Draft Determination

Application for revocation of authorisation A91100 and substitution with A91392

lodged by

Australian Medical Association of Australia Limited & Ors

in respect of

Collective bargaining with state and territory health departments

Date: 22 January 2014

Commissioners: Sims
Schaper
Cifuentes
Court
Walker

The ACCC proposes to revoke authorisation A91100 and grant authorisation A91392 to 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 ACCC proposes to re-authorise the arrangements for ten years.

The ACCC has also decided to grant interim authorisation which will remain in place until the date the ACCC's final determination comes into effect or until the ACCC decides to revoke interim authorisation.

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 is seeking 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.

4. The AMA also noted that its existing authorisation expires on 28 February 2014.

Background

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

6. 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.

7. 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.

8. 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.

Submissions received by the ACCC

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

10. 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.

11. 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.

12. 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.

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

14. 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.

ACCC evaluation

15. 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.

16. 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

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

- 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

17. 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.
18. 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
    - a positive effect on the attraction and retention of rural GPs as VMOs.
19. 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.
20. 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

21. 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

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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

29. 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

30. For the reasons outlined in this draft 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.

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

Length of authorisation

32. 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 no concerns have been raised in respect of this application.

Draft determination

Conduct for which the ACCC proposes to grant authorisation

33. For the reasons set out in this draft determination, the ACCC is satisfied that the tests in sections 90(5A), 90(5B), 90(6) and 90(7) are met.[2] Accordingly, the ACCC proposes to revoke authorisation A91100 and grant authorisation A91392 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).

34. The ACCC proposes to grant authorisation for ten years.

35. This draft determination is made on 22 January 2014.

Conduct for which the ACCC does not propose to grant authorisation

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

Interim authorisation

37. As any decision made by the ACCC is unlikely to come into effect by the time the Applicant's existing authorisation expires on 28 February 2014, the ACCC has considered the merits of granting interim authorisation at this time.

38. When considering interim authorisation, the ACCC considers a range of factors, including harm to the applicant and other parties if interim is or is not granted, possible benefit and detriment to the public, the urgency of the matter and whether the market would be able to return to substantially its pre-interim state if the ACCC should later deny authorisation.

39. The ACCC grants interim authorisation under section 91(2) of the Act for the proposed conduct as described at paragraph 33, and has had regard to the following issues:

    - it will enable the status quo to be maintained as the existing authorisation will expire on 28 February 2014.

    - the absence of interim authorisation could disrupt any ongoing negotiations resulting in unnecessary cost and uncertainty

    - the conduct will likely result in public benefits that outweigh any detriment

[2] See Attachment A to this Draft Determination A91383.

- no significant concerns have been raised by interest parties

40. Interim authorisation will commence on 1 March 2014 and remain in place until the date the ACCC's final determination comes into effect or until the ACCC decides to revoke interim authorisation.

Further submissions

41. The ACCC will now seek 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.

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.