Determination

Application for revocation of A91376 and the substitution of authorisation AA1000427
lodged by
the Rural Doctors Association of Australia
in respect of collective negotiations with providers of rural health services
Authorisation number: AA1000427

Date 19 December 2018

Commissioners: Sims
Rickard
Keogh
Court
Featherston

Summary

The ACCC has decided to grant re-authorisation until 19 December 2028 to enable the Rural Doctors Association of Australia and its constituent state associations (collectively the RDAA) to collectively negotiate with state and territory health departments, Local Hospital Networks, Primary Health Networks, and Hospital and Health Services, the terms of contracts for general practitioners and generalist visiting medical officers in rural areas.

Collective negotiation involving the RDAA may help in attracting and retaining doctors in rural areas.

1. The application for revocation and substitution

1.1. On 31 July 2018, the RDAA (the **Applicant**) lodged an application to revoke authorisation A91376 and substitute authorisation AA1000427 for the one revoked (referred to as re-authorisation). The RDAA is seeking re-authorisation to collectively negotiate on behalf of general practitioners and generalist visiting medical officers[1] in rural areas. The RDAA initially sought re-authorisation for five years. Following the ACCC's draft determination, in which the ACCC invited submissions on whether a period of 10 years would be appropriate, RDAA revised this position and instead requested authorisation for a period of 10 years. This application for re-authorisation AA1000427 was made under subsection 91C(1) of the *Competition and Consumer Act 2010* C'th (the **Act**).

1.2. The ACCC can grant authorisation, which provides businesses with legal protection for arrangements that may otherwise risk breaching the competition law, provided the arrangements are likely to result in a net public benefit or, in some cases, are unlikely to substantially lessen competition.

1.3. On 9 November 2018, the ACCC granted interim authorisation under subsection 91(2) of the Act. Interim authorisation suspended the operation of authorisation A91376, which expired on 21 November 2018, and enabled the existing arrangements with the various state-wide entities to continue while the ACCC considered the substantive application.[2] Interim authorisation will remain in place until the ACCC's final determination comes into effect.

The Conduct

1.4. The RDAA is seeking re-authorisation for ten years to collectively negotiate with state and territory health departments, Local Hospital Networks, Primary Health Networks and particular Hospital and Health Services, the terms of contracts for general practitioners and generalist visiting medical officers in rural areas.

1.5. Matters for negotiation could include payments to doctors for services provided to public patients or services provided within the hospital/facility, including payments for on-call and arrangements for rosters, as well as payments for the provision of primary care services, including after-hours services in the general practice or other primary care setting. Negotiations may also include broader terms and conditions such as

---

1 Visiting Medical Officers are medical practitioners appointed by a hospital to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. *Australian Institute of Health and Welfare* http://meteor.aihw.gov.au

2 See ACCC draft determination of 9 November 2018 available at: https://www.accc.gov.au/public-registers/authorisations-and-notifications

fatigue management, clinical governance processes and professional development support

(the **Conduct**).

1.6. The ACCC has authorised the RDAA to collectively negotiate with state and territory health departments since 2008. It has also authorised the RDAA to collectively negotiate with state-wide Local Hospital Networks in South Australia and Western Australia since 2013. In the current application, the RDAA seeks to extend the scope of authorisation to enable it to collectively negotiate with:

- Local Hospital Networks in Victoria
- 13 Hospital and Health Services in Queensland[3]
- Local Hospital Networks in South Australia (the RDAA submits the Country Health South Australia Local Hospital Network will transition away from a state-wide Local Hospital Network to six new Local Hospital Networks at a date as yet to be advised), and
- Primary Health Networks across Australia.

Rationale for the Conduct

1.7. The RDAA submits that people living in rural Australia have poorer health outcomes than their urban counterparts. The RDAA notes the findings of a report by the Australian Institute of Health and Welfare "*Australia's Health 2016*", which states that there is a higher prevalence of disease in rural areas and that "for nearly all causes of death, rates were higher for people living outside of Major cities, with people in Remote and Very Remote areas faring the worst". The RDAA also notes that:

- life expectancy in rural areas is up to 7 years less than the city
- mortality rates in rural areas are up to 3 times higher than those in the city
- there is a high prevalence of mental health issues and suicide rates are up to 30% higher.

