MIDWIVES

IN

PRIVATE

PRACTICE

Maternity Coalition INC
ABN 82 691 324 728

9 December 2009

The Committee Secretary
Senate Standing Committee on Community Affairs
Email: community.affairs.sen@aph.gov.au

Dear Sir or Madam

Re: Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

We are strongly opposed to the amendments that have been introduced to the above bills that would require midwives to enter into formal collaborative arrangements with medical practitioners. We believe this legislation, if passed, will have a negative impact on our ability to practise our profession, and that this could result in preventable adverse outcomes for mothers and babies.

We have included with this letter a selection of evidence supporting our position. We are happy to appear before the Committee to present our case and answer your questions.

Yours truly,

Joy Johnston
Signed on behalf of Midwives In Private Practice

Attachment 1: PDCU_Response 58-09.pdf
Attachment 2: Allan Fels 1998, 'The Trade Practices Act and the Health Sector'.

MIPP, C/- 25 Eley Rd, Blackburn South Vic 3130 Tel: 03 9808 9614

MIPP is a Participating Organisation in Maternity Coalition, which is endorsed as an income tax exempt charitable entity under Subdivision 50-B of the Income Tax Assessment Act 1997.

Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills

Submission by Midwives in Private Practice

Midwives in Private Practice (MiPP) is a collective of professional midwives who practise privately in Victoria. We ask the Senate Standing Committee on Community Affairs to do all in its power to block passage of the amendments to the midwifery bills under consideration for the following reasons:

1. We believe that the amendments will give doctors medical veto over a midwife's scope of practice, as well as midwives' ability to renew their licence to practice.

- Midwifery is a profession in its own right. Midwives, by definition (ICM 2005), have a duty of care to promote and protect normal physiological processes in birth. Midwives also have a duty of care in the "detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures. (ICM 2005)
- Midwifery is, by definition and in usual practice, collaborative primary maternity care. Midwifery entails the essence of multidisciplinary collaborative practice within a primary maternity care setting.
- When a midwife is the primary care provider, an obstetrician or other doctor is the specialist who is consulted when complications or variances from normal are detected by the midwife.
- Doctors do not practise midwifery, and cannot be held responsible to oversee the professional acts of a midwife unless the midwife is working under direct supervision of the doctor.
- A doctor's indemnity insurance could be compromised by the sort of collaborative arrangements foreshadowed in the draft legislation.
- Doctors are not required, under these amendments, to have collaborative arrangements with midwives. Can you imagine a doctor providing continuous intra-natal and post-natal care for his or her 'women' if there were not a band of helpful midwives in attendance?
- Australian obstetricians have an expectation that midwives in hospitals will assist them in their provision of maternity care. We do not understand this as collaboration, which requires mutual respect between co – labourers. The hierarchy of obstetrics makes the doctor the responsible primary carer, or 'designated clinical leader', and the midwife the subservient assistant.
- The Royal ANZ College of Obstetricians and Gynaecologists (RANZCOG) position statements make it clear that the obstetrician is the 'designated clinical leader' in all 'collaborations'. [eg http://www.ranzcog.edu.au/fellows/collegestatements.shtml#CObs C-Obs 30]

2. Pregnancy, childbirth, and the nurture of infants is not an illness (WHO 1985).

- The only times doctors are essential in the childbirth continuum are those when medical intervention is required.
- These include situations in which illness or complication are experienced by the mother or baby, or when restricted drugs or surgery are needed.

- The midwife providing primary maternity care works in partnership with the individual woman, transcending models of care and places where that care is provided.
- The midwife's guiding concern is the safety and wellbeing of mother and child.
- A midwife who provides primary maternity care for a woman in the childbearing continuum, pregnancy-labour-birth-post birth, is able to consult with and refer to specialist care providers and services if and when needed. This is no different from a dentist who refers you to an oral surgeon if you need surgery in your mouth that is outside the dentist's scope of practice.

3. MiPP supports a woman's right to employ a midwife privately.

- With current restrictions that prevent midwives from practising privately in hospitals, the majority of our members' practice is in the community, with well women planning homebirth.
- The outcome data from homebirths is collected and analysed by the Victorian Health Department's Perinatal Data Collection Unit, within the Consultative Council on Obstetric & Paediatric Mortality & Morbidity (CCOPMM). A recent analysis of data from approximately 1000 planned homebirths in Victoria in the past five years provides evidence of the safety and effectiveness of planned homebirth in this State. (See Attachment 1)
- International studies confirm the safety of planned homebirth with a midwife (De Jonge et al 2009)
- Midwives who provide private midwifery services for women giving birth in hospitals practise with a similar level of competence and safety.

