

Australian Medical Association

**SUBMISSION TO ACCC
SOME CURRENT IMPACTS OF THE TRADE PRACTICES ACT
ON THE PROVISION OF MEDICAL SERVICES**

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INTRODUCTION

Background

There has been an unfortunate history of misunderstandings leading to public arguments between the Australian Medical Association (AMA) and the Australian Competition and Consumer Commission (ACCC) about medical roster and work share arrangements and their legality under the *Trade Practices Act 1974* (the Act).

The Wilkinson Review said as to roster creation:¹

This is a significant issue that is threatening to have a detrimental effect on health service delivery, due to concerns about what activities are permitted or prohibited by the Act, even though it appears that rostering to ensure the availability of a service is not prevented by the Act.

Central to this is a fundamental difference of opinion over the legality of certain roster arrangements. The ACCC asserts that ‘genuine rosters’ are not unlawful:²

If the roster arrangement is to genuinely ensure the supply and availability of medical services after hours and/or weekends, it would not breach the primary boycott provisions of the Act.

And,

The ACCC has not targeted such roster matters in the past and will not in the future.

The AMA, on legal advice, asserts that genuine rosters can be unlawful because inherent in the arrangement of allocating periods of duty between the participants is a restriction of services, rendering the arrangements unlawful under the TPA irrespective of their ‘genuineness’. Further, and apparently not clearly understood by the ACCC, are the arrangements that would be in clear breach of the TPA that might be required in order to establish workable and viable medical rosters and other work force practices in the effort to supply essential medical services in areas of medical workforce shortage. Fee agreements (where needed for economic viability and patient certainty) and other arrangements that tend to lessen competition or include exclusionary provisions (where required to secure a service), can constitute breaches of the TPA.

The Wilkinson Review, largely accepting the ACCC’s articulation that ‘genuine rosters’ are not unlawful, concluded that doctors may collaborate in devising rosters but must not collude. This is misleading as the TPA doesn’t exempt all collaborate arrangements that breach its provisions.

As to fee setting the Wilkinson Review noted:³

There is considerable uncertainty about what the Act allows in terms of fee setting between medical practitioners. There appears to be uncertainty about what activities constitute collaboration and what constitute collusion in this process.

Yet fee setting between independent medical practitioners, even though they are collaborating for the purpose of providing a 24-hour roster service, is unlawful under the Act so long as those doctors are ‘competitors’ as the term is understood in the TPA.

¹ Executive Summary, p5

² Professor Fels, Media Release 30 March 2001

³ Executive Summary, p5

Another concern over rosters is the mechanism by which rostering contracts with hospitals can be negotiated by independent doctors (that is, not employed by the hospital) who are contracted to attend public hospital patients. The Wilkinson Review states:⁴

Uncertainties concerning the requirements of the Act when negotiating contracts are significant, as are complaints from doctors and health authorities, regarding power imbalances that underpin contract negotiations between individual medical practitioners and health authorities.

Collective bargaining by independent contractors around hospital roster arrangements can amount to a price fixing arrangement or an exclusionary provision, both of which are prohibited under the TPA. However, the Dawson Committee review accepted that in some circumstances it might be pro-competitive to permit small businesses, which includes doctors, to collectively bargain.

Amendments to the TPA that reflect the Dawson Committee's recommendations are currently before Parliament. If the passage of the Bill permits the negotiation of more satisfactory roster arrangements, some of the problems arising out of medical workforce shortages that are facing rural and regional communities might be addressed.

The purpose of this paper

The paper is not intended to be comprehensive. The AMA has already put detailed submissions to the Wilkinson and Dawson reviews.

The need for this paper is the apparent perpetuation of the belief by the ACCC that, other than some rare situations, roster arrangements that potentially breach the TPA are 'sham' or 'non-genuine' rosters that are not in the public interest. The paper aims to demonstrate the many circumstances, in an environment of an Australian workforce shortage, where roster and work share arrangements that potentially breach the TPA are not 'sham' arrangements, but rather aim to improve the provision of health services. If the medical workforce were oversupplied the dire need for rosters and work share arrangements would be absent.

The purpose of this paper is to help the ACCC's understanding of the range of arrangements and the circumstances in which they are required that the medical profession perceive as being for the public benefit, notwithstanding that the arrangements incorporate anti-competitive or exclusionary provisions.

The Wilkinson Review noted:⁵

The recruitment and retention of doctors in rural and regional areas continues to pose a major challenge for rural communities and governments. In some areas the rural medical workforce is in such a parlous state that any additional burden, whether actual or perceived, can threaten the existence of medical services and, therefore, potentially threaten basic rural community infrastructure.

The Review concluded that more effective communication and cooperation, achievable with some goodwill, could overcome these problems through constructive working relationships and improved communication strategies between all parties. It also saw a clear need to ensure that the legal obligations conferred by the Act are understood by doctors, medical and representative organisations.

⁴ Executive Summary, p5

⁵ Executive Summary p6

It failed to acknowledge that the serious problems that exist in some regional communities require more than merely improving communication between the ACCC and the medical profession and improving the understanding by the medical profession of the TPA.

This paper argues that in many of these circumstances it is impractical and unrealistic to expect medical practitioners to take the time and incur the expense of seeking authorisation for these arrangements when the unlawful conduct they seek to have approved is undertaken for the benefit of the public rather than for purely commercial reasons. It requires appropriate amendments to the Act.

In the AMA's opinion the Wilkinson Review erred in two respects. First, in accepting the ACCC's approach to the effect of "We won't find 'genuine rosters' unlawful" it ignored doctors' absolute obligation to abide by the law (though the Review and the ACCC deny their approach is not to choose to ignore illegal conduct). Secondly, it was dismissive of the concerns raised by medical groups about the arrangements needed to establish sustainable rosters and about fee-related restrictions. This led to its inadequate recommendations.

Its recommendations that relations between the ACCC and the medical profession and doctors' understanding of competition policy and their TPA obligations be improved, has by and large been achieved. The AMA and the ACCC have opened frank dialogue and have improved communication under the new ACCC leadership. The ACCC's TPA kit for medical practitioners consists of documents that explain what arrangements are and are not lawful under the TPA and explain to doctors that rosters are not unlawful if they meet certain criteria. The AMA is committed to assisting the ACCC in this work.

In turn, however, the AMA would like the ACCC to have a better understanding of those situations where it is not practical or realistic for those criteria to be met by reason of which some communities go without the roster and work share arrangements that they ideally need.

In response, both the ACCC and its Health Service Advisory Committee have invited the AMA to provide specific examples of the types of roster or work share arrangements that could prove to be unviable or unworkable under the TPA in the absence of the required authorisation.

The paper sets out various scenarios to demonstrate that anti-competitive or exclusionary provisions in situations where there are medical workforce shortages might be required to provide or maintain certain medical services, and to permit safe work hours for medical practitioners.

The paper is written in the context of worsening doctor shortages and maldistribution of medical services, particularly in rural and outer urban areas. Generally country doctors are much more vulnerable to ACCC scrutiny because of their heavy reliance on rosters, work sharing, negotiations with local hospitals and varying independent contractor and partnership status in different roles in their day to day work.

