined business practices below) to engage in:

   - intra-practice price setting;
   - collective bargaining as single practices, in relation to the provision of Visiting Medical Officer services (**VMO Services**)[2] to public hospitals, with '**VMO Service Purchasers**' which includes health departments, local area networks and hospitals as relevant; and
   - collective bargaining as single practices with Medicare Locals in relation to the provision of medical services (**Medicare Local Services**) including afterhours services[3]

   (the **Conduct**).

3. Broadly, the AMA has sought authorisation to cover GPs engaging in the Conduct who practise in a single general practice where those GPs:

   a) operate within one of the following business structures:

      i. a partnership of two or more GPs where not all partners are natural persons (that is, where at least one is a body corporate or other separate legal entity);

      ii. an associateship of two or more GPs[4];

[1] General practitioner is defined by the AMA in its letter dated 13 November 2012, available on the ACCC's Authorisations Public Register at www.accc.gov.au/authorisationsregister.

[2] VMOs 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/*.

[3] Medicare Locals have been established as independent legal entities by the Federal Government to perform the activities that Divisions of General Practices previously undertook and also to identify and fill gaps in local health care systems.

[4] The definition of an associateship is based on paragraph 3.3 of ACCC determination A91024 and is defined as:

   a) two or more GPs who are co-located or operate as a branch practice; and

iii. any other business structure which involves two or more separate legal persons, whether natural persons, partnerships and/or bodies corporate; or

iv. any of the above which, from time to time, employs GPs on a locum basis;[5] and

b) share three or more of the following: patient records, common facilities, a common trading name and/or common policies and procedures.

4. The ACCC considers that the AMA's definition of a single practice provides the flexibility to cover the range of business structures and practice management arrangements used by Australian general practitioners. For example, the ACCC understands that in remote areas, a single general practice may include a branch facility as well as the main practice, and that such practices may use more than one of the business structures in paragraph 3(a) above. However, the ACCC has assessed this authorisation application on the basis that it is intended to cover genuine shared single practices, even when more than one of these business structures is involved. Accordingly, the ACCC considers a shared practice to be one which satisfies three or more of the factors listed in paragraph 3(b) above, and which uses one or more of the business structures listed in paragraph 3(a) above.

Draft determination

5. Section 90A(1) requires that before determining an application for authorisation the ACCC shall prepare a draft determination. On 12 December 2012, the ACCC issued a draft determination proposing to grant authorisation in respect of the Conduct for a period of five years.

6. A pre-decision conference was not requested in relation to the draft determination.

2. Previous relevant authorisations

RACGP 2007 Authorisation (A91024) and 2002 A90795

7. The ACCC granted authorisation A90795 to the Royal Australian College of General Practitioners (**RACGP**) in 2002 and granted A91024 in substitution in 2007. Broadly, these two authorisations permitted GPs and other medical practitioners in general practice to engage in intra-practice price setting and collective bargaining (as single practices) over VMO services to public hospitals. Authorisation A91024 was granted for four years and lapsed on 14 June 2011.

RDAA 2008 Authorisation (A91078)

8. The ACCC granted authorisation A91078 to the Rural Doctors Association of Australia (**RDAA**) in 2008 for five years, until 30 June 2013. Broadly, this authorisation permits the RDAA and its constituent state associations to collectively negotiate, on behalf of RDAA members which are rural generalists and GPs, with state and territory health departments regarding the provision of VMO services.

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b) which has a common service entity, in which each of the GPs must either have an interest in the service entity; have contracted with the service entity; or be employed or otherwise engaged by the service entity to provide medical services on the service entity's behalf; and

c) the service entity is responsible for managing and/or maintaining a common reception, common fee collection, common bank account, common trading name, common medical records and, except for branch practices, common policy and procedures.

[5] On 13 November 2012 the AMA amended its application for authorisation in these terms.

3. Submissions received by the ACCC

9. The ACCC tests the claims made by an applicant in support of an application for authorisation through an open and transparent public consultation process. In assessing authorisation application A91334 the ACCC sought submissions from 103 interested parties (other than the AMA) potentially affected by the application. These interested parties included various health departments, each of the Medicare Locals and a variety of consumer and medical representation organisations.

10. Prior to issuing its draft determination, the ACCC received public submissions from Inner East Melbourne Medicare Local, Northern Territory Medicare Local, Consumers Health Forum of Australia (CHFA) and the RACGP. After the ACCC issued its draft determination, it received submissions from the CHFA and the RDAA.