1.8. The RDAA submits that the shortage of rural doctors appropriately skilled in advanced community and hospital medical care is a significant contributing factor to poor health outcomes in rural communities. The RDAA also notes that an increase in the number of GPs in the over 55 years age bracket is impacting on the interest and willingness of this workforce to provide services, particularly the after-hours services at hospitals.

1.9. The RDAA submits that Commonwealth Government initiatives and support for medical students provides an opportunity to build the rural workforce, but that this will only be achieved if there are support networks in place as well as mature industrial arrangements comparable to those available in major cities and large regional centres' hospital systems.

1.10. The RDAA submits that, if granted, authorisation will enable it to continue to support rural doctors and facilitate their participation in the provision of VMO and other services. It submits that this, in turn, will promote more efficient delivery of health care services, better work force recruitment and retention, and improved health outcomes for rural and regional communities in the longer term. It submits the inclusion of Local Hospital Networks in Victoria and Hospital and Health Services in Queensland aims to

[3] Cairns and Hinterland, Central Queensland, Central West, Darling Downs, Mackay, Metro South, North West, South West, Sunshine Coast, Torres and Cape, Townsville, West Moreton, and Wide Bay Hospital and Health Services.

enable a more cost efficient process for the engagement of VMOs in rural and remote hospitals across all of Australia.

2. Background

The Applicant

2.1. The RDAA is the peak organisation representing the interests of doctors working in rural medical practice throughout Australia. It represents the full range of rural doctors, including specialists, rural generalists, general practitioners, and doctors working in both the public and private sectors. The RDAA submits that its objectives focus on acquiring the highest standard of medical care for people living in rural and remote Australia, which includes advocating for a highly skilled and motivated rural medical workforce, which is appropriately trained, remunerated and supported.

2.2. The RDAA submits that the existing authorisation has facilitated effective negotiations and agreements in a number of states. For example, the RDAA cites the state-wide agreements reached in NSW. The RDAA notes multiple examples where it has worked collaboratively with the Australian Medical Association in negotiating on behalf of its membership.

Key entities relevant to the Conduct

2.3. **Local Hospital Networks (LHNs)** are separate statutory authorities which are responsible for the management of public hospitals throughout Australia. The boundaries for the 137 LHNs include 124 geographically-based networks, together with 13 state-wide networks which deliver some specialised services across some jurisdictions. LHNs are made up of small groups of local hospitals that collaborate to deliver patient care. They manage their own budgets and are held accountable for their performance. The size and scope of LHNs varies from state to state.

2.4. **Queensland Hospital and Health Services (HHS)** are 16 independent statutory bodies which are responsible for delivering public health services in their areas. Each HHS is governed by a Hospital and Health Board and managed by a Health Service Chief Executive. The RDAA identified 13 relevant HHSs in its application for re-authorisation.

2.5. The Australian Government established 31 **Primary Health Networks (PHNs)** in 2015 with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. PHNs are overseen by a board of directors and advised by a clinical council and a community advisory committee. They are expected to fund:

- after hours services
- mental health services
- health promotion programs
- primary care support.

2.6. **Medicare Locals** have been replaced by PHNs. Medicare Locals were primary health care organisations established as a key component of the Australian Government's National Health Reform agreement reached in 2011. Medicare Locals were set up to coordinate the delivery of primary healthcare services and address local health care

needs and service gaps. There were 61 Medicare Locals across Australia, 41 of which had a significant rural constituency.

Visiting Medical Officer (VMO) services

2.7. The RDAA anticipates that VMO agreements will continue to be made on a state-by-state basis, or with individual Local Hospital Networks in some circumstances. The RDAA submits that the nature of negotiations, which take place at the state level, and the extent of RDAA involvement in these negotiations, varies widely between states.

2.8. Under current arrangements, VMO fees for rural doctors in all states except Victoria are set on a state-wide basis by State Departments of Health. In Victoria, VMO arrangements are negotiated directly between medical practitioners and practices and the LHNs. In Queensland, while doctors negotiate individually with local HHS', the previous state-wide contract is currently used as the guide for service contracts.