4. MiPP considers it highly likely that the influence on the health care market of the amendments proposed in this legislation will be anti-competitive, effectively excluding midwives from the private maternity care market. Quoting from the words of the then Chairman of the ACCC, Professor Allan Fels (1998, page 5), in a paper 'The Trade Practices Act and the Health Sector' (Attachment 2), we believe the proposed amendments would effect:

- **"Misuse of market power** – that is, taking advantage of a substantial degree of power in a market for the purpose of eliminating or substantially damaging a competitor, preventing the entry of a person into any market or deterring or preventing a person from engaging in competitive conduct in any market (Section 46), and
- **"Exclusive dealing** – that is, one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal." (Section 47)

The legislation under consideration would clearly allow and support '***misuse of market power'*** leading to '***exclusive dealing***' by obstetricians, who would have the ability to exclude private midwives from the primary maternity care market. Obstetricians '***already have a substantial degree of power in a market'*** because Medicare funding, private health insurance rebates for consumers, and hospital access have privileged obstetricians over their '***competitors'***, privately practising midwives when providing the same primary maternity care services for well women: the usual scope of a midwife's practice. This monopoly situation would be enforced with the proposed amendments which would allow '***one person'***, the obstetrician, '***who trades with another'***, the midwife, '***imposing restrictions on the midwife's freedom to choose with whom, or in what, to deal***'.

MiPP considers the current monopoly which excludes midwives from the majority of the maternity care market as private practitioners to be in breach of the Trade Practices Act. The government's amendments will, if passed, secure that monopoly to an even greater extent. Midwives have pointed this fact out to government competition reviews and to the competition authority, the ACCC in past years, without success. Midwives are under-resourced to fight legal battles with defending our right to exist in a competitive market against strong and well funded medical interests.

5. MiPP considers that the Government's amendments will create difficulties in delivering intended access and choice for Australian women.

- This is a logical conclusion from the arguments presented above.
- There is strong evidence that Australian women want access to private midwife led primary care.
- We will present scenarios in person to the Senate Committee if requested, describing difficulties of access that will be experienced by Australian women, and the extent to which some women and midwives are likely to go in accessing care if the Government's amendments become law.

6. MiPP considers that the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers. Aspects of safety and continuity of care, likely to be of significance for mothers and babies include:

- The excellent outcomes that are currently achieved by privately employed midwives will no longer be possible under the Government's proposed amendments to the midwifery bills.
- Continuity of midwifery care for mothers is already difficult to access in mainstream maternity care, outside a private midwifery arrangement.
- Homebirths are likely to continue, and unregulated attendants are likely to step into the gap left when qualified midwives are removed from the market. These unregulated attendants, who use various titles including 'lay midwife', 'spiritual midwife', 'shamanic midwife', and 'doula' do not have the education or skill that is required for registration as a midwife, and are likely to compromise the safety of mothers and babies.
- Furthermore, the safety of mother and baby are likely to be compromised when open and transparent processes for consultation, referral and transfer of care, which are standard professional midwifery practice, are no longer in use.

7. We raise an additional matter: Workforce considerations

- The midwifery workforce is facing serious shortages, and can not afford to lose midwives who are currently in private practice.
- Many of our members believe that they would be unable to continue practising midwifery if the government's amendments are passed.

References:

de Jonge A, van der Goes B, Ravelli A, Amelink-Verburg M, Mol B, Nijhuis J, Gravenhorst J, Buitendijk S. Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. BJOG 2009 10.1111/j.1471-0528.2009.0217

Fels, A. 1998, 'The Trade Practices Act and the Health Sector'. Australian College of Helath Executives. (Attachment 2)

ICM 2005. Definition of a midwife. International Confederation of Midwives.

WHO 1985. 'Birth is not an illness'. Fortelesa Declaration. World Health Organisation.

