30 April 2013

The General Manager
Adjudication Branch
ACCC
PO Box 1199
DICKSON ACT 2602

Dear Sir/Madam

I enclose an application from the Rural Doctors Association of Australia Limited (RDAA) for revocation and substitution of **Authorisation no: A91078,** which was granted in May 2008 to the Rural Doctors Association of Australia (RDAA) and its constituent state associations to collectively negotiate with state/territory health departments regarding the terms of contracts for general practitioner or rural generalist visiting medical officers (VMOs) in rural areas, particularly with respect to payments for services provided to public patients and for on-call services. This authorisation was granted for a period of five years and will expire on 30 June 2013.

As outlined in the attached application, Authorisation A91078 is still relevant and necessary with respect to collective negotiations between RDAA and its constituent state associations and State and Territory Health Departments. This authorisation has facilitated effective negotiations and agreements in a number of States and it is anticipated that these arrangements would continue under this application.

The implementation of the Federal government's health reform agenda, specifically the formation of Medicare Locals and Local Hospital Networks, has resulted in a need to expand authorisation A91078 to include these organisations. The proposed revocation and substitution of this authorisation would allow RDAA and its constituent State Associations to become involved in negotiations between rural doctors and rural practice entities for the provision of a range of primary health care services, including after-hours services, with their respective Medicare Locals, where this involvement is appropriate. These arrangements would largely take place at the local level and it is not envisaged that any state or national agreements could or would be put in place.

Given the time frames involved in undertaking a full assessment of this application, RDAA requests that an interim authorisation be granted, so that continuity and certainty can be provided particularly with respect to current and ongoing negotiations, while the attached application for revocation and substitution is under consideration. However while there may be ongoing negotiations, it is not anticipated that any new agreements with State and Territory Health Departments regarding the provision of VMO and other hospital-based services will be formally signed in the period to December 2013.

Agreements between Medicare Locals and rural general practitioners and practices regarding the provision of after-hours and other primary care medical services are already being signed, and will continue to be negotiated and signed during the period for which any interim authorisation is provided.

Payment of the fee of $2,500 has been made by electronic funds transfer. The details of this transfer are attached.

Thank you for your consideration of this application and the request for interim authorisation. I would be happy to provide further information if required.

Yours sincerely

Jenny Johnson

Jenny Johnson
Chief Executive Officer

Form FC

Commonwealth of Australia

Competition and Consumer Act 2010 — subsection 91C (1)

APPLICATION FOR REVOCATION OF A NON-MERGER AUTHORISATION AND SUBSTITUTION OF A NEW AUTHORISATION

To the Australian Competition and Consumer Commission:

Application is hereby made under subsection 91C (1) of the *Competition and Consumer Act 2010* for the revocation of an authorisation and the substitution of a new authorisation for the one revoked.

PLEASE FOLLOW DIRECTIONS ON BACK OF THIS FORM

1. Applicant

A91376

(a) Name of applicant:
Rural Doctors Association of Australia Limited.

(b) Description of business carried on by applicant:

The Rural Doctors Association of Australia (RDAA) is the peak organisation representing the interests of doctors working in rural medical practice throughout Australia. RDAA represents the full range of rural doctors, including both specialists and generalists, and doctors working in both the public and private sectors.

The objects of RDAA focus on acquiring the highest standard of medical care for people living in rural Australia. This includes advocating for a highly skilled and motivated rural medical workforce which is appropriately trained, remunerated and supported.

(c) Address in Australia for service of documents on the applicant:

Postal address: PO Box 3636, Manuka, ACT 2603

2. Revocation of authorisation

(a) Description of the authorisation, for which revocation is sought, including but not limited to the registration number assigned to that authorisation:

Authorisation no: A91078 was granted in May 2008 to the Rural Doctors Association of Australia (RDAA) and its constituent State associations to collectively negotiate with state/territory health departments regarding the terms of contracts for general practitioner or rural generalist visiting medical officers (VMOs) in rural areas, particularly with respect to payments for services provided to public patients and for on-call services.
This authorisation was granted for a period of five years and will expire on 30 June 2013.