3. Consultation

3.1. A public consultation process informs the ACCC's assessment of the likely public benefits and detriments from the Conduct.

3.2. The ACCC invited submissions from a range of potentially interested parties including state and federal government agencies, industry associations, consumer organisations and likely negotiation targets.

3.3. Prior to the draft determination, the ACCC received two submissions from interested parties in relation to the application:

- The Australian College of Rural & Remote Medicine (ACRRM) supports the RDAA's application for re-authorisation. ACRRM submits that the arrangements have "significant potential for community benefit, especially in regional, rural and remote areas, with little associated risk of limiting competition or other adverse impacts". ACRRM submits that because the arrangements are voluntary for all relevant parties and that authorisation of collective boycotts has not been requested, there will be "no adverse effects on competition and a minimal chance of adverse public impact from the arrangements."
- General Practice Registrars Australia (GPRA) supports the application for re-authorisation. GPRA notes that the voluntary collective negotiating arrangements, under both the current and proposed authorisation, enable RDAA to support rural doctors in negotiating the terms and conditions under which they provide VMO services to LHNs and other health services. GPRA notes that management and payment arrangements vary across states and individual hospitals, and seeks a collaborative approach between RDAA and GPRA in advocating for GP registrars, especially in rural and remote areas of Australia.

3.4. The RDAA acknowledged the submissions and agreed with GPRA that a collaborative approach would be beneficial.

3.5. On 9 November 2018 the ACCC issued a draft determination proposing to grant re-authorisation. The draft determination proposed a term of five years and invited feedback as to whether a longer duration, 10 years, would be appropriate. A pre-decision conference was not requested following the draft determination.

3.6. The ACCC received two submissions from interested parties following the draft determination:

- The Northern Territory Government Department of Health advises that the Conduct would have limited application in the Northern Territory and that it has no issue with the ACCC granting authorisation for 10 years.
- The Australian Salaried Medical Officers' Federation Queensland (ASMOFQ)[4] submits that the scope of authorisation should not be extended to enable the RDAA to negotiate with HHSs in Queensland because it is unlikely to result in public benefits and 'would significantly undermine the negotiation process, increase competition between organisations and subsequently reduce the public benefit.' In this regard, the ASMOFQ notes that it is advocating for VMOs to enter into a certified agreement and is concerned that authorising the RDAA to negotiate with HHSs would undermine this advocacy work. The ASMOFQ is also concerned that the Conduct will encourage the use of independent contractors and undermine the employment relationship to the detriment of its members. The ASMOFQ is concerned about the proposed length of authorisation, were the Queensland legislation to be changed to enable the RDAQ to negotiate for a certified agreement. ASMOFQ also noted its concern about an increased risk of "sham contracting" if attempts are made to contract outside of the employment relationship.

3.7. ASMOFQ also sought confirmation from the RDAA:

- that it is only proposing to represent independent contractor VMOs and not employee VMOs,
- about how the RDAA proposes to manage the relationship with the AMAQ when representing independent contractors during collective negotiations with HHSs, and
- that it will only represent VMO independent contractors working in rural locations and therefore, that the proposed extended scope of authorisation would not apply to all 16 HHSs.

3.8. In response the RDAA:

- acknowledged the lead role of ASMOFQ in the industrial framework for salaried doctors employed within Queensland Health and confirmed that the RDAA's intention is not to establish a separate arrangement for employee VMOs outside of this industrial framework;
- undertook to liaise with ASMOFQ to ensure that the Rural Doctors Association of Queensland (RDAQ) is a key stakeholder and is engaged in the consultation in these negotiations so that the voice and views of rural based employee VMOs are considered in the development of any new agreement;
- acknowledged that for VMO employees, one certified agreement is the preferred model for employment remuneration arrangements, and that it is not seeking any change to this arrangement;
- clarified that for independent contracted VMOs (non-employees), the RDAA and RDAQ remain committed to collaborating with AMA Queensland and

