Australian Doctors' Fund Submission to the Productivity Commission Inquiry into the Impact of Competition Policy Reforms on Rural and Regional Australia

The Australian Doctors' Fund supports the federal government's initiative in calling for a review of National Competition Policy and particularly it impact on rural and regional Australia.

The Australian Doctors' Fund has been an outspoken critic of the application of National Competition Policy primarily, but not solely, on the delivery of health care.

The provision of quality medical treatment and health care is of critical importance to the socio-economic health of any country.

In particular Rural Australia continues to experience deficiencies in the immediate provision of quality health care when compared to metropolitan areas.

The Australian Doctors' Fund accepts the view that there are benefits to the Australian economy from robust competition for the provision of goods and services which act to contain the development of monopolistic forces capable of exploitation , particularly of more vulnerable groups who are unable to exercise reciprocal market power.

The Australian Doctors' Fund contends that the application of National Competition Policy particularly in Rural Australia acts in a way that supports restraint of competition and the elimination of competitors. This is clearly evident in the area of health care.

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COMPETITION POLICY DOES NOT MEAN WIDER CHOICE

The Australian Doctors' Fund asserts that the ultimate intention of the implementation of National Competition Policy in health care is to shape the private health care 'industry' into a configuration that will facilitate dominance by a small number of large corporate players.

To achieve this goal it is considered appropriate by National Competition Policy regulators that large operators also be given legislative power to coerce and dominate the medical profession so as to dictate treatment regimes that will meet budget considerations and profit objectives ie the wholesale importation of the US style Managed Health Care system.

This process is clearly stated in *Towards a National Competition Policy*, Report by the Independent Committee of Inquiry, August 1993 (Hilmer Report) on page 3 where it states:

*"**Two or more persons or entities:** Early economic work suggested that large numbers of competitors were important for effective working of competitive forces. However, in some cases competition between a few large firms may provide more economic benefit than competition between a large number of small firms. This may occur due to economics of scale and scope, not only in production but also in marketing, technology and, increasingly, in management."* [1]

It is also interesting to note that Mr Mark R Rayner, who is currently Chairman of Mayne Nickless, was a member, together with Mr Geoffrey Taperell and Prof Fred Hilmer, of the National Competition Policy Review Committee which undertook an independent inquiry in to National Competition Policy following agreement by Australian governments on the need for such a policy. Mr Rayner, one of Australia's most experienced company directors, is clearly associated with the Report's findings that:

"However, in some cases competition between a few large firms may provide more economic benefit than competition between a large number of small firms." [2]

Further evidence of the desire of large corporations to dominate the private health care market has been given by Dr Barry Catchlove, Senior Executive, Mayne Nickless and Chairman of the Health Insurance Commission.

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[1] *Towards a National Competition Policy*, Report by the Independent Committee of Inquiry, August 1993. pg 3.
[2] *Towards a National Competition Policy*, Report by the Independent Committee of Inquiry, August 1993. pg 3.

" *'Health is an economic market and is capital intensive,'* Dr Catchlove [Senior Executive, Mayne Nickless and Chairman of the Health Insurance Commission] *said. 'I have no doubt in my mind that what has happened to private hospitals and pathology, and is happening as we speak to radiology, will happen to clinicians. You will become partners in bigger and bigger groups and, dare I say it, you will joint venture with groups like us to provide you with management services and infrastructure.'* "[3]

The Australian Doctors' Fund accepts the right of corporations, their directors, and management to pursue greater market share and strong growth.

This is not the issue. The issue is whether the ACCC should enhance and empower these corporations to achieve market share objectives at the expense of smaller and weaker players such as independent rural and regional hospitals.

HOW IS COMPETITION POLICY APPLIED TO THE HEALTH SECTOR?

In order to ensure our submission has the objective view of a non-medical observer the following extract by Mr Roger Kilham, Senior Economist from Access Economics, is included:

"How is competition policy applied to the health sector?

The single word answer to this question is "unevenly".