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OUR REF: ADF09 4817

YOUR REF: 58-09

15 October 2009

Ms Joy Johnson
Midwives in Private Practice
25 Eley Rd
Blackburn South VIC 3130

Dear Joy

Please find below the information that you requested from the Consultative Council on Obstetric & Paediatric Mortality & Morbidity (CCOPMM).

The data that you requested on planned home births is from our 2006 and 2007 PDC databases, which are updated as new information becomes available.

The response below answers most of your questions. During your telephone discussion with Mary-Ann Davey it was agreed that the rates of caesarean section (CS) for standard primiparae and vaginal birth after caesarean section (VBAC) for women who achieved a home birth were not meaningful because CS cannot be performed at home. These have been produced for women who planned a home birth, regardless of where they actually gave birth. It was also explained that the VPDC is unable to calculate Mat2 for you because the Maternity Services unit obtains this data elsewhere.

Planned home births

There were 170 standard primiparae who planned a home birth in 2003-2007. Of these:

- none had labour induced (0%);
- 11 had caesarean sections (6.5%);
- of the 159 who had a vaginal birth, 1 sustained a 3rd or 4th degree perineal laceration (0.6%).

State Government Victoria

Achieved home births

138 of these 170 standard primiparae achieved a home birth:

- none of them had labour induced (0%); and
- none sustained a 3rd or 4th degree laceration (0%).

Vaginal births after caesarean section

30 women who planned a home birth fitted the criteria to be included in the denominator for the Maternity Service Performance Indicator related to Vaginal Birth After Caesarean Section. All of these achieved a vaginal birth (100%).

The reference for your request, in case you require any further information or explanation is 58-09.

Yours sincerely

ALISON J McMILLAN
Director, Statewide Quality Branch

J Johnston

AUSTRALIAN COLLEGE OF HEALTH SERVICE EXECUTIVES

THE TRADE PRACTICES ACT AND THE HEALTH SECTOR

Chairman Professor Allan Fels

27 February 1998

INTRODUCTION

Good morning. It is a pleasure to be here today to discuss the issue of the Trade Practices Act 1974 (TPA) and the health sector. I intend to speak for about 30 minutes and would then be pleased to accept questions from you on the issues covered and any other relevant matters you may wish to raise.

First, I would like to state that the purpose of the Australian competition laws (including the TPA), and of the ACCC's enforcement of those laws in the health sector, is to ensure that competitive forces will be allowed to stimulate the development of products and services desired by consumers. Generally speaking, competition policy is based on the premise that consumer choice, rather then the collective judgement of sellers, should determine the range and prices of goods and services that are available. Or in other words that competitive suppliers should not pre-empt the working of the market by deciding themselves what their customers need, rather than allowing the market to respond to what consumers demand.

The health sector is likely to face an increasing exposure to competition and fair trading issues in coming years. Competition policy reform in the health sector and the application of the TPA to the sector involves many issues. For the purposes of my presentation today I will cover the following major issues:

1. Competition policy and the extension of the TPA to the health sector;
2. The role of the Commission;
3. Part IV of the TPA;
4. The Commission and the health sector;
5. Authorisation.
6. Competition in the health sector and effects on private hospitals;

BACKGROUND

In 1991 the Commonwealth, State and Territory Governments agreed to examine a national approach to competition policy. A National Competition Policy Review Committee chaired by Professor Fred Hilmer was established. On the completion of this committee's report in 1993 (Hilmer Report) and after extensive public consultation on the reports recommendations, the various governments, as part of the Council of Australian Governments ("COAG") agreed to implement the recommendations. The two major recommendations agreed to by the COAG and relevant to the health sector were -

- universal application of the TPA to cover areas such as unincorporated businesses and State and Territory Government Business Enterprises ("GBE's") and
- a review and reform of anti-competitive regulation by all Governments.

To achieve the former recommendation the State and Territory Governments had to pass legislation to allow the provisions of Part IV of the TPA to be applied to all business in Australia - previously this part of the TPA applied mainly to incorporated business in trade. I will speak more about the application of Part IV to the health sector shortly.

The latter recommendation, the regulation review, imposed an obligation on all governments to review all legislation and regulation and remove anti-competitive regulation not in the public interest. The governments have until the year 2000 to complete this review and they will determine if anti-competitive regulation in the health area on issues such as restrictions on advertising, restrictions on employers, ownership restrictions and the often anti-competitive stance of many statutory health boards can be justified in the public interest.