[4] The Australian Salaried Medical Officers' Federation (ASMOF) and its state counterpart, the Queensland Branch of the Australian Salaried Medical Officers Federation (ASMOFQ) represents salaried doctors in industrial negotiations and in workplace disputes. Membership with Australian Medical Association (AMA) Queensland entitles members to joint membership with ASMOFQ.

where rural doctors are members of AMA Queensland, the RDAA/ RDAQ would respect AMA Queensland's leadership in contract negotiations;

- reiterated that its application for re-authorisation listed the HHSs with rural services within their boundary, and proposes to limit any representation to rural based members; and
- submits that it only seeks to engage with the HHSs to support its members and that it will collaborate with the AMA Queensland as part of this process to ensure that there is alignment and any risks of "sham contracting" are managed appropriately. The RDAA also noted the long history of collaboration between the RDAA and the AMA and that it is important that the views of RDAA members are strongly represented in negotiations, as often there are unintended consequences when city based models are imposed on rural communities.

3.9. In response to the draft determination, the RDAA noted its support for a longer period of authorisation and stated that it does not anticipate needing to change the authorised arrangements within the proposed ten year period.

3.10. Public submissions by the RDAA and interested parties are on the Public Register for this matter.

4. ACCC assessment

4.1. The ACCC's assessment of the Conduct is carried out in accordance with the relevant authorisation test contained in the Act.

4.2. The RDAA has sought re-authorisation for Conduct that would or might constitute a cartel provision within the meaning of Division 1 of Part IV of the Act and may substantially lessen competition within the meaning of section 45 of the Act. This is because, for the purpose of competition law, independent contractors are regarded as competitors. Therefore an agreement among rural doctors relating to the supply of VMO services to hospitals and health networks is at risk of breaching the Act. Legal protection is required for collective bargaining by rural doctors who are providing VMO services as *independent contractors*, but not for collective bargaining by those providing VMO services as *employees*, since such collective bargaining does not breach the Act.

4.3. Consistent with subsections 90(7) and 90(8) of the Act[5], the ACCC must not grant authorisation unless it is satisfied, in all the circumstances, that the conduct would result or be likely to result in a benefit to the public, and the benefit would outweigh the detriment to the public that would be likely to result (authorisation test).

Relevant areas of Competition

4.4. To assess the likely effect of the Conduct, the ACCC identifies the relevant areas of competition likely to be impacted.

4.5. The RDAA submits the relevant areas of competition are:

- the provision of VMO services by rural doctors to rural hospitals and health care facilities within a defined geographic area, and usually in the community in which the practitioner is located. There may be some instances where these

[5] See subsection 91C(7).

services are provided to hospitals and health care facilities in other towns in the vicinity.

- the provision of health care services by rural doctors to Primary Health Networks within a defined geographic area and usually restricted to the community in which the doctor is located.

4.6. The ACCC considers that rural public hospitals are likely to seek VMO services from doctors practising in areas around the hospital. The size of these regions is likely to differ depending on the remoteness of the area and other geographic factors.

Future with and without the Conduct

4.7. In applying the authorisation test, the ACCC compares the likely future with the Conduct that is the subject of the authorisation to the likely future in which the Conduct does not occur.

4.8. The ACCC considers that in the future without collective negotiations, the RDAA could continue to play a consultative role on behalf of rural doctors, but higher transaction costs from individual negotiations would mean individual rural doctors would be likely to accept standard form contracts with limited ability to negotiate the terms and conditions of their agreements.

4.9. The ACCC notes that the arrangements for acquiring VMO services varies between states and territories, with most states effectively having a state-wide contract while in Victoria, for example, VMO services are individually negotiated by each of the 86 LHNs. In Victoria, there are likely to be many different agreements from one LHN to the next with or without the conduct. In these circumstances, the ACCC considers that collective negotiation is likely to result in stronger advocacy for rural doctors and more effective negotiations.

Public benefits

4.10. The Act does not define what constitutes a public benefit. The ACCC adopts a broad approach. This is consistent with the Australian Competition Tribunal (the **Tribunal**), which has stated that the term should be given its widest possible meaning, and includes:

> *…anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress.* [6]

4.11. The ACCC has considered the following public benefits:

- transaction cost savings
- better input into contracts leading to attraction / retention of rural doctors.