Since the Rockhampton case, the mere threat of investigation by the ACCC is enough to drive doctors out of rural practice into the safer harbour of urban employment. Rural practice is totally dependent on rostering. No doctor is in a position to challenge or be challenged by the power of the ACCC. The rules must be simple and crystal clear and beyond "interpretation".

The structure of the paper

The paper is divided into three parts. The first part of this paper sets out some matters of common ground. It assumes agreement on the ideals to strive for in the delivery of health services in the public interest; the agreed legitimate reasons for rosters; the importance of

maintaining medical services across all communities and the importance that doctors' working conditions enable them to adhere to the AMA's Safe Hours Code.⁶

It also provides a brief outline of the TPA provisions that create potential obstacles to the viability of certain roster arrangements, and then deals with the differing views held by the ACCC and the AMA as to the impact of the TPA on rosters and the supposed different opinions the two organisations hold on the legality of rosters under the Act. It examines the characteristics of what the ACCC defines as a 'genuine roster'.

Part Two of the paper sets out specific examples of work practices from which the public will benefit that incorporate anti competitive agreements in order to ensure viable and workable medical services arrangements. First, it is noted that there are inherent difficulties in collecting evidence of problematic scenarios under the Act, as the difficulties are manifested not in the operation of unlawful rosters, but in the absence of adequate services in particular communities. The anecdotal scenarios are set out under headings descriptive of the arrangements that might breach the TPA, such as the need for fee agreements for the viability of some rosters and for fee certainty for patients; the need to restrict doctors from practicing whilst rostered off; the need to select appropriate practitioners to participate in rosters (and thereby restrict others) to meet patient needs; work share arrangements and collective negotiations. This part includes discussion of particular difficulties faced by groups of doctors in particular regions working within the legal framework of the TPA.

Part Three comprises a discussion of possible solutions to the problems outlined, including the reasons for the AMA's perception of the inadequacy of the current authorisation process as a means of addressing the difficulties.

⁶ National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors, March 1999.

PART ONE

The efficient delivery of health services and the role of the TPA

Collaborative rosters and work-share arrangements

Competition laws should permit not hinder arrangements to improve provision and maintenance of health services of the kinds and in the regions and at the times needed throughout Australia. It seems to be accepted that a variety of medical workforce practices, including the establishment of rosters, are required as a normal part of providing 24 hour cover for patients. In devising these practices it is important:

- to encourage observance of safe hours of work by doctors and other health service providers,⁷ in the context that the Health Insurance Act 1974 requires GPs to provide patients access to care on a 24 hour basis to maintain vocational recognition under the Act;
- for doctors to obtain their patient's fully informed financial consent before or as soon as practicable after undertaking treatment;
- that efforts continue to improve efficiency in the deliver of quality health services.

Medical rosters are a necessary way of providing after-hours and weekend services whilst giving participating doctors required rest breaks. They can provide for a rational delivery of medical services both when those services are in short supply at certain times of the day or the week as well as at times when the need for services is less. Certain work-share arrangements can secure specialist services and improve efficiency in the delivery of health services.

Rosters ideally are therefore designed to:

- provide and maintain quality emergency services, or round the clock general services;
- facilitate regular breaks for doctors; and
- deliver services more efficiently and/or more cost-effectively.

Competition policy should not apply to impede doctors from:

- organising the provision of their services;
- getting proper returns;
- operating their practices in a sensible manner;
- influencing their decisions to go or stay in a rural or regional area; or
- acting jointly to encourage specialists to supply services in their area.

Doctors need to collaborate on the arrangements required to achieve better service delivery. Rosters need to have sufficient participants to be workable, be economically viable, and share the work sensibly.

⁷ The AMA's Safe Hours Code was developed in consultation with the College of Surgeons and others to encourage a culture in both the public and private medical sectors to ensure reasonable hours are observed and breaks are taken. The Code identifies the elements of rosters in terms of light, medium and heavy risk working hours per week.

What are the potential TPA obstacles to this?

Sections 45 and 45A of the TPA deal with exclusionary conduct and price setting that might have the effect of lessening competition. Those sections have to be read with section 4D which defines an exclusionary provision as a provision of a contract, arrangement or understanding between competitors which has the purpose of preventing, restricting or limiting the supply or acquisition of goods or services to or from particular persons or classes of persons either altogether or in particular circumstances or on particular conditions. This exclusionary conduct is frequently described as a collective or primary boycott.

Together these sections potentially impede some of the arrangements that are required to achieve the above objects of a roster.

Sections 45 and 45A prohibit the making or giving effect to a provision in a contract, arrangement or understanding that has the purpose, effect or likely effect of substantially lessening competition⁸. These are not *per se* prohibitions, but section 45A(1) deems price fixing contracts, arrangements or understandings to have the purpose, effect or likely effect of substantially lessening competition with the result that price fixing is effectively prohibited *per se* under section 45. Collective bargaining by independent medical (non staff) contractors over terms and conditions of public hospital rosters might amount to a prohibited price fixing agreement.

Section 45 also prohibits any contract, arrangement or understanding which contains an exclusionary provision. One of its aims is to prevent collective boycotts as defined in section 4D, which involve the deliberate exclusion of a person from participating in a market.⁹ This provision may also prohibit arrangements for the sharing of a market amongst doctors.

Do the ACCC and the AMA hold different opinions on the legality of rosters?

Much has been made by the ACCC in times past of the AMA's so called 'alarmist' and incorrect interpretation of the roster provisions of the TPA. The ACCC Chairman, Professor Allan Fels, warned:¹⁰

Rural and other general practitioners should not be alarmed or misled by Australian Medical Association public comments implying medical roster arrangements could put doctors at risk of breaching the Trade Practices Act or prosecution by the Australian Competition and Consumer Commission.

The ACCC asserts that a 'genuine roster', being one that is set up not for an anticompetitive purpose, but to ensure the availability of medical services and to provide appropriate breaks for practitioners, is lawful.

On the face of it the ACCC has incorrectly construed 'the purpose' in section 4D as meaning 'the main purpose', in suggesting that rosters are lawful if they are genuinely set up to provide out of hours availability of medical services. Professor Pengilley, former ACCC Commissioner, on the other hand, points out that section 4D refers to *a purpose* and such purpose is *a substantial purpose*, not *the main purpose*. Further, the prohibited purpose is one that limits the supply of services, and it need not have an anti-competitive purpose to be unlawful.

⁸ Section 45(2)(a)(ii) and (2)(b)(ii)

⁹ Sections 45(2)(a)(i) and (2)(b)(i)

¹⁰ ACCC Media Release 30 March 2001

So, an agreement reached between participating doctors that they will both meet their roster obligations by being available when rostered on, and will not practice when rostered off is unlawful as the arrangement restricts the supply of services, notwithstanding the main purpose is to ensure the availability of medical services and to provide appropriate breaks for doctors.¹¹

An infringement of the collective boycott provisions is a ‘per se’ offence. Therefore, any arrangement with the substantial purpose of limiting the supply of services by independent (not on staff) medical practitioners to a hospital or a community of patients is illegal. Under the TPA it is irrelevant that the arrangements are not anticompetitive. It is irrelevant if the limiting of the supply of services is not the sole purpose. The incorporation in a roster arrangement of an understanding that doctors rostered off are unable to practice renders the roster unlawful. Yet that understanding might be intended and necessary in order for the roster work to be economically viable for its participants and/or to ensure rostered-off doctors take rest breaks.