EXTENSION OF THE TPA

In summary, the changes to competition policy that I have outlined with respect to the extension of the TPA to all in business came into effect on 21 July 1996 with penalties coming into effect on 21 July 1997. This means that health sector professionals are now subject to the provisions of the TPA.

I would just like to stress here that doctors who are employed in a business enjoy the same level of protection from the TPA as employees in any other business - including those employees who are members of a trade union. These days, doctors who are employees also face the same restrictions on their conduct as do other employees. However, if doctors elect to organise themselves as independent businesses then they are covered by the TPA - the same as any other business in Australia.

Another factor that I would like to stress is that the TPA is clear in its basics. The Act emphasises the importance of competition in all areas. The presumption underlying the Act is that the outcomes provided by competition are preferred and that anti-competitive behaviour should be prohibited. On the other hand, the TPA also acknowledges that there may be overriding public interest in some forms of behaviour that would normally constitute a breach of the Act. The authorisation provisions are designed to cover this type of circumstance and I will discuss this in more depth shortly.

THE TPA GENERALLY

I now intend to just briefly run through the major issues underlying the TPA.

Part IV of the TPA contains the main competitive conduct rules of the statute. I will outline these in more detail shortly.

Part IVA of the TPA prohibits unconscionable conduct.

Part V of the TPA safeguards the position of consumers of goods and services in their dealings with producers and sellers. For example, most of you would be aware that it is a contravention of the TPA to engage in conduct which is misleading or deceptive or is likely to mislead or deceive. The provisions in Part V apply to all businesses as they are mirrored in State and Territory fair trading legislation.

Part VII of the TPA is headed "Authorisations and Notifications in Respect of Restrictive Trade Practices". This Part allows the ACCC to review some forms of anti-competitive conduct. If authorised by the ACCC, it gets immunity from court action. The related policy in Part IX of the TPA provides a mechanism for people affected by a Commission determination to seek independent review of that determination by the Australian Competition Tribunal.

THE ROLE OF THE COMMISSION

I would now like to say a few words about the ACCC's role.

The role of the Australian Competition and Consumer Commission is to perform the functions conferred upon it by the TPA and *Prices Surveillance Act*. Among other things, the TPA provides the Commission with the duty to enforce compliance with some of its provisions.

Enforcement takes place in the Australian court system. The Commission has no law-making role - this belongs to federal, state and territory legislatures. The Commission cannot fine those who breach the Act - that is the role of the courts. It is important for you all to realise or remember that the Commission shares its right to take legal action under the TPA with the private sector.

The Commission's role as an enforcer depends upon what is and isn't prohibited by the Act. Broadly speaking Part IV of the Act aims to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business with the result of greater choice for consumers in price, quality and service. In the health sector, this can mean looking at health professionals' conduct to determine whether it promotes or hinders patients' interests in being able to choose among a variety of service and price options according to their needs.

Part V of the Act safeguards the position of consumers in their dealing with producers and sellers and prohibits conduct which is misleading or deceptive.

PART IV OF THE TPA

Having given you a background, the best place to start is to run through the anti-competitive practices prohibited by the TPA and provide a few examples to explain each of the sections in Part IV. The provisions contained in Pt IV are now applicable to all persons engaged in business, including those involved in the health sector.

The anti-competitive practices which are prohibited by Part IV are:

- Agreements that have the purpose or effect or likely effect of substantially lessening competition in a market (section 45).

  For example, two or more competing hospitals which agree on a market sharing arrangement may be in breach of the TPA if the agreement results in a substantial lessening of competition. A specific example would be two private hospitals agreeing that they will each treat patients depending on where the patients live. That is, dividing up the market on the basis of the geographic location of their residence.

- Agreements that contain an exclusionary provision. (sections 45, 4D).

  For example, if competing specialists in a market area agree not to sign contracts with hospitals in the market area they will be in breach of the TPA.

- Agreements that have the purpose, effect or likely effect of fixing, controlling or maintaining prices (section 45A).

  For example, if medical practitioners collude on price, they are deemed to be in breach of the Trade Practices Act.

- Secondary Boycotts - that is, action by two or more people which hinders or prevents a third person from supplying goods or services to a business, acquiring goods or services from a business or engaging in interstate trade or commerce where this substantially lessens competition (section 45D);

  This provision is often used in industrial disputes but has wider implications. For example, two or more anaesthetists who act in concert to prevent a surgeon from supplying services to a patient may breach this section if the conduct can be shown to substantially lessen competition.