For competition policy to work effectively, markets have to be open and market forces allowed to work. That means allowing price signals to function, In Australia, as in most countries, governments intervene in health markets in myriads of ways. Here is a sample:

- *The market for hospital services is contestable only for the private sector, say 30% of the beddays, and not for the public sector;*
- *The health insurance system distorts both the demand and the supply of health services;*
- *The health insurance system imposes a set of regulated prices for medical benefit purposes, in the process distorting the prices paid;*
- *The medical workforce is subject to extensive regulation, both in respect to undergraduate training and practice requirements despite all the regulation*

[3] *Health Administrator*, 16 June 1998, pg1.

the medical workforce is too large overall yet exhibits shortages due to the maldistribution of numbers between the specialties and between urban and rural areas; and

- *The public health financing and delivery systems as they are operated within Australia's Federal system of government are imbroglios of ill-defined, overlapping and conflicting objectives and responsibilities.*

Interventions are not always or necessarily "bad" when judged in terms of economic and social objectives., The medical profession has fought for and would be first to defend some of these interventions. Although the interventions may seek to counter the imperfections and the unwanted social outcomes of market forces, too often the result they produce is even worse.

It would take a brave, foolish person to argue that anyone should be free to set up practice as a doctor without a medical degree and without practical training. But at the other end, under the Government's policy of restricting provider numbers, completing a medical degree and hospital residency is not necessarily enough to guarantee access to large parts of the market. Here you have a policy tightly focused on a budget savings objective and blind to everything else:

- *the distortions it brings to the medical labour market;*
- *the windfall for doctors already in a practice; and*
- *the negative outcome for doctors-in-training.*

It is poor policy and it would not be needed if undergraduate numbers were right in the first place. They rarely are, for medicine or for anything else.

Where government regulation is applied extensively, to modify, and sometimes prevent, the operation of market forces, it is easy to end tip with a poor allocation of resources and it is much harder to sensibly apply the competition policy to achieve any positive outcome. I asserted that competition policy is applied unevenly to the health sector. Why so?

First, the scope for competition policy is uneven because the regulation of the health sector is uneven. The private health insurance sector has been absurdly over-regulated for years. Successive Federal governments have bred and nurtured an oligopolistic industry that can not and will not innovate or adapt to its declining market share, that is highly dependent on Government direction and that is now dependent upon Government subsidies.

Second, there are quirks in the way the current policy works. There are grave inconsistencies between what a union is allowed to do in representing its members and what a professional association can do for its members. It is still

the labour that is rewarded, or not rewarded, as the case may be, but the industrial relations legislative framework is very different to the TPA framework. The medical profession seems to be covered by the TPA when it suits governments. But what of the country GP deprived of admission rights to the local hospital. Has he or she been unfairly subject to a restraint of trade? Don't hold your breath. The State Governments have plenty of places to hide from the TPA. That is a little more than a quirk of policy. It is governments saying that they set the rules, but do not play by them.

Third, and to my mind most important of all, is the way governments have tended to protect their health institutions from any form of external competition or market discipline, particularly their public hospitals.

Competition policy seeks to slant the playing field in favour of the consumer, It does not always produce that outcome. The Lawrence legislation sought to introduce managed care to the private health care industry. It was perfectly acceptable to the ACCC for the private .health funds to collude in regard to doctor contracts yet it was made clear that any collusion by doctors in the negotiation of contracts, either through their representative bodies or in informal groups, would be severely punished. This is the big ugly buyer model, where the "big guy" buyer uses extensive market power to force down further the prices of the thousands of "little guy" suppliers who are already competing with one another.

In theory, the private health fund uses its market power to broker a better deal for its members. US experience gives us a good insight into the likely outcomes:

1. *Doctors re-organise their practices into much larger economic units to counter the power of the funds, a form of organisation which would not naturally emerge.*

2. *Before long you have a form of corporatism where big business, big unions and big government are carving up the consumer surplus among themselves.*

3. *The insurance companies in the US undoubtedly used their market power to force down health costs, but pocketed the gain instead of passing it on to*

   consumers. Evidence? Cost ratios of up to 35% compared with 13% for the Australian funds and CEO salaries of over $US 100 million pa for the large players.