The AMA’s warning to doctors that participating in rosters potentially breaches the TPA is founded on its understanding that inherent in roster arrangements is that rostered-off doctors are unable to carry out the duties of the rostered-on doctors.

Professor Pengilley states:¹²

Necessarily fundamental to any roster system is that Doctor X and Doctor Y agree that Doctor X will work between certain hours. Necessarily, this agreement also involves the obverse (ie that Doctor Y will not work those hours),

If this is accepted as an integral part of a roster there is no room for the ACCC to differ with Professor Pengilley’s conclusion that the AMA is correct in its view that such rosters are unlawful. The underlying reason for the different stands taken between the ACCC on the one hand, and Professor Pengilley and the AMA on the other, is therefore to be found in the ACCC’s denial that there are circumstances where ‘genuine rosters’ need to restrict rostered-off doctors from practicing. The ACCC does not acknowledge that it is as important for doctors to agree who does not work as it is to agree on who does work in a medical roster designed not only to secure the provision of services, but to provide appropriate rest breaks for doctors.

The ACCC’s recent roster guidelines clearly recognises that a roster is unlawful unless ‘doctors on the roster are free to practice when not rostered on’.¹³ Thus, those rosters set up to ensure the availability of medical services and which, in order to provide appropriate breaks for doctors, are developed in the understanding that rostered-off doctors are unable to practice, are unlawful irrespective of whether or not they are anti-competitive. They have the unlawful purpose of restricting the supply of services. The AMA’s warnings to doctors about the potential of infringing the TPA by participating in rosters were, therefore, well founded.

It is unfortunate that the Wilkinson review concluded that:

...doctors may collaborate together if the effect of that collaboration is to provide arrangements that will serve their patients better. Any form of collusion in that process which may result in restricting care options, would be a clear breach of the Act.

Professor Pengilley points out the incorrectness of this statement. The collective boycott provisions as defined in section 4D are breached if the provision of an agreement,

¹¹ Pengilley, W. Medical rosters and the Trade Practices Act, MJA 2003;178, p338

¹² *Ibid* p338

¹³ “Medical Roster Checkup”, July 2004.

arrangement or understanding has the purpose of preventing, limiting or restricting the supply of services irrespective of whether it is *collaboration* or *collusion*, and there is no legal basis for asserting that one is legal and the other is not.¹⁴

The test under the TPA is not whether the arrangement provides for better patient care (relevant to the question of public benefit and authorisation of the arrangement), or whether it restricts competition, but rather whether there is a substantial and immediate purpose to restrict the supply of medical services.

In the interests of the AMA's Safe Hours Code being adhered to by doctors and hospitals alike, it is necessary that rosters be as much about ensuring doctors are off work, in the pursuance of a safe hours policy, as they are about being at work. Such rosters require authorisation.

Clear cases of unlawful arrangements

There is no dispute between the ACCC and the AMA that rosters are unlawful, if the roster arrangements prevent rostered off doctors from being free to practice, fix prices, or restrict a doctor's participation in the roster.

A roster is a list of persons or groups with their turns or periods of duty.¹⁵ A roster agreement is generally made to ensure work gets done that otherwise would not get done in any given period. It requires a cooperative approach of a group of people and willingness and reliability of the participants.

Sufficient doctors need to be willing to participate in a roster for the roster to hold. It might require, for example, an agreement that the rostered off doctors do not to perform the same work as the doctors rostered on because the availability of those rostered off undermines the imperative of the roster. The roster participants are likely to become unreliable if their services are not consistently required. It might require, by way of a further example, an agreement as to a minimum price charged for the rostered services in order to provide the incentive necessary to ensure the willingness of participants. Price cutting between participants can undermine the cooperation required for the roster to secure the willingness of the participants. It might require the setting of a maximum price to be charged to meet particular health fund requirements and patient expectations. Professional service providers might also require agreement on standards and quality of the service to be provided, and necessarily need to exclude willing participants who fail to provide a standard or quality of service guaranteed to the service users.

Instances of where such arrangements might be needed in order to establish any roster service at all are discussed below.

¹⁴ Pengilley, W. *op. Cit*, p339

¹⁵ Macquarie Dictionary

PART TWO

Roster and work share arrangements

Collecting the evidence

The AMA has been invited to provide details of problematic scenarios where roster arrangements made to benefit the public are nevertheless likely to be in breach of the TPA.

It is important to note at the outset that collection of this information from doctors is difficult. The inability for doctors to establish lawful rosters and work share arrangements has left certain communities with some inadequate medical or specialist medical services. In some situations the doctors are no longer practicing in the region to provide the evidence.

Further, some doctors are reluctant to give details of their efforts to maintain rosters and devise work share arrangements to meet the communities health services needs as they are fearful of being exposed to investigation. This concern is understandable given the dispute over what is regarded as a 'genuine' roster and what that entails.

The AMA is not aware of any roster or other medical practices operating in breach of the TPA. However, it is possible fee-setting arrangements or exclusionary conduct required to provide economically viable services by way of roster or otherwise do exist. These would be long established rosters in the best interests of a local community, unaware of any breach, but able to be challenged by the ACCC. There are many reports of rural and regional communities who are not able to access round the clock services, or are referred to metropolitan areas for particular specialist services, because of medical work force shortages or maldistribution of doctors. This issue needs to be addressed on their behalf.

The realities of roster arrangements

Viable and workable rosters of private specialists that meet their patients' expectations as to quality and cost of the service, can breach the TPA in a number of ways. The three types of arrangements that potentially breach the TPA are fee setting, agreement that rostered off doctors won't practice in competition with rostered on doctors, and exclusion of certain doctors from participating in the roster. Yet arrangements about these matters are sometimes required to establish a viable and workable roster to suit the needs of patients.

This section of the paper attempts to outline the types of arrangements that, in a different legal environment, would be considered necessary to meet workforce shortages and maldistribution of doctors. It covers the following:

Fee setting:

- Roster fee agreements for economic viability
- Fee agreements to meet financial consent requirements
- Fee setting for consistency and safety

Limiting the supply of services

- Arrangements that assume rostered off doctors will not practice
- Rosters that restrict participants to those that meet patient needs
- Roster arrangements that limit provision of services
- Disbandment of rosters
- Work share agreements

Public hospital rosters and collective bargaining

- Public hospital rosters of independent contracting doctors
- Collective bargaining of doctors not acting in an employed status

1. Fee setting

For economic viability

If doctors are to spend a large part of their safe working hours being on an 'on-call' roster they reasonably expect proper returns. Patient and doctor dissatisfaction occurs with fee variation which inevitably causes rosters to break down.