- Misuse of market power - that is, taking advantage of a substantial degree of power in a market for the purpose of eliminating or substantially damaging a competitor, preventing the entry of a person into any market or deterring or preventing a person from engaging in competitive conduct in any market (section 46);

- Exclusive Dealing - that is, one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal (section 47);

  For example, if a medical equipment supplier with a unique instrument demands as a condition of supply that a medical practitioner or hospital purchases further products from its range, this conduct would be a breach of the TPA if it could be shown that it resulted in a substantial lessening of competition. If the same supplier demanded as a condition of supply that the buyer purchased other

products from a third manufacturer, that conduct is known as third line forcing and is deemed to be a breach of the TPA. So, in that case, a substantial lessening of competition would not need to be established.

- Resale Price Maintenance - that is, suppliers specifying the minimum price to a reseller (section 48, 96-100);

  For example, if pharmaceutical suppliers specify a minimum price below which goods cannot be sold or advertised they will breach the TPA. The supplier may recommend a resale price, provided that the document setting out the suggested price makes it clear that it is a recommended price only and the supplier takes no action to influence the reseller not to sell or resupply below that price.

- Mergers which have the effect, or likely effect, of substantially lessening competition in a substantial market for goods or services (section 50).

THE COMMISSION AND THE HEALTH SECTOR

I would now like to turn to the involvement that the Commission has had, and is having, with the health sector. Since the current Act was proclaimed in 1974, the Commission has been involved in numerous investigations and litigation relating to health service providers to the extent that the law has covered health services.

One of the Commission's earliest investigations involved a boycott of Canberra hospitals by Canberra doctors. A few years ago the Commission took Court action against five of Tasmania's six health funds for an alleged anti-competitive arrangement to attempt to stop the State's private hospitals from discounting their fees for Commonwealth repatriation patients.

Now that coverage of the TPA has been extended, it is very important that all involved in the health care industry understand their obligations, rights and responsibilities under the Act. However, participants should not be uneasy about the effects of the extension of the Act to the health care industry. The Act is not designed to harm business or prevent fair and fierce competition - in fact it protects both consumers and business from unlawful anti-competitive conduct and unfair market practices.

I would like to briefly mention a matter in the health sector that is currently before the Courts. The Commission instituted proceedings in the Federal Court against five Sydney anaesthetists and the Australian Society of Anaesthetists late last year. The Commission has alleged that the parties to this action engaged in two separate forms of anti-competitive conduct in breach of Part IV of the Act.

The allegation from the Commission is that three of the anaesthetists, through their medical practice companies, arrived at agreements with other anaesthetists to charge a $25 per hour on call services fee. The two other anaesthetists are alleged to have been knowingly concerned in, or a party to, one or more of the agreements.

The Commission has alleged that this conduct amounts to an illegal price fix in relation to after hours anaesthetic services at the three Sydney metropolitan hospitals that were effected by the agreement.

The Anaesthetists Society of Australia (NSW Section) circulated a report to its members in late 1995. The report recommended that the Society's members set an appropriate recommended on call fee to be paid by private hospitals to anaesthetists. The Commission alleges that the anaesthetists involved in this matter agreed to illegally fix the price for this service.

The Commission has also alleged that the anaesthetists involved in the agreement threatened to boycott of one of the three hospitals involved. The Commission has alleged that such a boycott would be anti-competitive and in breach of Part IV of the Act. As I mentioned, this matter is presently before the Courts.

I would like to stress that the Commission takes the type of conduct that is alleged in this matter very seriously. Price fixing is per se illegal under the Act and the Commission will investigate any allegations of this type of conduct very rigorously. The same applies to any form of boycott conduct. The penalties that are now in operation for any breach of Part IV are very severe - up to $10 million per breach for companies and $500,000 for individuals.

ACCREDITATION

A further matter currently being investigated by the Commission, and of direct interest to those of you who manage or aspire to manage Private Hospitals, is the accreditation process at Private and Public Hospitals. The Commission is aware that certain hospitals will only accredit doctors who are Australian Fellows - and in some cases, also belong to the specialist society or association. Both criteria involve a per-se breach of the TPA (third line forcing).