Transaction cost savings

4.12. Generally there are transaction costs associated with contracting. These transaction costs can be lower where a single negotiating process is employed, such as in a collective bargaining arrangement, relative to a situation where multiple negotiation processes occur.

6 Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242; cited with approval in Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677.

4.13. The ACCC considers that collective bargaining allows parties to share these costs which in turn may improve the level of input into negotiations and result in more efficient outcomes.

4.14. The ACCC notes ASMOFQ's submission that authorising the RDAA to negotiate on behalf of VMOs with HHSs would introduce an alternative body representing VMOs in Queensland. The ACCC has considered whether this potential for duplication of VMO representation is likely to reduce the transaction cost savings that may otherwise occur.

4.15. In this case, the ACCC considers such duplication appears unlikely to eventuate and is therefore unlikely to impact on transaction savings. In this regard the ACCC notes that the RDAA does not intend to establish a separate arrangement for employee VMOs outside of this industrial framework. Rather, it intends to work with ASMOFQ (acknowledging ASMOFQ's lead role in these negotiations) to ensure the position of those rural doctors, who are VMOs but not employees, is taken into account in the development of any new agreement.

4.16. The ACCC considers that the Conduct is likely to result in continued transaction cost savings and that this constitutes a public benefit. The ACCC notes that the extent of these savings may vary as a result of the different contracting arrangements adopted by various jurisdictions. As noted, negotiations may be undertaken at the LHN level (e.g. Victoria) or at the state or territory level in other jurisdictions.

Better input into contracts

4.17. The ACCC has previously accepted that collective bargaining may result in more effective representation of rural doctors in dealing with state and territory health departments. To the extent that this occurs, this outcome may provide rural doctors with greater confidence with respect to the stability and development of health care services in rural areas, which in turn may have a positive influence on the recruitment and retention of rural doctors.

4.18. The ACCC accepts there may be some public benefit where the RDAA can assist rural doctors to better participate in the negotiation process such that it results in a more efficient outcome, particularly where that leads to a greater retention of rural doctors or the increased provision of medical services in rural and remote areas that are currently under-supplied.

4.19. While the RDAA could still provide some support and assistance to members even if it did not have authorisation to engage in collective bargaining on their behalf, this would be more limited and would not include any agreement on rates or certain other terms and conditions.

ACCC conclusion on public benefit

4.20. The ACCC considers that the proposed collective bargaining arrangements are likely to result in public benefits in the form of cost savings and more effective input into contracts, which may result in better availability of doctors in rural communities.

4.21. The ACCC notes that these public benefits may vary according to the various contracting methods applied by different states and territories.

Public detriments

4.22. The Act does not define what constitutes a public detriment. The ACCC adopts a broad approach. This is consistent with the Tribunal which has defined it as:

> *…any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.*[7]

4.23. In the absence of collective bargaining, VMOs, as independent contractors, would operate individually in their dealings with hospitals, health departments and networks. However, the ACCC considers the effect of any reduction in competition between members of the group as a result of acting collectively is likely to be minimal.

4.24. This is consistent with its findings in 2013 when the ACCC granted authorisation to the RDAA to conduct collective negotiations at the state and territory-wide level on behalf of rural doctors. In reaching this view, the ACCC noted that:

- the level of competition amongst these doctors (in this context) in the absence of collective bargaining was likely to be limited
- the voluntary nature of the arrangements and the fact that they do not include the possibility of a collective boycott by the doctors further limit the potential detriment
- the RDAA was unlikely to be able to compel state or territory health departments to negotiate with it.

4.25. At the time, the ACCC also considered there could be some detriment from allowing the RDAA to collectively bargain with Medicare Locals and particular LHNs in areas where there may be a relatively small number of rural doctors who are potentially all members of the RDAA. The ACCC considered that in such circumstances, sharing fee information amongst those practitioners could reduce competition in the provision of health care services within a region.

4.26. Therefore, in 2013 the ACCC did not grant authorisation for the RDAA to collectively negotiate with Medicare Locals or LHNs other than those in Western Australia and South Australia, which were effectively state-wide entities.