One US health economist characterised the doctors as outlaws shooting up the town. The funds and their managed care were brought in as the bounty hunters to clean up and control the outlaws. Who controls the bounty hunters? Not, on the face of it, the ACCC.

The real irony of the Lawrence legislation is that it seeks to impose a system which really sidelines the consumer. I would sooner see a system which empowers the consumer. The TPA legislation seeks to empower the consumer, but in reality empowers the buyer, or in the case of the private health funds, what we might call the proxy buyer, the buyer who acts on behalf of another. There is only a benefit to the consumer if the funds in turn operate in a competitive environment so they are forced to pass on the benefits.

When the Minister stops making noxious regulations like the one designed to eradicate Silver Cross, and when the Government deregulates the private health insurance industry and opens it to competition, then and only then will I concede that they might be starting to get half serious about applying competition policy to the health sector."

HOW DOES NATIONAL COMPETITION POLICY EFFECT RURAL AND REGIONAL HOSPITALS?

The application (or as we contend, the misapplication) of National Competition Policy in rural and regional Australia HAS ADVERSE EFFECTS ON INDEPENDENT HOSPITALS in the following ways:

1. **No Negotiation**
   The prohibition on hospitals being able to collectively bargain with health funds means that there is no effective negotiation process. A small independent hospital finds itself being forced to accept terms dictated by a

   multi-national corporation or health fund who have no requirement to maintain the viability of a smaller independent hospital for rural and regional Australians. In fact the health fund may even own or have a financial interest in a competing hospital in close proximity.

2. **Costly Exemption Process**
   The ACCC response to this problem is to point to its ability to provide exemptions from the prohibition of group negotiation to small independent hospitals if they can mount a case for such an exemption.

In reality this means that a small hospital must commit to spending thousands of dollars on legal advice and be prepared to make a total disclosure of all of its sensitive commercial information and financial position to the ACCC (which may use such information at any time in any action it may wish to take against the hospital). The exemption process can also become so bogged down that by the time the application is determined the applicant may not be in a strong enough financial position to continue trading.

3. **Profitability a disadvantage**
   The ACCC's view may well be that while the hospital is profitable it has no justification to request a collective bargaining exemption. The dilemma here is that the case for the hospital is strengthened if its directors allow the hospital to trade into financial difficulties. However a hospital in financial difficulties would have trouble committing to finance the exemption process in the first place.

4. **Incentive to deny contracts**
   Independent hospitals that are forced to accept non-profitable contractual arrangements with health funds become easy targets for larger corporateswith stronger financial backing. They can also be purchased at firesale prices or be rendered ineffective as real competitors.

5. **Collocation works against rural and regional public hospitals**
   The collocation of private and public hospitals in metropolitan areas also makes it more unattractive for public hospital doctors to accept rural appointments in non-collocated public hospitals given the private patient benefits that are being offered to salaried public hospital doctors at metropolitan collocated hospitals.

   Furthermore collocation and collaboration between major public and private hospitals with the enhanced ability ensured by a government contract to combine resources and compete with non-collocated hospitals is completely acceptable to the ACCC. The secrecy of collocated contractual agreements means that the price paid for the use of public assets by the collocated private hospital owner is not able to be judged on a transparently competitive basis.

Example

Under the application of National Competition Policy, National Mutual Health Insurance (NMHI) was able to exclude from full member benefits a number of hospitals in South Australia and Victoria. Using the powers of the Lawrence Legislation (which introduced the Trade Practices Act into health care), National Mutual determined not to contract with 21 hospitals in South Australia and 31 hospitals in Victoria.

In summary 52 private hospitals are now not available to National Mutual health fund members unless those members are prepared to pay an additional charge.