(b) Provide details of the basis upon which revocation is sought:

The existing authorisation (A91078) is still relevant and necessary with respect to collective negotiations between RDAA and its constituent state associations and State and Territory Health Departments.

However the formation of Medicare Locals and Local Hospital Networks has resulted in a need to extent the scope of authorisation A91078 to include those organisations.

3. Substitution of authorisation

(a) Provide a description of the contract, arrangement, understanding or conduct whether proposed or actual, for which substitution of authorisation is sought:

The Rural Doctors Association of Australia (RDAA) seeks a substitution of authorisation for the Association and its constituent members (being the Rural Doctors Associations in each State) to enter into agreements with State Health Departments; Local Hospital Networks and Medicare Locals where applicable, regarding the contracting rural doctors, otherwise in local or other practice, as Visiting Medical Officers (VMOs) or for the provision of primary health care services, including after-hours services, by these Departments and Authorities.

These agreements 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 and other broader aspects of support and remuneration. They could also include payments for the provision of primary care services, including after-hours services in the general practice or other primary care setting.

VMO Services: VMO agreements are expected to be made on a state-by-state basis, or with individual Local Hospital Networks in some circumstances. They would continue or develop arrangements already in place in those States where the State Health Department unilaterally elects to determine the arrangements for the contracting of doctors to state hospitals and facilities.

The nature of negotiations which take place at the State level, and the extent of RDA involvement in these negotiations, varies widely between States. National agreements concerning pay and conditions of rural VMOs are not expected at this time but remain a possibility for the future.

It may also be that responsibility for these agreements is devolved to Local Hospital Networks (LHNs) in the future. Circumstances may arise in which all parties, including health consumers, would benefit if RDAA and its constituent state associations were able to provide advice, or become involved in these negotiations. Once again, it is not expected that national agreements could or would be put in place.

Under current arrangements, VMO fees for rural doctors in all States except Victoria are currently set by on a state-wide basis by State Departments of Health. Under authorisation A91078, the Rural Doctors Association of Australia and its State constituent associations have been authorised by the ACCC to participate in the negotiation of these agreements with State Departments of Health on behalf of rural doctors.

In Victoria, VMO arrangements are negotiated directly between medical practitioners and practices and Local Hospital Networks Boards in rural areas. The Rural Doctors Association of Victoria (RDAV) continues to encourage the State Government under authorisation A91708 to implement a State-wide arrangement, which it believes to be allowed under the 1987 Health Services Act, as being in the best interests for the rural public.

Negotiations with Medicare Locals: With respect to Medicare Locals, the proposed substitution of authorisation would allow RDAA and its constituent State Associations to become involved in negotiations between rural doctors and practice entities for the provision of a range of primary health care services, including after-hours services, with their respective Medicare Locals, where RDAA involvement is appropriate. These arrangements would largely take place at the local level and it is not envisaged that any state or national agreements could or would be put in place.

This application does not extend to rural specialists working in specialist areas other than general practice (the Australian Health Practitioner Regulation Agency recognises general practice as a specialist discipline).

The proposed arrangements would be entirely voluntary. Parties to the application would not be bound to participate in the proposed arrangements and there is no provision or intention for any boycott arrangements as part of this application.

In February 2013, the ACCC granted authorisation (No: A91334) to general practitioners who operate within certain team-based practice structures to engage in collective bargaining with purchasers of VMO and primary care services. This authorisation is necessary and relevant; however it refers to single practice entities and therefore does not cover broader negotiations between purchasers of VMO or primary health care services on the one hand and organisations such as the RDAA on the other.

Under the proposed arrangements for this application for revocation and substitution, and further to any arrangements under ACCC authorisation A91334, rural doctors and practices will be able to have contracts with purchasers of VMO and other hospital services, and/or their respective Medicare Locals, where the content may be determined with input from RDAA or State RDAs.

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

Provision of medical services including surgery, obstetrics, anaesthetics, emergency services and broad inpatient care and medical consultations by rural generalists and rural general practitioners in rural public hospitals and health facilities.

Primary medical care and related services, including after-hours services, which may be provided under agreement to Medicare Locals.

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

The substitute authorisation is requested for a period 5 years. The negotiation of the arrangements relating to the provision of services in rural hospitals and health services is an ongoing process with fees and arrangements being reviewed/indexed usually on a yearly basis.