It is common practice for applications for accreditation to be given to the relevent hospital department for advice and recommendation. The Commission has noted that these competitors often, and in many cases without reason, reject the proposed accreditation. Some rejections are based on the earlier mentioned reasons, ie. the applicant is not an Australian Fellow and not a member of the relevant society.

I understand that the Department, ie. the group of competitors at the hospital, often enforce their rejection by threatening a boycott of the hospital. The message the Commission would want to convey here is:

(a) Competitors should not have control over who practices at any hospital.

(b) Third line forcing and threats of boycotts are serious anti-competitive conduct.

(c) Specialists of the same craft group must see themselves as competitors and the "club" spirit attaching to competition issues has to be eliminated.

Any hospital which acquiesces with the specialist department and refuses accreditation for non-clinical reasons is itself in breach s.47(6), the third line forcing provision.

SPECIALIST ENTRY

This year the Commission will be investigating the activities of certain specialist colleges who:

(a) limit training places &

(b) engage in trainee selection processes

with such conduct having anti-competitive purpose or effect. As a first step, we are currently seeking advice from Senior Counsel on the matter.

I would like to stress that the Commission intends to give the enforcement of the TPA in the health sector the highest priority and will be seeking to prosecute blatant breaches of the Act.

AUTHORISATION

As I mentioned earlier, the Commission is able to authorise anti-competitive conduct that would otherwise be prohibited with the exception of the misuse of market power. Authorisation is available where the conduct in question can be shown to result in a public benefit that outweighs its anti-competitive effect (benefits must be public not private). That is, the authorisation process is a balancing exercise - between public benefits and anti-competitive detriment. Decisions of the ACCC, in relation to authorisation applications, can be reviewed by the Australian Competition Tribunal.

For authorisation to be granted, the applicant must satisfy the ACCC that the conduct in question will result in a benefit to the public that outweighs any anti-competitive effect. Thus public benefits are the key in the authorisation process and their articulation should be given careful consideration. Also the benefits must be public, not private.

The Commission and Tribunal have in previous cases recognised the following as public benefits:

- fostering business efficiency, especially when this results in improved international competitiveness;
- industry rationalisation resulting in more efficient allocation of resources and in lower or contained unit production costs;
- promotion of industry cost savings resulting in contained or lower prices at all levels in the supply chain
- promotion of competition in industry

- promotion of equitable dealings in the market
- growth in export markets and development of import replacements
- assistance to efficient small business, for example guidance on costing and pricing or marketing initiates which promote competitiveness
- industrial harmony.

THE AMA AUTHORISATION

An example of an authorisation application currently before the Commission is one by the AMA in South Australia. The application deals with a common service agreement for the remuneration of doctors practising in South Australian rural public hospitals.

Doctors in these areas operate on what is known as a fee for service basis - they are paid for each procedure that they perform while in the hospital. Rural hospitals find it more effective to hire private doctors on a "piece" basis because the throughput is not sufficient to validate employing them on a full time basis.

The AMA has applied for authorisation because there are concerns that the collective negotiation for this fee for service agreement - negotiations between all rural doctors in South Australia - may amount to price fixing between these doctors who may otherwise be in competition with each other. The price fix would relate to the prices that doctors charge public hospitals for their services.

As I noted earlier, authorisation provides an immunity from the Trade Practices Act and the doctors would therefore be allowed to "price fix". The Commission is obliged to grant authorisation if it considers that the public benefits from the conduct outweigh the anti-competitive effects from the conduct.

The AMA has claimed many public benefits in its application and while I don't have time to discuss all of them today, I should mention that the issue that the Commission is looking at is that the benefits must:

- firstly - be public, and
- secondly, must derive purely from the collective negotiation of the fee for service agreement.

An example from the application is the claim that "*the arrangements facilitate the collective acquisition by the ... hospitals of the full cross section of medical skills and specialities to cover state obligations to the community under the Medicare agreements*". It may be argued that while this is a valid public benefit, it arises because the SA Government has arranged for the provision of medical services in rural South Australia, not because the doctors collectively negotiate as to how they are paid. If it did not derive from the collective negotiation process it would not be a valid claim for the purposes of the application.

