Determination

Application for revocation of authorisation A91100 and substitution with A91392

lodged by

the Australian Medical Association of Australia Limited & Ors

in respect of

Collective bargaining with state and territory health departments

Date:19 March 2014

Commissioners: Sims
Rickard
Schaper
Cifuentes
Court

Summary

The ACCC revokes authorisation A91100 and grants authorisation A91392 in substitution. The substitute authorisation is for the Australian Medical Association Limited and its state and territory AMA organisations (excluding New South Wales and the Australian Capital Territory), to continue to collectively negotiate with state and territory health departments the terms of contracts, including fees, for rural general practitioners providing services as Visiting Medical Officers in public hospitals and health facilities in rural and remote areas of Australia (except NSW and the ACT). The arrangements are re-authorised until 10 April 2024.

The application for authorisation

1. On 31 October 2013 the Australian Medical Association Limited, on behalf of itself and its state and territory member organisations in Victoria, South Australia, Western Australia, the Northern Territory, Queensland and Tasmania (collectively the **AMA**), lodged an application with the ACCC to revoke authorisation A91100 and grant a substitute authorisation A91392 (re-authorisation) under section 91C(1) of the *Competition and Consumer Act 2010* (the **Act**).

2. The AMA sought re-authorisation to maintain the status quo – that is, to enable it to continue to collectively negotiate with relevant state and territory health departments, the terms of contracts (including fees) for general practitioners (**GPs)** providing services as visiting medical officers (**VMOs**) in public hospitals and health facilities in rural and remote areas of Australia (except New South Wales and the Australian Capital Territory).

3. The AMA submits that for the purpose of this application, a GP is defined as a doctor who holds vocational recognition status under the *Health Insurance Act 1973 (Cth),* or has access to A1 Medicare rebates under the Commonwealth Government workforce programs.

Background

4. The ACCC previously granted authorisation to the AMA for this conduct on 10 December 2008 until 28 February 2014.

5. The AMA is the peak health advocacy organisation in Australia, representing more than 27,000 doctors. The AMA membership includes doctors employed in the public sector and private practice. The AMA membership encompasses all craft and special interest groups including salaried doctors, general practitioners, other specialists, academics, researchers and doctors-in-training and rural, regional and metropolitan practitioners.

6. The AMA submits that in essence, standard VMO agreements are set at the state and territories level – except for Victoria where public hospitals in rural and remote areas negotiate directly with doctors regarding VMO appointments.

7. Further, the AMA submits that generally, under current arrangements and with the exception of South Australia, state and territory health departments

unilaterally determine the arrangements for the contracting of doctors in public hospitals and health facilities in rural and remote areas.

Interim authorisation

8. On 22 January 2014, the ACCC granted interim authorisation for the arrangements effective from 1 March 2014. 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.

Draft determination

9. Section 90A(1) requires that before determining an application for authorisation the ACCC shall prepare a draft determination.

10. On, 22 January 2014 the ACCC issued a draft determination proposing to re-authorise the proposed conduct for ten years.

Submissions received by the ACCC

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

Prior to the draft determination

12. The ACCC sought submissions from 35 interested parties potentially affected by the application, including industry associations, consumer organisations and state and territory government departments. The ACCC received five submissions.

13. Three of the submissions support the application - the Australian Healthcare and Hospitals Association submitted they believed the current arrangements are satisfactory and South Australia Health advised that it would be happy for the arrangements to be re-authorised as the AMA will be part of the next round of discussions.

14. The Royal Australian College of General Practitioners supports the application for re-authorisation as it believes that it provides a wide range of benefits to government health departments, rural health services, GPs and the rural communities they serve.

15. The Consumers Health Forum of Australia submits that it would expect to see empirical evidence of the AMA's claims.

16. The Northern Territory (NT) Department of Health noted that although it did not object to the arrangements, they were unlikely to be utilised as services in NT rural or remote settings are typically provided by locums and not VMOs.