4.27. The RDAA submits that collective negotiating for state-wide VMO agreements has worked well and that there is no evidence of public detriment. The RDAA also submits that there are issues, particularly in Victoria, which support the RDAA's proposal to expand the scope of authorisation to allow it to collectively bargain with LHNs, in contrast to the conclusion of the ACCC in 2013. For example:[8]

> *… issues in Victoria are significant and the Rural Doctors Association of Victoria has seen its membership grow by over 25% in the last 12 months. Contracts for Visiting Medical Officers in a survey was one of the main issues identified by members which they want RDAV*[9] *to address. RDAA recognises that negotiation remains optional for the LHN management if this expansion is approved.*

4.28. The ACCC considers that there are factors which distinguish the ACCC's decision in 2013 to the circumstances that arise now:

---

7 Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

8 RDAA submission, 22 October 2018.

9 Rural Doctors Association of Victoria, a constituent State association of the RDAA.

- Medicare Locals no longer exist and have been replaced by PHNs, which are larger entities (there were 61 Medicare Locals across Australia and there are just 31 PHNs).

- As noted, the RDAA submits that there are significant problems in Victoria that arise because rural doctors (in particular, junior doctors undertaking GP training) have to negotiate directly with the LHNs, which is a deterrent to rural GP recruitment. In addition, the RDAA submits that the individual contract arrangements have also created an environment where more rural GPs are declining to participate in the after-hours service, which is placing the sustainability of the service at significant risk. In these circumstances, it appears less likely that there would be meaningful competition between practitioners in the absence of collective negotiations.

- No concerns have been raised by potentially interested parties, including PHNs and LHNs, about the potential loss of competition or sharing of information between rural doctors.

4.29. In addition, with the exception of some LHNs in Victoria, the ACCC understands that none of the entities that the RDAA proposes to collectively bargain with are individual hospitals but instead cover regional areas or otherwise include multiple purchasers of VMO services. For example, PHNs cover broad regions of Australia such as Western Queensland, Western NSW and Country Western Australia. Accordingly, there is unlikely to be a significant imbalance in the size of the RDAA (or its state constituencies) versus the PHNs such that the RDAA would have market power and be able to extract unreasonably high fees from collective negotiating. In addition, negotiations with these entities would take place within a framework set by state and territory health departments.

4.30. The ACCC notes that the circumstances are likely to vary by local region. However, the ACCC considers that authorising the RDAA to collectively negotiate with LHNs has the potential to result in some public detriments as some doctors are likely to have a degree of market power in certain local areas, which may result in higher prices than would be the case without collective negotiation. The extent of any such detriments, however, is likely to be limited by the voluntary nature of the arrangements and because collective boycott activity has not been proposed.

4.31. The ACCC notes the concerns raised by ASMOFQ following the draft determination and set out at paragraphs 3.6-3.7. In particular, the ACCC notes ASMOFQ's concern that authorising the RDAA to negotiate on behalf of employee VMOs would increase competition between organisations representing employee VMOs, undermine the advocacy work of ASMOFQ and subsequently reduce public benefits. However, the ACCC notes that authorisation does not compel potential target organisations to negotiate with the RDAA; rather, it removes the risk that independent contractor VMOs that wish to negotiate collectively may be in breach of the Act. Accordingly, while the RDAA submits it intends to ensure the views of all rural VMO service providers are heard in contract negotiations, as noted above at 4.2, this authorisation extends to independent contractor VMOs only; legal protection under the Act is not required for the RDAA to represent and negotiate on behalf of employee VMOs.

4.32. The ACCC also notes the RDAA's response to ASMOFQ's submission at para 3.8 and considers that in the context of the RDAA's response, the concerns raised by ASMOFQ are unlikely to result in any public detriments.

ACCC conclusion on public detriment

4.33. The ACCC considers that the Conduct is likely to result in some limited public detriment in particular local areas as a result of the loss of competition between practitioners where such competition is replaced by collective negotiations undertaken by the RDAA. However the extent to which meaningful competition would exist without the Conduct is likely to be limited, no concerns have been raised by potentially interested parties (including those parties who the RDAA would be negotiating with; i.e. those who would be paying higher fees if this conduct reduces competition) and the magnitude of any resulting public detriments is likely to be small.

