Rural Doctors Association of Australia Ltd

A.C.N. 062 176 863

Caring for the Country

fax: 02 62739308
policy@rdaa.com.au

Susan Stratigos
Policy Advisor
PO Box 5361
Kingston, ACT, 2604
tel: 02 6273 9303
mob: 0402 597 259

The Secretary
Trade Practices Act Review
c/- Dept of Treasury
Langton Crescent
PARKES ACT 2600.

Dear Sir

Re: review of the Competition Provisions of the Trade Practices Act 1974

The Rural Doctors Association of Australia (RDAA) is seriously concerned about several matters which fall within the terms of reference of the Dawson Review. These relate to the medical services provided to rural communities by general practitioners.

RDAA is therefore very pleased to have this opportunity to bring these issues to the attention of the Review Committee.

Our concern with the unintended impact of the Trade Practices Act (TPA) on the recruitment and retention of an adequate rural medical workforce is longstanding. In March 2001, following a number of discussions with the Commonwealth, the RDAA and the Australian Medical Association (AMA) formally requested an independent inquiry into this matter. RDAA prepared a substantial submission to the Wilkinson Review which set up in response to this request. RDAA also appeared before the Review Panel twice and responded to three requests for further information and comment.

The Wilkinson Report is not yet available and apart from one issue (national authorization re price-fixing within certain general practice structures) which is currently the subject of a draft ACCC determination, the situation remains the same as outlined to that Review.

Our submission to the Dawson Review therefore consists mainly of material supplied to the Wilkinson Review with references to the initial documents which are attached to this correspondence.

RDAA would be happy to discuss these or related matters with the Dawson Review Committee and to provide any clarification or further information which may be needed. Please contact Policy Advisor Susan Stratigos, whose details are given above, should this be required.

RDAA looks forward to assisting the Review to ensure the TPA is applied in a way conducive to its stated objective – the welfare of all Australians.

Yours sincerely

Ken Mackey
President
12 August 2002

Cc Brian Curren
Susan Stratigos

Attachments:
RDAA – Submission to the Review of the impact of the TPA on the recruitment and retention of the rural medical workforce. Dec 2001
RDAA – Letter from Dr Ken Mackey to Mr Warwick Wilkinson 16/04/02

SUBMISSION TO THE REVIEW OF THE COMPETITION PROVISIONS OF THE TRADE PRACTICES ACT 1974

Background

The Rural Doctors Association of Australia (RDAA) was established in 1991 in order to give rural doctors a national voice. It has a strong focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to support the health of people who live in rural and remote Australia and so enhance the social capital and economic vitality of the communities in which they live.

The RDAA fully supports the object of the Trade Practices Act which is the welfare of all Australians. However, as indicated in the attached submission to an earlier review[1], RDAA contends that some aspects of the application of the Act have the unintended effect of undermining the recognized public benefits of an adequate rural medical workforce. Moreover, they run counter to policies and initiatives designed to maintain and regenerate rural communities through the on-going provision of local medical services.

Uncertainty about the operation of the TPA

An atmosphere of uncertainty about the operation of the Act and its implementation by the Australian Competition and Consumer Commission (ACCC), for example in relation to collaborative arrangements, price fixing within certain structures or collective bargaining to resolve social and remuneration issues, often contributes to doctors withdrawing from procedural practice (notably obstetrics, anaesthetics and general surgery) or rural medicine altogether. While this uncertainty is unlikely to be the sole or major determinant in these decisions, a growing body of evidence shows that it does influence them and can be "the straw that breaks the camel's back." [2]

[1] RDAA (2001) – Submission to the Review of the impact of the TPA on the recruitment and retention of the rural medical workforce.

[2] Ibid pp25-44; Rural workforce and skills surveys conducted by the Rural Workforce agencies; Access Economics (2001a) – An analysis of the widening gap between community need and the availability of GP services. Canberra; Access Economics (2001b) – The general practice workforce in Australia: results of the 2001 AMA GP Survey. Canberra; Alexander C (1998) – Why doctors would stay in rural practice in the New England Health Area of New South Wales, *Aust. J. Rural Health* **6**:3; AMA (2001) –Training and workplace flexibility: final report. Prepared by TQA Research, Melbourne; Humphreys J, Jones J, Jones M, Hugo G, Bamford E & Taylor D (2001) – A critical review of rural medical workforce retention in Australia, *Australian Health Review* **24**:4; Humphreys JS, Jones MP, Jones JA & Mara PR (2002) – Workforce retention in rural and remote Australia: determining the factors that influence length of practice, *MJA* **176**:7; Hyndman I & Ward C (2002) – A cooperative approach to sustainable rural general practice in neighbouring towns. Paper presented at the WONCA World Rural Health Conference, Melbourne; Kilmartin MR, Newell CJ & Line MA (2002) – The balancing act: key issues in the lives of women general practitioners in

Unbalanced market power

The prohibition of collective bargaining creates an asymmetrical market in which one party – the local hospital or health services authority – usually operates as a monopoly with which individual doctors have little bargaining power. Their ability to negotiate safe working hours and acceptable conditions in the hospital work which is part of the role of most rural doctors is thus severely limited. The problem is exacerbated as the rural medical workforce ages and younger doctors demand a better balance of professional and personal responsibilities and reasonable remuneration.[3]

Impact on rural economic activity

The benefits of a resident doctor to a small community go beyond health care and the socio-economic activity which it underpins. It is a small business which itself generates considerable economic activity. The viability of a local hospital, pharmacy and medical practice is so closely linked that the loss of any one of these services is likely to lead to the loss of the others. It has been estimated that a small centre can lose up to $1000 in local spending when a patient has to go to a bigger town for medical care. This occurs both directly, through expenditure related to the health care, and through a multiplier effect of general business being transacted there.[4]

This drain is counterproductive in terms of government strategies to encourage the well-being and growth of rural Australia.