Following the draft determination

17. The ACCC received one public submission from the Consumers Health Forum of Australia in response to the draft determination in which it reiterated its

request that the AMA collect key data to support its public benefit claims, particularly in light of a proposed longer authorisation period.

ACCC evaluation

18. The ACCC's evaluation of the proposed arrangements is in accordance with the relevant net public benefit tests[1] 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, and that the conduct is likely to result in such a benefit to the public that it should be allowed to take place.

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

    - the impact of the existing arrangements
    - submissions
    - information provided by the AMA
    - the likely alternative future without the conduct
    - the relevant areas of competition - which the ACCC considers relate to the provision of VMO services to public hospitals and health facilities in rural and remote areas of Australia with the exception of NSW and the ACT. However, the ACCC does not consider that it is necessary to precisely identify the relevant areas of competition in this instance as the outcome of the assessment will not be affected, and
    - the five year authorisation period requested.

Public benefit

Submissions

20. The Consumers Health Forum is disappointed that the AMA's application does not include any conclusive evidence to demonstrate tangible public health and consumer benefits in the five years since authorisation was granted. The Consumers Health Forum submits that it would expect to see more quantitative and qualitative evidence of the AMA's claims that collective negotiations with state and territory health departments have been effective. In particular, the Consumers Health Forum notes that the AMA is unable to find empirical data on transaction cost savings resulting in the five years since authorisation was granted.
21. Broadly, the AMA submits that since 2008, the authorisation has delivered, and will continue to deliver the following public benefits:

    - reduced transaction times and costs associated with contracting of GPs as VMOs,
    - more effective representation of rural doctors to state and territory health departments; and

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

- a positive effect on the attraction and retention of rural GPs as VMOs.

22. The AMA acknowledges that while the existing authorisation has had limited use in direct negotiations, except for South Australia and to some extent Western Australia, authorisation nevertheless provides peace of mind to all jurisdictions for consultations, and these consultations often form the backdrop for settlement agreements.

23. In response to the Consumers Health Forum's submission, the AMA submits that public benefits flowing from the existing authorisation have been supported by experiences gained since authorisation was granted in 2008. The AMA submits that given the voluntary nature of the arrangements, it is highly unlikely that health departments would agree to collective negotiations unless they were able to deliver a mutual benefit and part of that benefit is efficiency and cost savings that flow from it.

ACCC View

24. The ACCC considers that the collective bargaining arrangements are likely to continue to result in some public benefit from:

- Reduced transaction times and costs

  The ACCC has previously recognised that there are transaction costs associated with contracting and these transaction costs can be lower where a single negotiation process is employed, such as in a collective bargaining arrangement, relative to a situation where multiple negotiation processes are necessary.

  The ACCC considers that collective bargaining allows parties to share these costs which in turn may improve the level of input into negotiations with state and territory health departments and result in more efficient outcomes. This may provide VMOs with greater confidence in the stability and development of medical services in rural and remote Australia.

- Attraction and retention of rural GPs as VMOs

  To the extent that there are medical workforce shortages and issues associated with recruitment in rural and remote areas, the collective bargaining arrangements may provide VMOs with greater confidence with respect to the stability and availability of medical services in rural and remote Australia. This in turn may have a positive influence on the attraction and retention of VMOs in the Australian rural and regional health system.

Public detriment

Submissions

25. The Consumers Health Forum submits 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 increases in the price of medical services supplied by VMOs, and reductions in service availability, quality and choice.

26. The AMA submits that little if any public detriment has resulted from the authorisation and it is unlikely that any new or unexpected detriment has arisen or is likely to arise in the foreseeable future.

27. The AMA submits that the current level of individual bargaining between rural GPs for VMO services in public hospitals and health facilities in rural and remote areas of Australia, and the state/territory health departments, has been and remains consistently low, limiting the overall anti-competitive effect.

28. The AMA submits that in the majority of states VMOs have some ability to vary the terms and conditions of their contracts, including with respect to theatre access, after hours needs and quality and safety factors, to reflect their particular practice needs and that of the hospitals they serve. However, the AMA submits that experience has demonstrated that this is rarely exercised.