Balance of public benefit and detriment

4.34. The ACCC considers that the proposed collective bargaining arrangements are likely to result in public benefits in the form of transaction cost savings and the ability for rural doctors to have more effective input into contracts, which may result in some improvement in recruitment and retention of doctors in rural areas.

4.35. While the Conduct is likely to result in some limited public detriments in certain local areas as a result of the loss of competition between rural doctors in some circumstances, the magnitude of such public detriment is likely to be small.

4.36. The ACCC notes there is a spectrum of hospitals, health service providers and health networks which the RDAA seeks to collectively negotiate with pursuant to this re-authorisation and that the benefits and detriments differ according to factors such as the relative size of the target and the extent to which negotiations occur at localised or state/region wide levels.

4.37. Overall, the ACCC is satisfied that allowing the Conduct is likely to result in a net public benefit.

Length of authorisation

4.38. The Act allows the ACCC to grant authorisation for a limited period of time.[10] This enables the ACCC to be in a position to be satisfied that the likely public benefits will outweigh the detriment for the period of authorisation. It also enables the ACCC to review the authorisation, and the public benefits and detriments that have resulted, after an appropriate period.

4.39. In this instance, the RDAA initially sought re-authorisation for five years. Following the ACCC's draft determination, in which the ACCC invited submissions on whether a period of 10 years would be appropriate, RDAA revised this position and instead requested authorisation for a period of 10 years.

4.40. In 2008 and 2013, the ACCC granted authorisation to the RDAA for a period of five years. In proposing a period of five years but seeking feedback as to whether a period of 10 years would be more appropriate, the ACCC noted that structural aspects of the delivery of rural health services change over time, and that the Conduct has been broadened since 2013 to allow the RDAA to enter into collective negotiations with smaller entities (LHNs and PHNs). On the other hand, the ACCC noted that collective bargaining under the RDAA's current authorisation appears to have been operating well, and no concerns have been raised since the conduct was last authorised in 2013,

[10] Subsection 91(1)

and prior to the draft determination, no interested parties had raised concerns about the proposed new aspects of the authorisation.

4.41. The RDAA and the NT Government Department of Health expressed support for a longer period of authorisation. Conversely, ASMOFQ expressed concern with the length of the authorisation owing to its broader concerns about the involvement of the RDAA in negotiating processes. Given the assessment of these concerns as discussed at paragraph 4.31, the ACCC is of the view that an authorisation period of 10 years is appropriate.

5. Determination

The application

5.1. On 31 July 2018 the RDAA lodged an application to revoke authorisation A91376 and substitute authorisation AA1000427 for the one revoked (referred to as re-authorisation). This application for re-authorisation AA1000427 was made under subsection 91C(1) of the Act.

5.2. The RDAA seeks authorisation for the Conduct described in paragraphs 1.4 and 1.5.

The authorisation test

5.3. Under subsections 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied in all the circumstances that the Conduct is likely to result in a benefit to the public and the benefit would outweigh the detriment to the public that would be likely to result from the Conduct.

5.4. For the reasons outlined in this determination, the ACCC is satisfied, in all the circumstances that the Conduct would be likely to result in a benefit to the public and the benefit to the public would outweigh the detriment to the public that would result or be likely to result from the Conduct, including any lessening of competition.

5.5. Accordingly, the ACCC has decided to grant re-authorisation.

Conduct which the ACCC has decided to authorise

5.6. The ACCC has decided to revoke authorisation A91376 and grant authorisation AA1000427 in substitution to enable the RDAA to collectively negotiate the terms of contracts for general practitioners and generalist visiting medical officers in rural areas as described in paragraphs 1.4 and 1.5 and defined as the Conduct. The Conduct may involve a cartel provision within the meaning of Division 1 of Part IV of the Act or may have the purpose or effect of substantially lessening competition within the meaning of section 45 of the Act.

5.7. The ACCC has decided to grant authorisation AA1000427 until 19 December 2028.

6. Date authorisation comes into effect

6.1. This determination is made on 19 December 2018. If no application for review of the determination is made to the Australian Competition Tribunal it will come into force on 10 January 2019.