A disparity in charges will mean that a roster will not hold together because of embarrassment with patients and other difficulties, despite initial goodwill between the participants. Fees must sometimes be discussed between roster participants so that they can provide their patients with up front advice. Significant differences between charges within rosters tend to be ironed out. While this is not collusive doctors are vulnerable to the accusation of price fixing.

Many doctors, while desiring to meet their professional requirements and participate in a roster in the interests of the community, might not find it economically viable to do so without minimum fee agreements. Some have found the need to increase their hours of work in their private practice to meet, for example, large indemnity costs, and cannot spend additional time on low-paying rosters. Most 'on-call' roster arrangements pay only when the doctor is 'called-out' and it is understandable that when attending other doctors' patients the rostered doctor seeks to be properly remunerated.

Rosters incorporating fee agreements

A country town might have three specialists of a particular kind, say obstetricians. To ensure round the clock availability of their services and to permit each to have breaks from being on stand by, participation of all three is required to maintain the roster. If a condition of one is that they all charge the higher fee he or she charges, the roster cannot lawfully be established.

Where a doctor reasonably determines that because of the nature of the practice bulk billing is not economically viable, the sharing of an after-hours roster with bulk-billing doctors might raise justifiable concerns of leakage of that doctor's patients to the bulk-billing doctors. The higher charging doctor might refuse to participate, or insist on a minimum fee being charged to prevent his or her patients being lured to the other doctors, or participate and then quit the roster, or leave to establish a practice in a metropolitan area.

If the roster is established and survives notwithstanding that one doctor charges higher fees, the other doctors' patients should ideally be notified of the charges they might incur. This might cause patient reluctance to seek medical help when the higher charging doctor is on duty.

On the other hand, a uniformity of fees could emerge in order to keep the roster arrangement going. This could expose the roster participants to allegations of price setting.

If bulk billing doctors refuse to allow a higher charging doctor to participate in their roster and encourage instead another doctor to come to the region to join the roster, the arrangement could constitute a collective boycott as it excludes the participation of an available suitably qualified doctor.

In the absence of establishing a viable roster the doctors might have to continue to be available for their private patients round the clock to the extent they can contrary to safe working hours practice. The absence of a roster or work share arrangement could leave an uncertain and irrational provision of services for the community and lead to unsafe work practices.

The Rockhampton case

The Rockhampton case is an example of roster arrangements established to meet the fee demands of one of the participants.

One of the doctors indicated that he would not participate in the particular private health insurance ‘no gap’ arrangements that applied to patients of the other doctors. Thus, to establish the roster the patients were made aware that if they had their babies with these doctors they would have 24-hour 7-day coverage and in return they might not be fully covered by their private health insurance and may have to pay an additional amount. The three obstetricians agreed not to sign on to the MBF no-gap scheme for their obstetric patients. All three were prosecuted for the clear breach of the Act.

The unlawfulness of the fee arrangement was clear. Yet, without the lower charging doctors agreeing to charge their patients the fees of the higher charging doctor, a roster of two doctors was unworkable.

As a consequence of the impact of the TPA on the Rockhampton doctors’ roster arrangements the three private obstetricians ceased their private obstetric practice in Rockhampton and located elsewhere. The obstetric roster and a number of other projects of the obstetricians such as attendance at the local aboriginal health service have ceased.

Effect of market forces

The unsatisfactory work situation for doctors where a roster is not workable or viable is a disincentive for them to continue working in that region. It deters other doctors from coming to the area to practice. Market forces cause fee increases by those doctors who remain.

The market driven increase of fees does not necessarily lead to the entry of another doctor to the locality, in an environment of medical workforce shortages. The current reality is that as older specialists retire there is a shortage of younger specialists to take their place.

Fee agreements to meet financial consent requirements

Under Gap Cover Scheme legislation doctors are obliged to provide written financial advice and to obtain their patient’s fully informed financial consent. In all other situations, AMA policy is that patients be fully informed.

Doctors looking after each other’s patients after hours and on weekends need to know the fees each will charge their patients. The ACCC accepts that discussion is needed between rostered doctors so that they can fully inform their patients as to what costs they might expect.

The variety of Health Fund products available makes the task difficult. This is particularly so when dealing with long-term care such as a confinement for a pregnancy and in the long-term multidisciplinary treatment and care of, say, cancer patients and chronic disease patients. The recent introduction of the Medicare safety net makes the business of informing patients even more difficult as eligibility for safety net benefits recommences each 1 January.

Ideally, patients should have some upfront certainty of the fees they will be expected to pay. Confinement costs will, however, vary depending on which rostered doctor attends the mother and which Health Fund the mother belongs to and whether the doctor participates in ‘no gap’ or ‘known gap’ schemes. The impact of the various Health Fund schedules and their ‘no gap’ and ‘known gap’ products needs to be explained.

‘No gap’, ‘known gap’ and ‘gap per episode’ products

If HCF is the predominant fund in the town, it having a ‘no gap’ obstetric product that provides a scheduled fee of 140% of MBS, Medicare will pay 75% of the MBS and the HCF will cover everything above that, provided the doctor charges 140% or less. If a doctor charges say, 150% of the MBS, then HCF will pay 25% being the balance of the MBS fee up to 100% after the Medicare rebate, and the patient is up for, not just the additional 10% charge, but the 50%, as the condition for payment of the HCF no gap product has not been met.

Medibank Private, under its ‘known gap’ product, would allow the doctor to charge a gap of up to a certain amount. The doctor who charges another doctor’s patients 150% of the MBS in the above example, might do so because he or she has patients who belong to Medibank Private and who are prepared to pay a gap. All the funds have different products. Some have known gaps and some don’t. All have different charging cut-off points.

To further complicate the issue, Medibank Private also allows doctors to charge a ‘\$900 gap per episode’ above the Fund's rebate. This means that a rostered obstetrician needs to negotiate with the anaesthetist, pathologist and others how to divvy up the \$900 the pregnant patient has been informed she is liable to pay. If a patient's confinements costs are agreed under one product and it transpires that the rostered doctor dealing with the patient charges a higher gap per episode, it is impossible to obtain the patient's informed financial consent at the outset, unless roster arrangements are worked out clearly in advance and agreed to.

In summary, in the absence of agreement between participating doctors, if doctor X charges slightly more than doctors A, B and C, who all charge near to the ‘known gap’ limit allowed by some health funds, Dr X’s slightly higher fee may well bring the doctor outside the ‘known gap’ or ‘no gap’ product, leaving the patient with no rebate other than the Fund’s contribution towards the 100% of the MBS.

A doctor would like to say to a pregnant patient words to the effect of, “When I’m away you will be attended by one of the (say, three) doctors I have chosen. I have arranged for one of two of these doctors to be available to attend my patients on a rostered basis” or, “We work together on a roster so that some one is always available for each of our patients. I have chosen these doctors to work with because they are good, and they charge fees close to mine that meet your Health Fund no gap (or known gap) requirements, so that you will have no surprises in that respect.”

Agreeing only on maximum fees to be charged

Leaving aside agreements to bulk bill which the ACCC claims is not unlawful, other fee agreements, even those limiting the amount to be charged, will potentially breach the TPA. Further, agreements on maximum fees to charge each other’s patients could have the effect of uniform charges.