NMHI has the majority of its policy holders in South Australia and Victoria. Its operations are mainly in Victoria and South Australia, where it has market shares of 32% and 60% respectively. It is 100% owned by National Mutual Holdings which in turn is 51% owned by the French insurance giant AXA.

AXA has substantial international insurance interests. AXA is headquartered in Paris.

NMHI has aggressively pursued preferred provider arrangements involving contracts with hospitals and doctors. The vast majority of doctors have consistently refused to sign up. Small hospitals have no effective bargaining power in contract negotiations in comparison to a company the size of National Mutual.

Amendments to competition legislation have prevented doctors and small independent hospitals aggregating (unless exempted by the ACCC, a process stacked against small players) to resist the powerful competitive pressures capable of being bought by organisations like NMHI.

It must be remembered that rural patients with private health insurance have less private hospitals to choose from by virtue of their remoteness from city markets. Any closures of existing hospitals further restricts their choice.

Recommendations

1. That quality assurance accreditation by a body independent of all parties including government be the only criteria required for any hospital, including a rural or regional hospital, to attract benefits from a health fund and that any dispute arising from the accreditation process be referred to an independently qualified and professionally recognised arbitrator for resolution.

2. That where agreement between a health fund and hospital cannot be reached as to the benefit payable that an independently qualified and professionally recognised arbitrator be appointed to determine the outcome.

3. That all hospitals be allowed to charge a premium or co-payment above any health insurance benefit as an incentive to provide the highest possible standard of quality and service that the market can afford.

4. That hospital size or geographical location not be a determining factor in negotiation over the quantum of benefit payable to a hospital.

5. That all hospitals be allowed to group negotiate if they so desire without fear of legal intervention by the ACCC or any other third party and without the need to apply for an exemption from the ACCC.

6. That the default benefit for non-contracted hospitals be superseded by the process outlined in Recommendations 1-5.

RURAL AND REGIONAL MEDICAL PRACTITIONERS

The demands of Rural Practice

Australian rural medical practice is without questions one of the most demanding jobs any doctor could ever undertake.

The fact that the practitioner must often work independently of other colleagues and can be without the benefit of supportive medical infrastructure means that rural doctors must be capable of using special and extra skills to compensate for these deficiencies.

Added to this is the physical and mental demands of a 24 hour on call practice often with limited relief.

The demands of rural medicine, in particular its cost to spouse and family, narrows its attractiveness as a career choice for many doctors.

Medical negligence issues worsened
Added to this is the potential injustice that sees a rural doctor being judged in cases of alleged medical negligence by standards comparable to a professor of medicine at a large well resourced metropolitan teaching hospital.

State government disinvestment
Also moves by all State governments to disinvest in rural and regional hospital infrastructure and health care facilities in order to meet the increasing demand of larger metropolitan electorates consuming 'perceived' free hospital services is an added burden and disincentive to practice rural medicine.

PRICE SIGNALS REMOVED

The Australian Doctors' Fund contends that the outlawing by the ACCC of any fee schedule likely to meet with reasonable compliance is counterproductive to competition. This action denies the market essential information from which to make an informed judgement and comparison of medical fees.

In a similar fashion the move towards commercial in-confidence contracts between all parties in health care is in itself contradictory to the need for an informed market to have transparent information on market prices.

Freedom of speech
In a democracy individuals should be at liberty to discuss with anyone any matter of choice to publish any material provided it is not defamatory or morally objectionable.

The Australian Doctors' Fund therefore contends that threats against doctors who may meet to discuss fees or other professional matters concerning money or who seek to publish fee schedules is not only anti-competitive but in effect a denial of basic human rights and natural justice.

This is borne out by the stupidity of a situation which says that if a person who is an employee meets with other employees or to discuss a wage claim there is no illegality. However, if two contracted doctors meet to discuss a claim for their hourly rate at a local hospital each are liable to a fine of $250,000.