11. A summary of the submissions received from the AMA and interested parties follows. Copies of public submissions may be obtained from the ACCC's website www.accc.gov.au/authorisationsregister**.**

The AMA

12. Broadly, the AMA submits that authorisation of the Conduct is likely to result in a number of public benefits arising from the promotion of a collegiate atmosphere within general practices and facilitation of the identification and implementation of measures to produce greater contractual, operational, transaction and administrative efficiencies.

13. The AMA submits that any public detriments arising through anti-competitive effects are likely to be limited by the high levels of bulk billing for GP services, the small size of each practice group, the voluntary nature of the Conduct and the constraints of health budgets.

Interested parties

14. Submissions from interested parties generally support the potential public benefits of the Conduct claimed by the AMA. However, submissions received before the draft determination was issued raised concerns that:

    - the expected benefits would not arise in practice, given the original limitation in the AMA's unamended authorisation application to only apply to AMA members;
    - the team structure of general practice (as described by the AMA) would not be supported if non-AMA members were excluded from participating in the Conduct;
    - non-AMA members would be disadvantaged compared to AMA members, should the Conduct be limited to AMA members; and
    - authorisation would cause confusion amongst GPs due to the mix of GPs covered by any authorisation.

15. Originally, the AMA's application applied only to AMA members. In response to the above concerns, on 13 November 2012 the AMA amended its application to extend it to cover non-AMA member GPs in practices that meet the criteria in paragraph 3. On 5 December 2012, the AMA further amended its amended application, seeking to extend the scope of the authorisation to cover all GPs within defined practice structures that satisfy the criteria in paragraph 3.

16. The ACCC considers that the effects of the AMA's further amendment of its application are likely to address the concerns raised by interested parties. The submissions received by the ACCC in response to the draft determination support this assessment.

4. ACCC evaluation

17. The ACCC's evaluation of the proposed Conduct is in accordance with the relevant net public benefit tests[6] contained in the Act. In broad terms, under the relevant tests the ACCC shall not grant authorisation unless it is satisfied that the likely benefit to the public would outweigh the detriment to the public constituted by any lessening of competition that would be likely to result.

18. In its evaluation of the effect of the proposed Conduct, and the public benefits and detriments likely to result, the ACCC has taken into account:

    a) the submissions received in response to the ACCC's initial consultations, following the AMA's further amendment of its application and after issuing its draft determination;

    b) the AMA's further amendment to extend its application for authorisation to include all GPs that practise in the defined business structures;

    c) information available to the ACCC from previous relevant matters including the RACGP 2007 Authorisation and the RDAA 2008 Authorisation;

    d) the likely alternative future should authorisation not be granted. In particular, absent authorisation, the ACCC considers that in relation to:

        i. **intra-practice price setting -** other than general practices that meet certain limited exemptions,[7] GPs within practices will set prices for patients on an individual basis, which is likely to reduce the attractiveness and benefits of shared practices;

        ii. **collective bargaining over VMO Services** - apart from any GPs covered by the RDAA 2008 authorisation (which expires in 2013) and GPs in practices that meet certain limited exceptions, [8] GPs will continue to negotiate individually with VMO Service Purchasers in relation to VMO Services; and

        iii. **collective bargaining over Medicare Local services** – apart from GPs in practices that meet certain limited exceptions,[9] GPs will contract on an individual basis with individual Medicare Locals;

    e) the relevant areas of competition likely to be affected by the authorisation, in particular localised geographic areas of competition for:

        i. the provision of primary medical services to the public;

        ii. the provision of VMO Services to public hospitals; and

        iii. the provision of Medicare Local Services to Medicare Locals;

    f) the five year authorisation period requested;

[6] Subsections 90(5A), 90(5B), 90(6) and 90(7). The relevant tests are set out in Attachment A.
[7] For example, practices that involve partnerships of natural persons, practices that constitute single bodies corporate or related bodies corporate and certain joint ventures.
[8] As above in note 7.
[9] As above in note 7.

g) that the scope of each bargaining group is limited to, at most, all of the GPs within a single practice; and

h) that participation in all aspects of the Conduct is voluntary for all parties and no collective boycott activity is proposed in relation to the collective bargaining aspects of the Conduct.

Public benefit

19. The ACCC considers that the Conduct in its amended form is likely to result in a number of public benefits. The ACCC considers that the Conduct is likely to increase the attractiveness and benefits of shared practices through:

    a) administration efficiencies for single general practices which can reduce the number of different charging schedules each practice must administer and allocate costs against;

    b) a greater ability (at the margin) for single general practices in remote and regional areas to attract and retain locums and GPs (through greater certainty relating to remuneration packages); and

    c) improved continuity and consistency of patient care by providing a seamless integrated service across GPs in each practice.