For a roster to work, doctors will expect that their patients will not be charged more than a fee that meets the requirements of the applicable health fund’s ‘no gap’ or ‘known gap’ product. So long as all the doctors agree not to charge more than permissible under the patients’ health fund, the patient will have the certainty that there will be no gap (or the agreed ‘known gap’). If those doctors charge the maximum permitted by the health fund in line with the patient’s expectations, they will be exposed to an allegation of price setting.

Fee setting for consistency and safety

Consistent charging in rural medical centres requires agreed fee structures. It is logistically very difficult to estimate fees for a patient in a multiple doctor practice with associates,

locums, registrars in their basic, advanced and mentor years charging different fee rates. It is very confusing for the patients, doctors and staff when the same patient could be seen by several different doctors with different fee structures, in-hours and after-hours for different procedures and at different consultation times. It is almost impossible to give correct pre-treatment financial details in these circumstances. Significant variation in fee rates works against safe continuity of medical care. Doctors feel vulnerable even discussing these issues with other doctors even though it would seem to be the most sensible path to take because of the TPA implications in the event that discussion brings about consistent fee structures.

The after hours care roster arrangements run by non incorporated medical groups (who practice in competition with each other in core hours) can provide better patient care if the group bills in a similar manner for reasons of efficiency and patient certainty. The inability to agree to this under the TPA threatens the workability of the after hours service. Practice managers have difficulty meeting efficient management standards and providing accounting efficiency without some standard charging practices.

The critical fact is that the different doctors are not in competition with each other but work together to provide the best continuity and availability of medical care.

2. Arrangements that limit the supply of services

Rosters needed to meet obstetric standards

In South Australia, it would seem that no anaesthetist wants to do more 'on-call' work. Some anaesthetists will do extra shifts, but this often entails working long, unpredictable and unsafe hours. They all tend to set their own fees in their own practices, which vary widely in relation to their desire to provide a service, or to avoid incurring fatigue or inconvenience. This makes more difficult the obstetrician's task of informing the patient of the charges they might expect.

Adelaide obstetricians have set out standards for after hours obstetric care. For example, to make themselves available they must have arrangements in place for 24-hour cover for anaesthetists, access to hospitals and so forth. Some of these city obstetricians are facing difficulties maintaining those standards because of the limited number of anaesthetists available for, or willing to do, extra after hours work. The anaesthetists' inability to put satisfactory roster arrangements in place exacerbates the problem.

If an on call roster is to be maintained obstetric anaesthetists need certainty that they will not be standing by on the off chance that they, rather than a rostered-off or non-rostered doctor, will be called. It is unlawful for the obstetrician to guarantee the work only to those rostered on call. It is unlawful for the anaesthetists to agree that rostered-off doctors are not free to be on call. Similarly, it is unlawful for the rostered anaesthetists to make an agreement with, say, the hospital's existing rostered anaesthetists not to take the obstetric after hours calls.

Rosters may simply break down if a rostered doctor who makes him or herself available for a period, or stays at home on call close to the hospital and avoids drinking with dinner, and finds that when an emergency occurs another doctor is free to provide the service.

While Adelaide anaesthetists are in short supply and are overworked there is no enticement for them to participate in unviable roster arrangements. This means that the obstetricians often have difficulty getting access to the rostered anaesthetist in time to inform the patient on admission who their anaesthetist will be, what the costs will be, and in time for the anaesthetist to see the patient. The obstetricians rely on ringing around whoever is on call, or might be available, or who happens to be in the hospital or who is the closest available in an emergency.

Furthermore, the unreliable availability of an anaesthetist out of hours limits the provision of best standard quality care where, for example, a caesarean section is indicated or where the option of epidural anaesthesia is not available without the certainty of an anaesthetist being on duty or attending in time.

The ‘double up’ disincentive for South Australian rural anaesthetists

Specialist or GP obstetricians providing services in rural and regional public hospitals in South Australia require the services of anaesthetists to be available on call out of hours. The hospitals that provide obstetric services have in place general anaesthetic on call rosters (although Central Districts and North Eastern Community have difficulty with obtaining anaesthetic services). However, those existing rostered doctors might understandably withdraw from hospitals that are serviced by a dedicated obstetric anaesthetic roster, rather than ‘double-up’ cover. Roster agreements that avoid such double up cover are unlawful.

An alternative model is one where a particular practice (say a procedural GP practice) covers a particular hospital or hospitals, on a rotational basis. For this to be lawful it must not preclude any other anaesthetist or practice from covering that hospital. The possibility of existing rosters causing ‘double up’ cover deters overworked anaesthetists from participating in such arrangements. The possibility to ‘double up’ cover leads to inefficient roster arrangements.

A solution would be for a separate obstetric anaesthesia roster to be created at a limited number of hospitals, with a hospital on call payment (‘retainer’). However, this is likely to be in breach of the Act, first, because the roster participants are only agreeing to the roster where the retainer is paid and secondly because the roster service would only be available to some hospitals. The overall roster arrangements would fail if they were not limited to ensure that there were sufficient anaesthetists to provide comprehensive cover for those other hospitals.

Another solution is that the hospitals pay the anaesthetists’ practice a retainer, rather than having an arrangement where by an individual anaesthetist is on call, or for the hospital to pay a ‘bonus’ if the anaesthetist attends within a given time frame, for example. These arrangements might avoid TPA implications and avoid the need for a dedicated roster of individuals or practices. However, to achieve this outcome the anaesthetists as a group need to collectively negotiate with the various hospitals. This is unlawful unless authorised; about which more is said below.

The need in South Australia for more rational and efficient on-call anaesthetic roster arrangements is dire. This arises out of the short supply of anaesthetists and the need for hospitals to pay them adequately. There is a need for more satisfactory agreements to be reached on terms of conditions of work to allow for rest breaks and no ‘double up’ cover. The anaesthetists would also need to work hand in hand with the obstetric services to maintain minimum clinical standards to simplify and make more efficient the provision of the services.

Disbanding rosters

While the ACCC approves of rosters for certain purposes, it indicated in its second submission to the Wilkinson Review that, if doctors get together and agree to disband a roster and no longer offer the combined services of the roster arrangement, this would be regarded by the ACCC as a boycott.

However, in the ACCC’s recent roster guidelines it acknowledges that there will be occasions where it might be necessary for doctors to end a medical roster, for personal, professional or commercial reasons. It goes on to suggest that where independent doctors who form a roster collectively decide to end the roster, this agreement is not an exclusionary one and will not

breach the competition laws so long as ‘the purpose of ending the roster is not to inhibit the supply of medical services to patients by any roster doctor’.¹⁶ The guidance offered explains that the ‘purpose’ test is a subjective one.

While the AMA welcomes this more sensible approach, the legal issue is raised as to whether or not such an agreement will be in breach of the TPA. Just as exclusionary provisions are inherent in roster arrangements, so is the inhibiting of the supply of medical services to patients inherent in disbanding or limiting rosters.