RDAA anticipates that there will be a continuing need for this authorisation, as the nature and demands of rural medical practice are unlikely to change in the short to medium term.

The current authorisation (no A91078) for which revocation and substitution is applied, was granted for a period of 5 years. Given that this authorisation has worked effectively, a similar time frame would be appropriate for this application.

In February 2013, the ACCC granted authorisation (No: A91334) through the Australian Medical Association to general practitioners who operate within certain team-based practice structures to engage in collective bargaining with VMO service purchasers. This authorisation also has a duration of 5 years.

4. Parties to the contract, arrangement or understanding (whether proposed or actual), or relevant conduct, for which substitution of authorisation is sought

(a) Names, addresses and description of business carried on by those other parties to the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct:

Members of RDAA and its Constituent State Associations: The individual doctors who would be a party to contracts with the State Health Authorities would be current and future members of the RDAA and its constituent State Associations. These doctors are rural general practitioners (including GP Registrars and locums) who provide services in public hospitals and health facilities as Visiting Medical Officers, and primary care services, including after-hours services, which may be contracted by Medicare Locals.

It is not intended for the RDAA or its constituent State Associations to negotiate on behalf of rural medical specialists who are not engaged in the specialty of general practice as a part of this authorisation.

State Health Departments/Authorities in each State, as listed below:

Party	Postal address
Department of Health - New South Wales	Locked Mail Bag 961 North Sydney NSW 2059
Department of Health and Community Services - Northern Territory	PO Box 40596, Casuarina NT 0811
Queensland Health	GPO Box 48 Brisbane Queensland 4001
Department of Health - South Australia	PO Box 287 Rundle Mall Adelaide SA 5000
Department of Health and Human Services - Tasmania	GPO Box 125, Hobart TAS 7001
Department of Human Services – Victoria	GPO Box 4057 Melbourne Vic 3001
Department of Health - Western Australia	PO Box 8172 Perth Business Centre Perth WA 6849

The nature of negotiations for VMO and other hospital-based services varies from State to State, as does the level of RDA involvement in these negotiations. More information on these negotiations is included in Section (5).

Local Hospital Networks (LHNs): LHNs are separate statutory authorities which are responsible for the management of public hospitals. The boundaries for the 137 LHNs include 124 geographically-based networks, together with 13 state-wide networks which will deliver some specialised services across some jurisdictions.

LHNs are made up of small groups of local hospitals that collaborate to deliver patient care and manage their own budget. LHNs will be held directly accountable for their performance. The size and scope of responsibility for LHNs will vary from State to State.

Although it is likely that current arrangements for the negotiation of VMO fees and conditions will continue at the State level for all States except Victoria, this may change in the future, and the role of LHNs may possibly evolve to include direct negotiations with organisations such as RDAA and its constituent state associations, as well as with individual doctors, regarding the provision of these and other services.

At this point in time, the governance and catchments of health services in Victoria are not expected to change, and hospital boards (which will be referred to as LHNs) will continue to negotiate VMO fees and conditions directly with doctors. The Rural Doctors Association of Victoria (RDAV) wishes to continue negotiations towards State-wide arrangements in Victoria, believing these to be beneficial in other States.

However the establishment of LHNs is a relatively new initiative, which is in the first stages of implementation, and the scope of their activities and

responsibilities may be extended in the future.[1]

Medicare Locals: A nation-wide network of Medicare Locals has been progressively established as a key component of the Australian Government's National Health Reform agenda. Medicare Locals are primary health care organisations which will coordinate the delivery of primary health care services and address local health care needs and service gaps. They are charged with the responsibility to drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.

Each Medicare Local has an independent company structure. Each of these organisations will receive federal government funding to undertake a number of tasks and achieve outcomes determined by the government. However Medicare Locals may also seek funding from other sources. Medicare Locals will be expected consult and collaborate with general practitioners and other stakeholders within their geographic coverage to undertake health services planning and to facilitate the delivery of a range of primary care services.