PENALTIES

I would just like to reiterate here that the penalties that apply to breaches of the TPA can be very severe. The penalties imposed by the courts on parties that breach Part IV of the Act are monetary penalties, with maximums of $10 million for corporations and $500,000 for individuals. Injunctions and damages can also be awarded by the courts. As mentioned, court action may be taken by the ACCC or by private parties (including doctors, health insurers and hospitals).

COMPETITION AND THE HEALTH SECTOR

Some commentators have questioned the appropriateness of applying the TPA to the health sector. This is on the basis that things like quality of service, ethical matters and the doctor/patient relationship are peculiarly important to the Health sector. It has also been suggested that there may be possible economic distortions in the market for health services - caused by things like supplier induced demand (ie. doctors creating additional work for themselves by encouraging patients to seek additional treatment) and distortions caused by the existence of health insurance, both private and public insurance.

However, I would argue that these things do not have an impact on the matters looked at by the Commission. This is because the sorts of issues that the Commission deals with in relation to the health sector usually do not raise these high level considerations. The issues where the Commission usually becomes involved in relation to the health sector are similar to the issues that the Commission becomes involved in in other sectors - ie. generally the use of market power to increase income. In this context, I would point out that the Federal Trade Commission (the American antitrust enforcement agency) spends a high proportion of its time (maybe 25%) on health matters. Most of these cases do not raise the sort of high level issues alluded to earlier.

Some commentators have also argued that increased competition in the health sector would be a bad thing as the focus would be on price competition which would be likely to lead to a decline in the quality of the service being provided. However, I would point out that a well functioning market will aim to provide consumers with what they want. In the medical market, consumers want a quality service first and a good price second. As a consequence, increased competition in the health sector will manifest itself in competition over the quality of the service being provided.

Experience in other sectors of the economy would not support the claim that service quality would be likely to decline as competition has been shown to lead to an increase in quality. For example, many in the community would agree that in Telecommunications, service provided by Telstra has improved since it was subjected to competition by Optus. And of course consumers now have a choice as to the supplier they want to deal with. In any event quality of care under any environment is a matter for governments, health departments and State and territory health boards and individual practitioners themselves.

EFFECTS ON PRIVATE HOSPITALS

The extension of the Trade Practices Act to the health sector has been designed to create a more competitive environment with resulting benefits on price, quality and service to consumers. There are a number of effects that this has had that are relevant to people in the health sector and Private Hospitals.

Private hospital negotiations with health funds for the provision of hospital services need to be completed on an individual basis to ensure there is no risk of breaching the Act. Hospitals that compete with each other, or are in a position to compete with each other, cannot collectively negotiate on price with health funds (nor can they appoint a negotiator) without risking breaching the price fixing provisions of the Act.

Private hospitals, however, have slightly more flexibility in dealings with health professionals to the extent that a group of private hospitals that enters an agreement to collectively acquire health services would not generally be considered to be price fixing (through the collective acquisition exemption in section 45A(4)). However, note that the definition of collective acquisition is generally considered to require collective negotiation and individual acquisition at the negotiated price. Agreements between private hospitals that relate to the prices for their acquisition of services not falling within that definition could be considered to be price fixing. However, in the event of private hospitals not being covered by Section 45A , the Act still requires an assessment as to whether the agreement has the purpose or effect of substantially lessening competition. If so it breaches Section 45. This is likely to preclude a group of private hospitals with a combined significant share in the market from entering into such arrangements as it is likely that the agreement will have the effect of substantially lessening competition.

I should like to add that private hospitals also need to be aware that arrangements or agreements with other private hospitals that don't directly focus on price still may have anti-competitive effects. In this category fall such things as market sharing agreements and boycotts.

CONCLUSION

I would also like to stress the point that the health sector really has to learn to live with the TPA in the same way that businesses in every other sector of the Australian economy do. The application of the Act to the health sector has strong political support - all major parties and States believe that the TPA should apply to the sector. Attempts by various bodies to lobby State Governments for exemptions to the TPA have failed. Thus, there is a need for all health sector participants to become familiar with their rights and obligations under the TPA. At the same time, the Commission is learning how to deal with the health sector and its special characteristics.

In conclusion I would like to say that I am confident that in a few years consumers will be much benefited from the extension of the TPA to the Health Sector. As well ethical traders will not be constrained by rules and regulations which inhibit their growth and success and protect the inefficient.