Collective bargaining class exemption notice

1. Who is in the collective bargaining group?

Describe or list the current members of the group and those who may join the group in the future.

If you have a small group that will not change you can list the names of all members, but in most cases, to enable the addition of new members over time, you should provide a **general description of the members of the group**. For example*: A group of dairy farmers in the Manning Valley area in New South Wales.*

Anaesthetists treating patients in private hospitals, within NSW.

2. Who does the group propose to collectively bargain with?

Describe or list the target business(es) or type of target business(es) the group proposes to collectively bargain with.

If you intend to negotiate with just one particular target business, or a small number of known target businesses, you can list the names of each target business, but in most cases, to enable the addition of new target businesses over time, you should provide a **general description of the type of target businesses the group intends to collectively bargain with**. For example: *Dairy processing companies*.

P*rivate hospitals in NSW.*

3. What does the group propose to collectively bargain about?

Describe the terms and conditions that the group proposes to bargain about with the target businesses. For example: S*upply of raw milk.*

Provision of clinical care, Management of on-call arrangements, Safety and quality of clinical care, Financial and industrial conditions relating to clinical care.

4. Contact details

Provide the contact details for a person the ACCC can contact in relation to the collective bargaining arrangements. This can be any member of the group or a nominated representative, provided they are in the position to provide the ACCC with further information about the group should it be required. Contact details will be redacted when the ACCC places these notices on its public register.

If the contact person, or their details, change, please advise the ACCC.

Contact person (name and, if relevant, position): _____

Telephone number: _____

Email address: _____

Signature of contact person: _____

7 December 2021

Ms Jaime Martin
Assistant Director
Australian Competition and Consumer Commission
GPO Box 520 Melbourne VIC 3011
E: jaime.martin@accc.gov.au

cc Mr David Hatfield
Director - Adjudication Australian Competition and Consumer Commission

Dear Jaime,

I refer to the phone conversation between the three of us last week - the Australian Society of Anaesthetists (ASA) welcomes the opportunity to provide some extra context to the application attached.

The ASA
The ASA is a membership association for anaesthetists across Australia. We operate state committees of volunteers and have a head office in Sydney. We consider and release advice on economic and professional standards issues and provide continuing professional development. We advocate to government and other stakeholders in relation to anaesthesia issues for the benefit of patients and our member doctors.

Relative sophistication of the parties
Anaesthetists who are visiting medical officers (VMOs) are independent contractors. Some are organised in small groups of one to about fifty for the purpose of accounting and bookings administration. None have an infrastructure comparable to a private hospital group or private health insurer, including access to financial and legal advice. They are very small enterprises in comparison.

Scope of application

The current issue of concern to the ASA relates to VMO doctors who are accredited to the Sydney Adventist Hospital (the SAN). The SAN has reached an agreement with a health
insurer (detailed below) which has led to a fee proposal that is not acceptable to many anaesthetists and those anaesthetists have sought the ASA's assistance. Whilst this fee proposal is currently specific to the SAN, health insurers often apply similar fees across the state and so it may be that similar issues will arise in relation to other hospital groups - hence the state-wide nature of this application. The ASA and anaesthetists

are **not** seeking a uniform or universal fee from this process. Local conditions are disparate and would require individual hospital discussion and bespoke solutions for hospitals, doctors and patients depending on local issues.

Origin of issues at the SAN.

Accredited anaesthetists provide services to obstetric and non-obstetric patients at the SAN. Each charges their own fees as they see fit. The roster for anaesthetic services is allocated voluntarily currently, but there is shortfall in interest rather than competition between anaesthetists for limited slots - meaning the SAN cannot fill its roster reliably.

Obstetrics is expanding in volume as a business aim of the SAN. The service requires 24-hour cover by anaesthetists for safety and quality. The hospital has promoted a branded "Swaddle" arrangement with HCF, a third-party health insurer, which sets a fee including an amount for the anaesthetists who deliver services to HCF insured patients.

This fee is quite low compared to current practice across the country, and much lower than the ASA relative value guide suggested fee.

This has resulted in market failure, in that there are insufficient anaesthetists accredited at the SAN who wish to participate in an obstetric roster, or who will participate for that fee.

The hospital is proposing to solve that problem by making participation in the obstetric roster and "Swaddle" mandatory for all anaesthetists accredited, rather than by increasing the fee to encourage more participation.

Thus, unrelated work on non-obstetric patients, for example orthopaedics work, would not be possible for anaesthetists unless the obstetric roster work and the lower fee for that were accepted.

There is no fee control proposed at this time for the non-obstetric work.

Subspecialty nature of obstetric work

While all anaesthetists have traditionally been trained in obstetric anaesthesia it has, over the last 20 years, become a subspecialty practice in metropolitan areas and large regional cities. Further training in the area via a fellowship, and recent experience, are pre-requisites for public teaching hospital positions in obstetric anaesthesia and, in many large private hospitals, for anaesthetist VMO obstetric accreditation.

Many of the SAN accredited anaesthetists have not practised in obstetrics for decades so it would not be professionally responsible for them to submit to an obstetric roster allocation. They do participate currently in a separate on-call at SAN for non-obstetric emergencies.

Result of compulsion

The likely result of compulsion would be that some anaesthetists would leave the SAN (particularly the more experienced anaesthetists who can readily obtain work elsewhere), including those who do provide obstetric services at no or known gap fees to all insurers currently. This is for a range of reasons, such as inadequate fees in this particular arrangement, likely increased roster frequency (which disrupts ability to work the next day) and philosophical objection to fee control and mandated rostering.

The non-obstetric work that they surrender as a result would thus likely be granted to the small number of anaesthetists who are prepared to enrol in the fee controlled obstetric roster at this time - thereby limiting patient choice options and removing the support network currently available to more junior practitioners.

Outcomes in other hospitals

Given that obstetric units are widespread across NSW and that other hospitals do not need to resort to compulsion and fee control to fill their rosters, one reason for the exemption is to protect discussions that involve considering other models of care from other hospital groups.

Pipeline for anaesthetists

Anaesthesia training is a long-term undertaking with a minimum of usually ten years being required post-graduation from medical school to becoming a first-year consultant. Support is provided from senior anaesthetists even then to their junior colleagues, on a pro bono basis. Disruption of safety culture by losing senior practitioners from the ecosystem of the hospital can adversely impact patient outcomes in the view of the ASA.

Matters for discussion with SAN during exemption include

- Safety and quality.
- Fees for Swaddle arrangement.
- Limiting access to other unrelated work at SAN because of the mandated obstetric roster participation.
- Other hospitals' roster arrangements including payment for time on call

The ASA believes that it is likely most SAN practitioners could potentially agree to a maximum fee that would not result in hardship to patients or the business aims of the SAN. The current data from Medicare shows very high participation in known and no insurance gap schemes by VMOs, which all vary in fee. Obviously, discussions which could achieve this outcome cannot occur without an exemption.

It is likely in our view that a negotiated outcome for roster coverage could also be concluded that enables the obstetrics unit to sustainably operate, as it does in other private hospitals.

Australian Society of Anaesthetists

Sustainability of the service for patients, at reasonable cost and with quality and safety, would be the aim of discussions.

We trust this information is of use and look forward to further communication with the ACCC.

Yours sincerely,

Dr Andrew Miller
President