From July 2013, Medicare Locals will assume responsibility for the provision of after-hours services. In order to fulfil this function, MLs will be entering into negotiations and contractual agreements with rural doctors and medical practices for the provision of these services. It is anticipated that that the range of services for which contractual agreements with these doctors and medical practices will be negotiated will extend beyond the provision of after-hours services in the future.

Of the total of 61 Medicare Locals which have been established nationally, at least 41 have a significant rural constituency. [2]

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[1] More information on LHNs, including their boundaries, can be found at: www.yourhealth.gov.au

[2] More information on Medicare Locals, including boundaries, can be found at: www.yourhealth.gov.au

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

Members of RDAA and its Constituent State Associations: The individual doctors who would be a party to contracts with the State Health Authorities would be current and future members of the RDAA and its constituent State Associations. These doctors are rural general practitioners (including GP Registrars and locums) who provide services in public hospitals and health facilities as Visiting Medical Officers, and primary care medical services, including after-hours services, which may be contracted by Medicare Locals.

(c) Where those parties on whose behalf the application is made are not known - description of the class of business carried on by those possible parties to the contract or proposed contract, arrangement or understanding:

n/a

5. Public benefit claims

(a) Arguments in support of application for substitution of authorisation:
(See Direction 6 of this Form)

RDAA is applying for this substitution of authorisation on the grounds that, if granted, it will support rural doctors and facilitate their participation in the provision of VMO and other services. This in turn will promote more efficient delivery of health care services, better workforce recruitment and retention, and improved health outcomes for rural and regional communities in the longer term.

Continuity of Existing Negotiations and Arrangements: The granting of this application for revocation and substitution of A91078 would enable the RDAA and its State members to continue to effectively negotiate with the State health authorities regarding VMO services provided by rural doctors. This is especially necessary in States such as South Australia, where these negotiations are ongoing.

It would also enable RDAA and the State RDAs to support their rural doctor members in any negotiations with LHNs and Medicare Locals which are carried out at the regional or local level.

The existing authorisation (A91078) has facilitated effective negotiations and agreements in a number of States and it is anticipated that these arrangements would continue under this application.

New South Wales - A series of state-wide agreements has been made between the NSW Department of Health (NSWDOH) and the Rural Doctors Association of New South Wales (RDANSW) and/or the Australian Medical Association (NSW) and that define the terms and conditions of individual VMO service contracts.

South Australia – the South Australian Department of Health (SADOH), through Country Health SA Local Hospital Network (CHSA LHN), operates as a single agency covering all health units in country SA. The South Australian government, through CHSA LHN, has adopted a collaborative model in negotiating the South Australian Rural Medical Engagement Schedule and the South Australian Medical Schedule of Fees. This involves consultation with Rural Doctors Association of South Australia (RDA SA) to work through the industrial process in a collaborative manner. Over the past five years, the existing authorisation has facilitated the provision of an official contract for rural doctors who provide services to SA rural hospitals.

Queensland - the State government (acting through Queensland Health, the Department of Corrective Services and the Department of Communities) negotiates an agreement with the Queensland Branch of the Australian Medical Association concerning the supply of VMO services. In Queensland, 'VMO' refers to Visiting Senior Specialists, Visiting Specialists and Visiting Medical Officers (GPs including Rural GPs/Rural Generalists). While not directly represented, the Rural Doctors Association of Queensland (RDAQ) has been involved in these negotiations.

Western Australia - most country doctors in the southern half of the state provide services to their local hospitals under contract. Visiting medical practitioners are engaged on the basis of a medical service agreement (MSA). The terms and conditions component of the MSA is largely non-negotiable. The content of the schedules is negotiated individually (with doctors or their agents), taking into account the skills of the doctor concerned, the service requirements of the hospital(s), the volume of service anticipated to be purchased and the payment models preferred by both parties. The Rural Doctors Association of Western Australia (RDAWA) supports individual members in these negotiations.

Tasmania - VMOs operate predominantly under arrangements set by the State government, with some consultations regarding these arrangements taking place with rural doctors and the Australian Medical Association.

As a result of RDAA and its constituent State Associations being able to be involved in these negotiations, there has been more certainty for rural doctors. This in turn increases the possibility of doctors participating in VMO rosters in rural areas.