In the event that a roster doctor is unable to continue on the roster and unilaterally withdraws, the remaining roster doctors might need to discuss what roster arrangements they can reasonably continue. They might decide they can continue the roster on a limited basis. They might reach an agreement to keep the roster arrangements going say, on Saturdays but not Sundays. The purpose of the agreement is as much to inhibit services on Sundays as it is to ensure the availability of services on Saturday in order for the roster arrangement to hold.

Similarly, if a non-participating roster doctor is available for out of hours consultations on an irregular basis and the existing roster arrangement thereby becomes economically unviable for a roster participant, that doctor may decide to withdraw from the roster. That doctor may feel it is unprofessional to unilaterally withdraw in the knowledge that the roster would be unworkable with the few remaining doctors and cause them undue strain and excessive work hours. Discussion about disbanding the roster might be required if the doctors are to responsibly notify the community, their patients, or a hospital dependent upon the arrangement. Yet, a joint decision to withdraw their services or to rearrange the roster that impacts on medical services is in breach of the TPA.

Unilateral withdrawal of roster doctors from roster arrangements that are breaking down is an unlikely scenario. Where roster participants are finding the arrangements unsustainable they will responsibly discuss the situation so that patients can be notified and alternative arrangements where possible, can be made. Terminating the roster in this way by agreement will have ‘the purpose of inhibiting the supply of medical services to patients’ by those roster doctors, and is unlawful under the TPA.

Selective rosters

Obstetricians

In metropolitan areas where there are sufficient obstetricians to form viable rosters, the need for consistency in practices, standards and quality will demand selection of participants to meet particular patient needs. For example, private obstetric medical specialists some of whom encourage active management of labour and others of whom believe in encouraging less active management of labour, may not be compatible on the same roster that share the care of pregnant women. Selection of participants for rosters and excluding other qualified doctors is unlawful.

To legally exclude a doctor from the formation of a roster the others must form an evidenced based view that he or she is lacking in knowledge or application of medical skills. This takes no account, for example, of the different schools of obstetric thought, though in accordance with the highest clinical standards, or different views on technique or medical protocols, or as to the various doctors’ charging policies that might have adverse impact on patients’ financial situations.

¹⁶ “Medical Roster Checkup”, July 2004.

Taking the Rockhampton obstetrician roster referred to earlier, could the two lower fee charging doctors have excluded the higher charging doctor for refusing to charge in compliance with the 'no gap' health fund product? In all likelihood, no.

Private obstetric doctors are likely to want to assure their patients at the commencement of the confinement that the rostered doctors selected by them are the most appropriate. That is, the attending doctor is likely to only participate on a roster with hand selected doctors he or she knows, has confidence in, and who are reliable.

Limiting the roster to certain obstetricians necessarily restricts others from participating, and is in breach of the TPA.

Psychiatrists

More informal types of rosters are sometimes established by groups of private specialists such as psychiatrists for periods during which they will be unavailable. Psychiatrists often consider it particularly important in arranging this type of cover that the patient is dealt with by a psychiatrist who is suitable to the particular needs of the patient, and with whom the patient is likely to feel comfortable. Accordingly, they may exclude other psychiatrists from their roster arrangements as not being suitable to the needs of their patients.

Specialist clinics

Specialist clinician services, such as those that attend to women's health, require rosters that guarantee that those women who seek female practitioners can, in emergencies rely on roster arrangements that provide them with access to female doctors, the roster thereby excluding male doctors.

Work Share Agreements

If a group of doctors in a country town agree on their availability to patients over certain time periods they run the risk of breaching the collective boycott provision. These arrangements are generally aimed at ensuring continuity of service.

Rotating practice opening hours

If a group of independent doctors reach an agreement on when each of them will open their practice, and to refer patients to one another, this is an agreement to share the market, and unlawful under the TPA. It is also unlawful if another doctor is excluded from such an agreement, even if for the good reason that he or she is not a bulk-billing doctor.

The result is that in a country town with a limited number of practitioners there might be no practitioner available on one or both days of a particular weekend, but all might be available on another day or the following weekend.

While the ACCC is adamant there is no breach of the TPA if there is no restriction of competition in these 'genuine roster' arrangements, the issue of breaching the collective boycott provision remains.

Referrals to proceduralists carrying indemnity cover

Doctors must not allocate different types of work to members of their local groups even if this is the only way to retain a service in an area. For example, additional medical indemnity premiums have been required for those GPs inserting and removing the contraceptive device, Implanon. In communities where there is some demand for the procedure, but insufficient to warrant the two or three GPs in the area to carry the indemnity costs, it is sensible for one GP to take out the additional cover on the strength of the other GPs agreeing to refer their patients who require that procedure to that GP to provide the critical mass to make the practice viable. This is unlawful under the TPA.

Freeing doctors for better patient access

One NSW clinic wanted to improve patient obstetric and gynaecologist services by devising a sensible work share agreement. The arrangement proposed a rotational roster that allocated one obstetric doctor to attend all the other doctors' private patients at the delivery ward over a particular period, leaving the other doctors free to consult their pregnant patients without interruption from having to attend at the hospital for deliveries. Patients would not be inconvenienced by unpredictable delays in the consulting room. The patients were to be informed of the arrangement at the commencement of their confinement. The arrangement has not been implemented because of the clear breach it would be of the TPA.

Referral to specialists

Lack of specialists of all kinds in remote and rural areas is a major problem. In some circumstances, doctors agree to refer all their patients to one specialist in order to provide the critical mass needed to induce that particular specialist to visit their areas and service their patients.

A group of doctors (GPs or specialists) practicing in a country town might see the need for a renal, gastroenterologist or cardiac surgeon to visit their locality once or twice a month to save patients the inconvenience of having to travel to a metropolitan area, or to rely on the public hospital system. They agreed to encourage a specialist to visit their locality. To provide the relevant incentive they agree with the specialist that they will refer their patients to that person, rather than to a specialist or hospital out of the region.

There is no real anti-competitive effect in this conduct. If other specialists were available the agreement would not be necessary. But the arrangement constitutes an unlawful primary boycott.

A rational sharing of particular medical services

A country town that has the services of a specialist anaesthetist and two GP anaesthetists might desire a rational work share arrangement to maintain the services of all three doctors. This might require them to agree on how to share their work. For example, the GPs might do minor surgery only, and agree to refer major surgery to the specialist so as to retain the services of the specialist in that region.

Taking that example further, the GPs might agree that one only of them undertakes the anaesthetic procedures for the minor work, accepting referrals from the other GP because indemnity costs for procedural work would be unaffordable for both if neither had a guarantee of the minimum work available in the area.

The same situation might apply in obstetrics. The GPs in a country town might agree to share the types of medical work in some way. For example, they agree that, if one of them pays the high cost medical indemnity premiums to cover the delivery of babies, the others will forgo obstetrics and instead refer their pregnant patients to the obstetric GP. The obstetric GP will be able pay the steep indemnity costs to deliver babies in the knowledge that there will be sufficient demand for his or her services by reason of the agreement.

The arrangement is for the public benefit as without it no one of the GPs can afford the indemnity costs for the small amount of procedural or obstetric work they undertake. Instead they refer their pregnant patients to metropolitan hospitals with the inconvenience, costs and loss of family support that it entails.