Example

A group of doctors meet and decide that the inability to attract doctors to participate in an after hours hospital roster is due to the poor remuneration for this service. The group decides to convey this view to the hospital administration. Under ACCC rules each doctor and the group run the risk of being accused of setting a market even though the improvement in remuneration for the roster would increase competition for this service by increasing supply and this would in turn have a direct benefit for patients needing after hours medical treatment.

However, if the same doctors independently came to the same conclusion concerning the remuneration for the roster and independently convey the same information to the hospital administration they would not be in breach of the Trade Practices Act.

THE RIGHT TO COLLECTIVE BARGAINING REMOVED

Under National Competition Policy doctors, including rural and regional doctors, are forbidden to collectively bargain for the renewal of a hospital contract. This action has impacted to a greater extent on public hospitals where visiting medical officers have traditionally worked under group contracts and negotiated largely through the Australian Medical Association or other representative bodies such as a specialist society or the Rural Doctors Association.

Rural doctors in vulnerable position

The Australian Doctors' Fund contends that a rural doctor is in no effective position to bargain with a rural hospital, public or private, as an individual although he or she should always be at liberty to do so. The Australian Doctors' Fund is acutely aware that this particular imposed imbalance and uncertainty has deterred and is deterring doctors from staying or taking up appointment in regional centres.

The fact that rural and regional doctors may be placed in the unenviable position of having to relocate to another town should conditions at their rural or regional hospital become unacceptable places them at a further disadvantage in an already one-sided process. What this means in practice is that if a doctor comes into conflict with the hospital CEO or hospital board about any non-medical matter his or her contract with the hospital can be put in jeopardy without the doctor having recourse to their professional association's representation. The doctor would then be forced to engage a solicitor at the

doctors own expense to sort out what may be a trivial problem. The doctor is always on the back foot.

Example

A small group of doctors in a small Victorian rural town were threatened with fines and penalties approaching $250,000 per doctor for holding a meeting to discuss a hospital directive that they change the terms and conditions of their contracts or have their contracts terminated by the hospital.

News of these events ensures that doctors are wary of entering into any arrangements with hospitals where they can be individually targeted and cannot fallback on the professional representation by their professional associations if they so choose.

ACCC exemption

One restricted exemption to permit collective bargaining in South Australia has been granted by the ACCC. On the ACCC's own admission this exemption is a very limited concession and comes at a time of heightened political sensitivity to rural and regional issues. The ACCC has stated its intention to limit this type of exemption.

Recommendations

1. That all doctors be allowed to group negotiate if they so desire without restriction or threat of fine or imprisonment by the ACCC and without the need to apply for an exemption from the ACCC.

2. That all medical associations be permitted to produce recommended fee schedules for medical services.

INDUSTRY COMMISSION REPORTS MEDICINE IS COMPETITIVE

However the most conclusive evidence of the competitiveness of the medical profession is contained in a report by the Industry Commission to the Council of Australian Governments entitled *The Growth and Revenue Implications of the Hilmer and Related Reforms Final Report March 1995.*

The Commission was asked to report on the potential gains on competition in the medical profession.

The Commission wrote of advertising restrictions:

"In general the focus of the advertising restrictions appear to be on preventing misinformation rather than impeding the flow of information on price and quality of service." Pg 114.

In regard to fees the Commission noted that medical practitioners were not obliged to charge either the AMA fee or the CMBS fee. It also noted that:

"Price competition is itself constrained by the existence of the Medicare fee schedule which removes any incentive to reduce fees below the level of the rebate." Pg 114.

We do not hear any call from the ACCC to abolish CMBS schedule in order to increase competition.

In regard to net present value of before-tax lifetime incomes:

"The evidence indicates that the returns to the medical profession as a whole do not appear to be in excess of the returns to other occupational groups where account is taken of the cost of acquiring the requisite education." Pg 116
In comparison to other professions this Industry Commission Report found that so-called employment supply restrictions (medical qualification and certification requirements demanded by various legislative licensing boards) if removed would result in a reduction of 0.17% (point one seven) of wages for the health industry precipitated by a decline of 1.25% in specialists salaries.