Negotiations with Local Hospital Networks and Medicare Locals: As previously outlined, there is the possibility that some VMO or other agreements could be negotiated directly with LHNs in the future. If this is the case, the proposed authorisation would provide support for doctors and practices in those negotiations.

Any initiative which facilitates rural workforce recruitment and retention, including the granting of this substitution of authorisation, will in turn improve health outcomes and result in considerable economic and social benefits for rural communities.

Health Outcomes in Rural Communities:

Rural Australians have poorer health outcomes than their urban counterparts.

Australia's Health 2012, the biennial report from the Australian Institute of Health and Welfare (AIHW), was released in June 2012[3]. The report shows that:

- people who live in regional, rural and remote areas are more likely to report four or more health risk factors than people who live in major cities[4]
- the five year survival of people diagnosed with cancer decreases as their remoteness increases, with five year survival being the highest for people living in major cities and the lowest for people living in remote and very remote areas[5]
- people living in regional and remote areas continue to have higher rates of death from cardiovascular disease than Australians living in the major cities[6]
- rates of potentially preventable hospitalisation increase with remoteness[7], and
- people living in areas outside major cities are also more likely to have lower health literacy, which places them at greater risk of adverse health outcomes.[8]

Additionally:

- life expectancy in rural and remote areas is up to 7 years less than the city[9],
- rural mortality rates are up to 3 times higher than city rates[10]
- There is a higher prevalence of mental health problems in rural and remote areas [11], and
- Suicide rates in rural and remote areas are up to 30% higher than in cities[12].

With approximately 31% of people living outside the major cities, tthese poor health outcomes have a significant range of economic and social impacts, including lost productivity and increased health care costs, at both the local, regional and national level.

The Rural Medical Workforce:

The shortage of rural doctors appropriately skilled in advanced community and hospital medical care is a significant contributing factor to poor health outcomes in rural communities.

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[3] Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no 13 Cat. No. AUS 156

[4] Ibid at 246.

[5] Ibid at 263.

[6] Ibid at 267.

[7] Ibid at 377.

[8] Ibid at 182.

[9] http://www.aihw.gov.au/ruralhealth/healthstatus/lifeexpect.cfm

[10] Ibid.

[11] Australian Institute of Health and Welfare (AIHW), 2010, Australia's Health 2010, AIHW, Canberra, at 248.

[12] Ibid, at xi.

Australia's Health 2012 also notes that, in the major cities, there is one doctor for every 255 people[13]. In outer regional areas, that ratio almost doubles to one doctor for every 485 people[14].

The rural and remote medical workforce is ageing. The average age of rural GPs is 49 years (51.32 years for male GPs and 46.50 years for female GPs)[15]. Rural doctors have been engaged in major contributions to medical student, GP registrar and advanced rural medical training for over 2 decades but this as yet has not translated into workforce renewal, with less than 5% of Australian graduates taking up rural careers. Every affirmative method has to be utilised to reverse this situation.

Currently, Overseas Trained Doctors (OTDs) make up more than 41% of the rural medical workforce[16]. In many cases, those doctors only partially fill the rural general practice service gap because, starting often with training inadequate to the Australian rural context, they are compelled to work in rural and remote areas where they face cultural and geographic isolation, with often limited opportunities for ongoing mentoring and training.

The upshot of this situation is that there has been and continues to be major loss of medical services from rural hospitals especially in terms of acute medical, emergency, obstetric, after hours, and advanced community medical care. This ACCC has previously been informed of this situation, which is ongoing, through the submission provided by the Rural Doctors Association of Victoria in April 2007 to the RACGP Application for Revocation and Substitution no A9124.

With greatly increased medical school output just commencing there is an opportunity to recruit and train a replacement workforce, however attracting these doctors to rural areas will be an ongoing challenge.

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

Statistics relevant to the rural medical workforce and to the health of rural Australians are provided in the previous section.