Some doctors depend upon other doctors in the same speciality who have clinical experience in a particular field to whom they can refer their patients suffering from particular conditions. It is a clinically responsible arrangement for a group of doctors to agree to send their patients

to the doctor with a special interest to provide a critical mass of patients to guarantee a level of experience compatible with the maintenance of clinical standards.

These agreements constitute primary boycotts.

3. Hospital roster systems

Specialists who contract to visit public hospital patients in their own right or through their service companies, as against being employees of the hospital, must abide by the TPA competition principles.

Similar specialist practitioners who visit particular hospitals generally agree between themselves on a roster arrangement to provide on call cover over the weekend. The hospitals rely upon such arrangements. The specialist practitioners will supply their services both to the hospitals and to their own patients. However, these arrangements can easily breach the collective boycott provisions of the TPA because in the current climate of medical workforce shortages the specialist practitioners are, in effect, dividing the market for their services by time and by location, albeit for reasons of coverage and consistency rather than for anticompetitive reasons.

While the specialist practitioners are not 'in competition with' one another to supply services to hospitals over the whole of the weekend, but rather seeking not to compete for those services, nevertheless they are competitors in their field and the arrangement is unlawful.

Collective negotiation required for some hospital rosters

A Sydney group of anaesthetists attempted to establish an on call rate for the purpose of an out of hours roster. They approached the hospital and said they will make themselves available on call if they were all paid a certain amount. This was found to be unlawful, and they chose not to be on call rather than to be exposed to ACCC's prosecution. The consequence was that the planned obstetric roster that depended upon the anaesthetists was not established. The two specialties wanted to work together to ensure an after-hour service was available. To do that the anaesthetists needed to be rewarded for being on call and for providing the service when called out. Generally, specialists on call are not paid unless called out. To ensure the availability of on call doctors who are to hold themselves available to attend a hospital at short notice and remain within reasonable distance from the hospital on the off chance of being called out after hours doctors require reasonable remuneration. A fee agreement not being possible under the law the roster arrangement was not viable. In this case there was no finding of wrongdoing by the anaesthetists. The case was settled out of court and the roster arrangement did not progress.

Staff specialists

Some staff specialists are entitled to engage in certain collective bargaining conduct. However, if they have rights of private practice engaging in the same conduct may be prohibited under the TPA. Confusion is likely to result for these practitioners. Further, in some instances a doctor is responsible for all private billings, and an arrangement is entered into whereby the hospital receives some of the receipts and the rest is divided between the practitioners. These doctors, by engaging in the same collective bargaining processes about their terms and conditions of engagement in their private capacity as they do for their salaried work, may unwittingly breach the TPA.

Collective Bargaining – Rural procedural GPs working on fee for service in public hospitals

Rural medical practitioners have grave concerns about the critical workforce shortages, especially in rural South Australia. The main area of difficulty lies in the fee for service agreements with the local Hospital which in theory should be negotiated and contracted individually by each doctor or legal entity that services the Hospital.

The ACCC is currently discussing the problems facing South Australian procedural GPs on whose roster arrangements the State hospitals depend. A description of the difficulties faced by these doctors is set out below.

South Australian country hospitals

The AMA, the Rural Doctors Association, the Rural Doctors Workforce Agency and the State Department of Human Services (DHS) are in discussion with the ACCC about the problem for country proceduralists.

In 1993 an agreement was first signed with the public hospitals by the AMA, the Rural Doctors and the DHS that dealt with fee structures for visiting medical officers' services. The agreement was renewed in 1996.

In 1999 an application was made by the South Australian AMA to represent its members and collectively negotiate with the state hospitals. The application was supported by the State Government. Despite this, and the ACCC's acknowledgement that the application was substantially for the public benefit, the application failed.¹⁷ As a consequence of the ACCC's refusal to grant the authorisation there has inadequate mechanisms to negotiate the fee scale since 1996.

There are about 300 rural procedural GPs relied on by country hospitals in this category. They have to individually negotiate with their hospitals for their working conditions and fees for anaesthetics, delivering babies, other procedures, consultations and so forth. These doctors have no political or administrative bargaining power as individuals to fix the outdated fee structure. At present the individual doctor signs a contract with individual hospitals to abide by the Rural Health Enhancement Package and the South Australian Medical Schedule of Fees (SAMSOF Agreement).

These procedural GPs work in their own private practices in conjunction with the arrangements for them to look after patients in the local state hospitals. Their patients are generally admitted to the hospitals as public patients and are attended by the same GPs who are paid a fee for service for their roster duties under the individually negotiated agreement.

The doctors express discomfort on negotiating with the hospitals because this requires them to negotiate with their medical and administrative friends, colleagues and sometimes these people are their patients. In any event the administrative and medical hospital representatives have no power without DHS approval and generally tell the doctors that they need to take the issue to the DHS. Individual doctors are powerless to do this. This is evidenced by the fact that there has been little change in the terms and conditions since 1996. It sets them apart from nurses and other employed health service providers who have unions to collectively negotiate for their terms and conditions of work.

¹⁷ P.15 of the ACCC's Determination in relation to the Application for Authorisation by AMA Limited and SA Branch of the AMA Inc in relation to Fee for Service Agreement in Rural South Australian Public Hospitals 31 July 1998.

The rural doctors are asking that their representative bodies be permitted to negotiate directly with the DHS on their behalf for more realistic terms and conditions of engagement. Improved working conditions for rural doctors will attract more doctors to work in country South Australia and will encourage safe work practices and improve the health care provided to rural South Australian patients.

Permission for collective bargaining by the GP's representative bodies on the basis that it extends to cover all procedural rural GPs in all rural state hospitals is desired if doctors are to be encouraged to work in rural areas.

The instances where different financial arrangements have been made between doctors and the hospitals in different towns have led to uncertainty and unhappiness amongst other doctors in the state. In some towns the disputes over working conditions have scared doctors away from working in those localities. This has led to critical doctor shortages and decreasing services to that particular area. This has made movement of doctors to different areas difficult and it has made it difficult for doctors to travel to work in hospitals relatively short distances away from their local area. To be lured into country areas doctors need certainty of the terms and conditions of their work, certainty of their agreements and certainty of the wage rates.

The current state hospital agreements make no reference to safe hours of work, or the AMA's Safe Hours Code. The GPs are expected to arrange their rosters to accord with safe hours. This means that they are expected not to practice when rostered off. However, those few doctors with indemnity cover for private obstetrics need to provide 24-hour cover for their pregnant patients. They can therefore be rostered off, but may have to go back in for their private patients in the public hospital, and work well beyond safe practice hours.

Country GPs often may consider the public patients as private patients and will often attend to them even when they are not on call and may be asked to come into the hospital after they have worked an on call shift and will provide care for them despite issues of the AMA safe work hours code of practice. They are trying to provide the most optimal level of care for their patients who they have looked after as primary health care physicians in their practice and will therefore continue the post natal care of looking after the mother and child as well.

Improving the work place for independent doctors providing services to the public hospitals, making it a happier, more comfortable and safer environment in which to work, is for the public benefit.