20. Specific benefits related to the proposed collective bargaining aspects of the Conduct are also likely to include:

    a) a greater ability for GPs within a practice to identify efficiencies in the way that the practice provides VMO Services to public hospitals and Medicare Local Services to Medicare Locals, following the information exchange inherent in collective bargaining;

    b) efficiencies for GPs within practices that can share negotiation expertise and costs;

    c) efficiencies for any VMO Service Purchasers and Medicare Locals that are able to reduce the number of negotiation processes that must be engaged in and contracts which must be monitored; and

    d) greater input by GPs within a practice into the terms and conditions under which services are provided by the GPs in that practice to public hospitals and Medicare Locals; which is likely to result in more efficient contracts and service provision.

Public detriment

21. The ACCC considers that the Conduct is likely to result in little if any public detriments in local markets since:

    a) the provision of primary medical services to the public is unlikely to be affected by reduced competition or services from intra practice price setting since:

        i. around 80% of GP services in Australia are bulk-billed;[10]

        ii. prices will only be set within each practice, and each practice will continue to compete with other practices on both price and non-price terms. The ACCC notes that patients who are not bulk billed in areas where bulk billing is available appear to value non-price aspects of GP care over price. These

[10] AMA *Application for authorisation* 11 September 2012, p. 29.

patients are less likely to change practice due to price changes but are more likely to value the non-price benefits of the Conduct such as greater continuity of care; and

iii. existing intra-practice competition (particularly on non-price factors) is likely to be limited in associateships and partnerships due to the sharing of patient records and emphasis upon a team approach;

b) VMO Services to public hospitals and Medicare Local Services to Medicare Locals are unlikely to be affected by reduced competition or services from collective bargaining over service provision since:

i. the relevant VMO Service Purchasers and Medicare Locals are not obliged to negotiate with a practice collectively;

ii. each bargaining group will be small and, except in some remote areas, will not represent all the GPs who may supply VMO Services to a particular hospital or Medicare Local Services to a Medicare Local; and

iii. public hospitals and Medicare Locals 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.

22. The ACCC notes that a number of submissions received by the ACCC in relation to the application questioned whether authorisation of the proposed conduct may relatively disadvantage non-AMA member GPs. The submissions note that the AMA represents less than a quarter of Australian GPs.

23. The ACCC considers that the AMA's further amendment to its application removes any potential concerns that might otherwise arise in this respect.

Balance of public benefit and detriment

24. For the reasons outlined in this determination the ACCC is satisfied that the Conduct is likely to result in a benefit to the public and the likely public benefit would outweigh the likely public detriment constituted by any lessening of competition that would be likely to result. Accordingly, the ACCC is satisfied that the relevant net public benefit tests are met.

Length of authorisation

25. The ACCC proposes to grant authorisation to the AMA for five years, as sought.

5. Determination

Grant of authorisation

26. For the reasons in this determination, the ACCC is satisfied that the tests in sections 90(5A), 90(5B), 90(6) and 90(7) of the Act are met[11]. Accordingly, under sections 88(1A) and 88(1) of the Act, the ACCC grants authorisation A91334 for a period of five years to permit all GPs who practise in a single practice that:

a) operates within one of the following business structures:

i. a partnership of two or more GPs where not all partners are natural persons (that is, where at least one is a body corporate or other separate legal entity);

[11] See Attachment A to this Determination A91334.

ii. an associateship of two or more GPs;[12]

iii. any other business structure which involves two or more separate legal persons, whether natural persons, partnerships and/or bodies corporate; or

iv. any of the above which, from time to time, employs GPs on a locum basis; and

b) share three or more of the following: patient records, common facilities, a common trading name, and/or common policies and procedures

to engage in:

- intra-practice price setting;
- collective bargaining, as single practices with VMO Service Purchasers, in relation to the provision of VMO Services to public hospitals; and
- collective bargaining, as single practices, with Medicare Locals, in relation to the provision of Medicare Local services.

27. Under section 88(10) of the Act, the ACCC extends the authorisation to other GPs who, in the future, practise in a single general practice (including a branch practice) that meets the criteria set out in paragraph 3 of this determination.

Conduct not authorised

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

Date authorisation comes into effect

29. This determination is made on 21 February 2013. If no application for review of the determination is made to the Australian Competition Tribunal, it will come into force on 14 March 2013.

[12] See footnote 4 above.

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.