29. In response to the submission by the Consumers Health Forum, the AMA submits that it is not aware of any evidence that the authorisation has led to a reduction in services or an increase in costs. The AMA submits that in relation to South Australia, the last agreement reached for rural GPs with SA Health included relatively modest adjustments to fees and targeted a number of issues including safe hours and locum support that are key recruitment and retention issues for rural GPs.

30. Moreover, the AMA submits that the authorisation covers VMO services in rural public hospitals and to that extent consumers can access these services at no cost as part of the public health system.

31. The AMA notes that data relating to service quality and access is collected by and reported on by health departments who monitor the delivery of public hospital health services. The AMA submits that it is not practicable, cost effective nor necessary for the AMA to obtain such data.

ACCC View

32. The ACCC considers that the collective bargaining arrangements are likely to result in little, if any, public detriments because:

    - the level of negotiations between individual VMOs and state and territory health departments is likely to be low without collective bargaining

    - while the coverage and composition of the bargaining group is extensive, the AMA is restricted to negotiations on behalf of its members who are rural GPs providing services as VMOs in rural and remote areas, in a particular state or territory, and is restricted to negotiations with state and territory health departments and not individual hospitals, and

    - participation in the collective bargaining arrangements is voluntary - there is no collective boycott.

Balance of public benefit and detriment

33. For the reasons outlined in this determination, the ACCC is satisfied that in all the circumstances the collective bargaining arrangements are likely to result in a

benefit to the public and that the benefit would outweigh any public detriment constituted by any lessening of competition that would be likely to result.

34. Accordingly, the ACCC is satisfied that the relevant public benefit tests are met.

Length of authorisation

35. The Consumers Health Forum raised concerns that the authorisation would be granted for ten years in the absence of conclusive evidence of public and consumer health benefits.

36. In this regard, the ACCC notes that it may initiate a review of an authorisation in particular circumstances, including if there has been a material change of circumstances since the authorisation was granted.[2] This would include circumstances where it appears that the benefits from the conduct no longer outweigh the detriments arising from that conduct.

37. The ACCC considers it is appropriate to grant authorisation to the AMA for ten years rather than the five years requested by the applicant, given that the conduct has previously been authorised and the arrangements are voluntary.

Determination

Conduct for which the ACCC grants authorisation

38. For the reasons set out in this determination, the ACCC is satisfied that the tests in sections 90(5A), 90(5B), 90(6) and 90(7) are met.[3] Accordingly, the ACCC revokes authorisation A91100 and grants authorisation A91392 in substitution.

39. The ACCC grants authorisation under section 91C(4) of the Act to the Australian Medical Association Limited to continue to collectively negotiate with relevant state and territory health departments, the terms of contracts (including fees) for general practitioners providing services as visiting medical officers in public hospitals and health facilities in rural and remote areas of Australia (except New South Wales and the Australian Capital Territory).

40. The ACCC grants authorisation until 10 April 2024.

41. This determination is made on 19 March2014.

Conduct for which the ACCC does not grant authorisation

42. The authorisation does not extend to the AMA negotiating on behalf of other medical specialists, nor to negotiations involving individual hospitals nor any group of hospitals.

2 Section 91C(3).
3 See Attachment A to this Draft Determination A91383.

Date authorisation comes into effect

43. This determination is made on 19 March 2014. If no application for review of the determination is made to the Australian Competition Tribunal (the Tribunal), it will come into force on 10 April 2014

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.

Section 91(2) permits the ACCC to grant interim authorisation if it considers that it is appropriate to do so:

(a) for the purpose of enabling due consideration to be given to:

(i) an application for an authorization; or

(ii) an application for a minor variation of an authorization; or

(iii) an application for the revocation of an authorization and the substitution of a new one; or

(b) [in relation to making an application to the Australian Competition Tribunal for a review of an ACCC determination]

(c) for any other reason.