Moreover, a community's ability to maintain and attract population and economic activity is severely constrained if it cannot offer the medical care families or industries need.

Confusion about the TPA and concerns about the ACCC

The RDAA's submission to the Wilkinson Review was based on input from over 75 practising rural doctors. The greater majority of them acknowledged they had little knowledge of the Act or how it operated. The words most commonly used to describe their attitude to it were "confused" and "concerned". This applied even to the small number of them who had attended meetings designed to explain it. Though they found the meetings informative, they were not necessarily reassured by

---

Australia, *MJA* **177:**2; McEwin K (2001) – *Discussion paper – Wanted: new rural workforce strategies for female doctors- findings from a survey of women in rural medicine.* Sydney, NSW Rural Doctors Network

[3] Ibid Ch 3
[4] Ibid pp44-5

them and in some cases their levels of suspicion and distrust were increased.

Media reports and apparently hostile and adversarial statements by the head of the organization fuel the flames of fear and antagonism. Some doctors were familiar, usually at second hand, with inquiries and investigations by the ACCC. Without exception, these respondents were highly critical of its methods, particularly in relation to its use of the media, a peremptory and arrogant tone in correspondence and apparent lack of understanding of the market for medical services in the bush.

The rigid administration of the parts of the Act designed to regulate anti-competitive behaviour in a market where the problem is lack of competition caused by the undersupply of providers is seen to ignore the realities of rural medicine and rural communities. [5]

Authorization

This perception understandably influences doctors' attitudes to the authorization process through which they could attain the certainty they need to develop and maintain viable models of rural practice. For example, public statements by chairman Alan Fels that label conduct requiring authorization as "anti-social"[6] suggest that they have been pre-judged.

The authorization process is expensive, with legal costs and reduced income due to earning time lost added to the sizeable application fee. It is time-consuming and ACCC statements notwithstanding, the process appears cumbersome, prolonged and outside the sphere of competence or confidence of most medical practitioners.

Extended timeframes may often be unavoidable due to factors outside the Commission's control, but their effect is still negative. For example, the finalization and publication of draft guidelines to raise awareness of the Act and its practical implications for general practitioners have been subject to continual delays at a time when clarification is sorely needed.

Authorizations can be granted for behaviour which, though possibly in contravention of Part IV of the TPA, would promote public benefit. However, as public benefit is not defined in the Act, its interpretation can be framed in terms or paradigms which may be inappropriate in particular situations. Although the ACCC has stated that public benefit should be considered in very broad terms *as anything of value to society*, its explicit *primary emphasis on encouraging competition and improving efficiency* naturally leads to a strong, and sometimes apparently exclusive, focus on quantifiable economic factors. These are not the only, or even major,

[5] RDAA op cit pp48-52

[6] Fels A (2001 – Efficiency un delivering health care: the professions, competition and the ACCC. Speech to the Centre for Health Program Evaluation, Monash University Melbourne, 8 November 2001

factors to be considered in some markets, including rural medical services.

Apparent anomalies in the granting of authorizations also contribute to confusion and frustration. For example, although the Act allows for on-going authorizations, these appear to have become less frequent over time for reasons which are not clear to external observers. In 2001, RDAA was told by ACCC staff that current policy precluded long term authorizations and that a two year period would be considered optimum. Yet three to five year authorizations have been granted in some industries in recent years and a 4 year duration is proposed in the draft determination on the Royal Australian College of General Practitioners (RACGP) application to allow price fixing in some practice structures.[7]

RDAA was also given to understand that national authorizations are unlikely and ACCC policy favoured exemptions for specific areas only. This would mean a repetition of the expensive and time consuming process to allow for country-wide adjustments. Such an approach is not conducive to a regulatory environment stable or consistent enough to allow national policies and strategies to address the rural medical workforce shortage to achieve their desired outcome. On the other hand, the draft determination referred to above does grant national exemption.

It is very difficult for external, albeit very interested, parties to trace the rationale and development of unwritten ACCC policies which do not appear to be mandated by the Act itself. Their apparent inconsistency, combined with high levels of distrust, do little to create the culture of cooperation which is needed if the TPA is to support, rather than undermine, a medical workforce adequate to the needs of rural Australia.

Recommendations

In its submission to the Wilkins on Inquiry, RDAA made three recommendations. Significantly, two of them related to the ACCC and the way in which it implements the TPA. These are repeated here, with slight modifications, as they remain relevant pending clarification of the Commission's implicit policy on some points. The third recommendation is developed from a request from the Wilkinson Review Panel for ideas which might enhance the ability of the ACCC to define public benefit in particular environments.

A. The ACCC authorization system should be adjusted to include:

- **simplified and less expensive processes;**
- **steps to modify the adversarial culture of the process;**
- **provision for long term &/or ongoing authorizations;**

[7] ACCC (2002) Draft determination: application for authorization…in relation to a framework arrangement allowing general practitioners in specified business structures to agree on fees 20/6/2002

- **the ability to grant national authorizations to address nation-wide problems.**

B. The ACCC and relevant professional bodies should collaborate on ways to prepare, disseminate and clarify issues pertaining to the interaction of the TPA, the ACCC and national competition policy with rural doctors.

The implementation of this recommendation should be accompanied by internal strategies to create an organizational culture which encourages transparency and external trust.

C. The interpretation of public benefit as the criterion for authorization should be devolved to small ad hoc committees with knowledge and experience relevant to the specific application (eg, in the case of rural doctors, local business and consumer interests, as well as representatives of medical organizations and government at the appropriate level.)[8]

[8] see Mackey, K : letter to Warwick Wilkinson 16/04/02. Attachment.