A country town example

One rural hospital in South Australia has approximately 300 deliveries a year. This delivery and anaesthetic work is shared between nine obstetric GPs. Six of them come from one practice and most of the time those six will provide 24-hour cover for the hospital. This is done by the practice as a whole entering into a contract or agreement with the hospital.

If the practice doctors can't provide that complete service the practice will talk to their neighbouring practice and perhaps on about five days of the year the neighbouring practice will provide the obstetric on call delivery assistance. Both practices are paid exactly the same by the hospital under the present inadequate schedule of fees.

The privately insured patients are attended to in the same public hospitals by the few private GPs outside the roster hours. One doctor will see about 35 patients in casualty on a Sunday and at the end of the day go home, only to get a call about a private patient in labour and have to go back to the hospital and attend the mother and baby throughout the night. As mentioned above, the situation leads to unsafe hours of practice.

Each delivery requires three doctors to be available. One to deliver, (with a midwife), another for backup in the case of an emergency caesarean, and an anaesthetist. All need to be accessed within an hour. The hospital standards require the doctors contracting to guarantee that level of care, and to ensure the availability of those doctors within a certain time frame. The hospital pays \$100 a night for the doctor to be on call and available in close travelling distance. This fee can't be negotiated currently because of the issues in dealing with administrators locally and because the administrators may not have the authority or resources to negotiate for change.

Most of those doctors cannot now afford to hold obstetric medical indemnity insurance for their private patients. There are therefore few private obstetric GPs, all having to make a living under the inadequate state fee structure.

Bringing this situation to the local hospital administrator's attention has caused friction and has failed to produce change. The current situation has created unhappiness at the coalface for doctors and the hospitals, and is unsatisfactory for patients.

The current reality is that the GP practice providing the service is unable to attract sufficient doctors under these terms and conditions to make a safe practice environment. More practitioners are needed and to attract those doctors, better negotiating power is needed to provide better terms and conditions of work.

PART THREE

Solutions

ACCC's suggested solutions

The ACCC answers the concerns raised above by repeating the statement that 'genuine rosters' are not unlawful, and by suggesting that:

- Doctors can apply for an authorisation of their arrangement if the public benefit outweighs the anti-competitive effect, and
- Doctors in competition with each other could incorporate a separate business entity for the purpose of running an after-hour medical service.

Comments have already been provided above as to the concept of 'genuine rosters'. The other two suggestions are not appropriate solutions to most of the situations outlined above.

Neither is in the community's interest and neither is practical. Both are expensive processes, the costs of which would inevitably be passed on to patients, as well as taking up valuable time which doctors should be using to fulfil the needs of their patients.

Further, as the need to do this arises to meet the needs of the public, the commercial incentive is absent for practitioners to incur the substantial costs involved. If the roster arrangements were sufficiently lucrative for the doctors to spend the money and time to pursue such an arrangement it would be a commercial arrangement where the anti-competitive effects did not outweigh the benefit to the public.

The inadequacy of these solutions

(a) The authorisation process

Experience has shown that there is little likelihood that the ACCC will grant the necessary authorisation. The case of the South Australian doctors' application for authorisation to collectively bargain with the state hospitals for terms and conditions of engagement is an example of this. Although the ACCC acknowledged that the arrangements were for the public benefit and the application received the support of the State Government and its local hospitals the authorisation was refused.

The authorisation processes undertaken by the College of Surgeons, and the RACGP have in all cases been as ponderous, tortuous and expensive with the outcome being a very narrow authorisation for a limited period of time involved extensive reporting arrangements.

There are three more concerns; cost, time and uncertainty:

- Cost. There is a \$7,500 application fee as well as legal costs.
- Time. It takes too long, in terms of time required to prepare an application and the time taken by the ACCC to consider it.
- Uncertainty. It does not provide sufficient certainty because an authorisation is only granted for a limited period and is subject to appeal by third parties.

Even a simpler authorisation process and with a waiver of the \$7,500 application fee would not address the legal costs or, if the doctor prepared the application him or herself, the doctor's time it involved. Further, a simpler authorisation process will be difficult to achieve. It would require the ACCC to prepare a proforma document for an umbrella authorisation on

rosters. Each roster is likely to be formed for a different purpose. Doctors are reluctant to discuss a community's need for a roster for fear that the ACCC will use the information obtained for evidence of collusive or anti-competitive practices.

(b) Incorporation

The ACCC provides guidance that says:

Individual practitioners who participate in an after-hours service AND who wish to set a common fee for this practice would need to set up an after-hours trading or management company to do so.

Fee setting is only unlawful between competitors. Competitors cannot be expected to run a commercial business together. Leaving aside the additional costs of doing so, forcing doctors who are in competition with each other to incorporate to provide a monopoly roster service defies the logic of competition principles. Further, such arrangements deprive doctors of basing their business decisions on sound commercial factors. Doctors are chosen by each other for rosters because of their particular skills, their availability and the similarity of their charges to the treating doctor, and their ability to meet the expectations and needs of the patients of the other doctors.

Required changes in the law

There are a number of ways in which the TPA could be amended to overcome the problems outlined.

The AMA in its Submission to the Commonwealth Review of the Impact of the TPA on the Recruitment and retention of Rural Doctors of December 2001 sets these out.

First, section 51 of the TPA provides for certain conduct to be excluded from the operation of the Act. This could be amended to provide exemptions either generally or as to specific category and conduct. The conduct that should be exempted could include, for example:

- Collaborative arrangements, including rosters between doctors in the provision of services to patients, hospitals and other third parties in rural and regional areas;
- Collaborative arrangements for exit from the provision of services to patients, hospitals and other third parties in rural and regional areas;
- Collaborative arrangements between rural and regional practices in relation to specialist referrals for the provision of services to patients, hospitals and other third parties in rural and regional areas.

Second, the Commission could authorise specific conduct in specified markets.

In addition, a legislative amendment of the authorisation process could be devised to provide for a simpler and cheaper notification process of rosters that allows doctors to obtain administrative sanction of their conduct. This envisages the ACCC having the onus of showing that it is not in the public interest, before the arrangements are declared unlawful.

Further, section 4D requires amendment. Professor Pengilley observes:¹⁸

The problem of medical rosters is but an illustration of the general overkill of section 4D. An amendment to section 4D to make it a more sensible tool of competition policy would solve the difficulty of the legality of medial rosters and mean that the law applies equally to all. The Australian deficiencies are shown by reference to United States and New Zealand experience.

¹⁸ Pengilley, W. *op. Cit.* p339

He points out that the target of a boycott has to be a competitor, actual or potential, of those engaging in the boycotting activity. That is, the TPA should be amended to remove the per se prohibition on exclusionary conduct so that it would be a defence if roster arrangements could be shown not to have the purpose or effect of lessening competition.

With the worsening workforce shortage, doctors should be encouraged to work cooperatively, whilst being prevented from undertaking arrangements that are blatantly anti competitive and not in the public interest.

The disincentives posed by the TPA to doctors making collaborative arrangements to improve the delivery of health services needs to be addressed.

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