6. Market definition

Provide a description of the market(s) in which the goods or services described at 3 (b) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):
(See Direction 7 of this Form)

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[13] Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no 13 Cat. No. AUS 156; at 503.
[14] Ibid at 503.
[15] Rural Health Workforce Australia, *Medical Practice in Rural & Remote Australia: National Minimum Data Set (MDS) Report* as at 30th November 2010, at 4.
[16] Australian Government Department of Health and Ageing (DoHA), 2008. *Report on the Audit of Health Workforce in Rural and Regional Australia,* April 2008. Commonwealth of Australia, Canberra,, at 27.

The provision of VMO services to rural hospitals and health facilities: These services are provided by rural general practitioners to rural medical facilities within a defined geographic area, and usually in the community in which the practitioner is located in the vast majority of cases. There may be some instances where VMO services are provided to hospitals and facilities in other towns in the vicinity. These would usually relate to procedural services such as obstetrics or anaesthetics, or to services provided to facilities in nearby locations where there is no available medical practitioner.

Given the distances and associated travel time involved, it is not usual for a rural medical general practitioner to provide VMO or other services to multiple hospitals or facilities. Where this does happen, it is usual for individual negotiations to occur.

The provision of services to Medicare Locals: These services would be provided by rural doctors within a defined geographic area and usually restricted to the community in which the doctor is located.

7. Public detriments

(a) Detriments to the public resulting or likely to result from the substitute authorisation, in particular the likely effect of the conduct on the prices of the goods or services described at 3 (b) above and the prices of goods or services in other affected markets:
(See Direction 8 of this Form)

The existing arrangements for the state-wide negotiation of VMO agreements have worked well to date with no evidence of public detriment. This application for revocation and substitution would see a continuation of these arrangements but with an extension to include Local Hospital Networks (LHNs) and Medicare Locals.

(b) Facts and evidence relevant to these detriments:

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, under existing arrangements and with RDA input.

In Victoria, the proposed arrangements are a continuation of those which have been in place since the previous authorisation which have not resulted in any known public detriment to date.

It should also be noted that there has not been and would be no compulsion associated with the proposed arrangements and that all parties can avail themselves of other arrangements.

8. Contracts, arrangements or understandings in similar terms

This application for substitute authorisation may also be expressed to be made in relation to other contracts, arrangements or understandings (whether proposed or actual)

that are, or will be, in similar terms to the abovementioned contract, arrangement or understanding

(a)Is this application to be so expressed?

No

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

(i) description of any variations between the contract, arrangement or understanding for which substitute authorisation has been sought and those contracts, arrangements or understandings that are stated to be in similar terms:
(See Direction 9 of this Form)

(ii) Where the parties to the similar term contract, arrangement or understanding(s) are known - names, addresses and description of business carried on by those other parties:
(See Direction 5 of this Form)

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

9. 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*)?

No

(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?

10. Further information

(a) Name, postal address and telephone contact details of the person authorised by the parties seeking revocation of authorisation and substitution of a replacement authorisation to provide additional information in relation to this application:

Jennifer Johnson
CEO – Rural Doctors Association of Australia Limited
PO Box 3636
MANUKA ACT 2603

Dated 7 May 2013

Signed by/on behalf of the applicant

Jenny Johnson

(Signature)

Jennifer Jane Johnson
(Full Name)

Rural Doctors Association of Australia
(Organisation)

Chief Executive Officer
(Position in Organisation)

DIRECTIONS

1. 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. In item 1 (b), describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding, or the relevant conduct, in respect of which substitute authorisation is sought.

4. In completing this form, provide details of the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, in respect of which substitute authorisation is sought.

   (a) to the extent that the contract, arrangement or understanding, or the relevant conduct, has been reduced to writing — provide a true copy of the writing; and

   (b) to the extent that the contract, arrangement or understanding, or the relevant conduct, has not been reduced to writing — provide a full and correct description of the particulars that have not been reduced to writing; and

   (c) If substitute authorisation is sought for a contract, arrangement or understanding (whether proposed or actual) which may contain an exclusionary provision — provide details of that provision.

5. Where substitute 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 contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, including quantification of those benefits where possible.

7. Provide details of the market(s) likely to be affected by the contract, arrangement or understanding (whether proposed or actual), in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the application for substitute authorisation.

8. Provide details of the detriments to the public, including those resulting from the lessening of competition, which may result from the contract, arrangement or understanding (whether proposed or actual). Provide 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.