Medical Specialists	Employment supply restriction.	1.25% decrease in medical specialists wages causing a 0.17% reduction in wages for the health industry. Smaller reductions in the other industries employing some medical specialists.

This was to be compared with a 12% reduction in legal services costs resulting from putting Hilmer through the legal profession and a 20% saving in construction costs and 10% in operating costs if optical dispensaries were allowed to sell consulting services as well as a 15% reduction in the retail margin of pharmaceuticals if restrictions on new pharmacies were lifted.

As far as the Industry Commission is concerned, there is only a minimal gains to make in applying Hilmer principles to medical specialist areas.

ANTI-COMPETITIVE ACTIONS BY GOVERNMENT IN HEALTH CARE CONDONED BY THE ACCC

1. **Medicare**
   The federal government is committed to bulk billing by General Practitioners which constrains price competition and hence distorts the supply and demand of medical services particularly in rural and regional areas by ensuring that General Practitioners are forced to compete on turnover rather than price. This naturally makes metropolitan areas more financially viable for General Practitioners irrespective of other lifestyle benefits.

2. **Medicare Provider Numbers**
   As mentioned by Mr Roger Kilham on page 4 of this submission the decision by the federal Minister for Health, Dr Michael Wooldridge, to deny Medicare rebates to patients who choose to be treated by a recently graduated doctor who is not part of a General Practitioner training program is an unjustified government created impediment to the supply of medical services particularly in rural and regional Australia.

   Young doctors who may be happy to enter solo practice in a country town early in their careers when they are free from the burdens of family responsibilities are now forced to jump through a maze of hoops to obtain a permanent Medicare provider number.

3. **Regulations governing the provision of private health insurance**
   Using the public interest argument as a defence, the current Minister for Health has rendered illegal any likely competitors to the existing private health insurance funds hence denying the market an effective competitive alternative. The most obvious example of this was the banning of a catastrophe insurance product known as Silvercross with a specific regulation solely for this purpose. Such a product would have been of major benefit to rural and regional Australians.

   Other financial institutions who have ventured into health care finance products have also been deterred or warned off for similar reasons.

   Furthermore the Australian Doctors' Fund has been told by the CEO of a major health fund that existing health funds have been constrained by government in their ability to offer higher excess (lower premiums) private health insurance products. This action inhibits the development of products such as **Medical Savings Accounts which could provide viable savings based solutions to Australia's growing health care financing problem and in particular prove attractive to rural Australian who have a low level of private health insurance participation**.

ABUSE OF HUMAN RIGHTS AND DENIAL OF NATURAL JUSTICE

Under the justification of improving Australia's standard of living, State and federal governments have created and empowered a bureaucracy of unelected individuals with an unprecedented authority to decide what is and what is not in the public interest.

The fact that the courts will ultimately determine the penalties for those who breach competition law is not an effective safeguard against abuse of process. This argument fails to account for the damage done by the threat of action against an individual or company by the ACCC. Such threats can be commercially damaging and personally destructive to the individuals involved. The average small business owner or professional has no effective redress other than to engage in a prohibitively expensive defence against a legal juggernaut such as the ACCC.

Furthermore the ACCC has made no secret of he fact that its approach is prosecutorially driven. In the area of health care it is keen to establish case law by selecting individual targets and putting them before the courts.

The Australian Doctors' Fund views this development particularly as it applies to small businesses and individuals as undemocratic and hence ultimately detrimental to the public interest to say nothing of the denial of natural justice implicit in the conduct of such a process. In addition to being a denial of natural justice for the individual so threatened.

There is therefore a compelling and urgent need for legislation to reform National Competition Policy and to remove the ability of the ACCC to act in an arbitrary and unrestrained manner.

If such action is not taken then vulnerable organisations and individuals including those in rural and regional Australia will continue to be disadvantaged by the misapplication of National Competition Policy and its enforcement through unaccountable agencies.

Submission Ends

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20 November 1998