Forum

The ACCC and competition in health

Following is an edited version of an address by Sam Di Scerni, the Commission's regional director in Western Australia, to the Western Australian Branch of the Association of Practice on 15 August 2001. Sam first gave some background to the Trade Practices Act including the Hilmer inquiry and report, the legislation and its aims and the Commission's role and priorities. He then discussed the relevance of anti-competitive and consumer protection provisions of the Act to the health professions.

Anti-competitive practices prohibited by Part IV

The first provision is the catch-all s. 45 prohibition on anti-competitive conduct which prohibits agreements that have the purpose or effect or likely effect of substantially lessening competition in a market. In assessing the effect of anti-competitive conduct, it is important to bear in mind that the Act is generally concerned with competition in a market rather than with the position of individual participants. Thus if the position in the market of an individual provider is being adversely affected by the conduct of a competing provider, it is unlikely that there will be a contravention of the Act unless the conduct substantially lessens competition in the market as a whole.

Price fixing (s. 45A)

Under s. 45A competitors are prohibited from having arrangements between themselves about prices, if such arrangements are intended to, or likely to, have the effect of fixing, controlling or maintaining prices. Price includes a 'charge of any description' as well as discounts, allowances, rebates and credit terms. No formal agreement is needed — a 'nod and wink' is sufficient for the Commission and the courts to infer the requisite meeting of minds.

Primary and secondary boycotts (ss. 4D, 45D)

Agreements that contain an exclusionary provision, that is, competitors agreeing not to deal with another party, are referred to as primary boycotts.

Secondary boycotts prohibit two or more people getting together to take any action that hinders or prevents a third person from either supplying or acquiring goods or services.

Misuse of market power (s. 46)

This is a company taking advantage of its market power for an illegal purpose, that is, (i) eliminating or substantially damaging a competitor, (ii) preventing the entry of a person into any market or (iii) deterring or preventing a person from engaging in competitive conduct in any market. The prohibition is largely self-evident but I would like to reinforce the point that s. 46 deals with the misuse of market power for an illegal purpose, not with the mere acquisition or holding of market power.

Exclusive dealing (s. 47)

In effect, this is one person trading with another and imposing restrictions on the other's freedom to choose with whom, or in what, to deal. There are various provisions within s. 47, two of the more relevant being full and third line forcing. Full line forcing or 'bundling' is one party forcing the second to deal with it exclusively for all the goods and services required (and is subject to a substantial lessening of competition test). Third line forcing is one party dealing with a second and making it a condition of the deal or transaction that the second party also deal with a third. This is a per se offence.

For example, if a medical equipment supplier with a unique instrument demands as a condition of supply that a hospital purchases further products from its range, this conduct would be a breach of the full line forcing provisions 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 hospital purchased other products from a third party, that conduct could breach the third line forcing prohibition in the Act.

Resale price maintenance (s. 48)

This occurs when a supplier specifies the minimum price to a reseller at which a good is to be resold. For example, if pharmaceutical wholesalers or suppliers specify a minimum price below which goods cannot be sold or advertised by the reseller, they will breach the Act.

To summarise:

> The least risk option for anyone engaging in market behaviour in the health sector, whether it be in setting premiums, fees or charges or in conducting negotiations with other participants, is to act independently and unilaterally.

Consumer protection provisions

The consumer protection provisions in Part V of the Act generally prohibit false and deceptive conduct or making misleading representations. They often crop up in relation to advertising. Many of you are probably covered by advertising restrictions imposed by Commonwealth/State or Territory government legislation and these are currently exempt from the Act (although many of these restrictions are currently being reviewed). Restrictions on advertising not backed by legislation but formulated and enforced by associations and societies will be subject to Commission investigation.

The Commission does not believe that removing advertising restrictions to allow professionals to advertise necessarily raises issues of ethics. For example, the Commission does not believe that ethical issues arise through doctors or other health providers advertising such things as their:

- ability to speak foreign languages;
- willingness, or unwillingness, to bulk bill; or
- listing of fees for procedures.

The Commission's attitude is: why shouldn't patients be informed about such things?

But, to allay your concerns, the consumer protection provisions of Part V of the Act, and equivalent provisions of state fair trading legislation provide significant sanctions against any advertising or promoting that genuinely raises issues of ethics or 'miracle cures'.

Under those provisions anyone whose advertising is false, misleading, or deceptive, or likely to mislead or deceive would be in breach of the legislation. The Commission has taken action when it has believed health providers made misleading claims and I will mention a few of these later.

Corporate structures

The following refers mainly to GPs, although the issues are applicable to all health professionals.

After qualifying and receiving a provider number from the Commonwealth Department of Health and Aged Care, GPs can choose how to structure their business affairs to deliver medical services to the public. For example, by providing medical services:

- through their own 'medical practice' proprietary limited company;
- as an independent unincorporated individual (a sole practitioner or natural person);
- through a legally binding partnership agreement with other general practitioners; or
- as an employee for a company in a standard employer–employee relationship.

Their choice will have implications under a number of Australia's laws: taxation, superannuation, corporation or partnership, and competition laws. A GP who chooses to provide medical services as an independent unincorporated natural person generally must make business decisions independently (not collectively with other GPs or competitors) to avoid any legal risk of breaching the Act.

The Act does not restrict the day-to-day provision of medical services from GPs to their patients but it does require business decisions — particularly setting fees or withdrawing services — to be consistent with the legal obligations of the chosen structure. For example, an independent sole practitioner operating either through an incorporated practice company or as an unincorporated natural person must make business decisions independently.

The Act also does not restrict how sole practitioners provide their medical services. Sole practitioners are always free to individually decide how to set their fees, or to supply or withdraw their services. In deciding, GPs may decide to obtain advice from their professional adviser, for example their accountant, lawyer, or financial adviser.

So you see, the Act does not require or force GPs to adopt any particular business structure and is absolutely neutral as to what structure a GP chooses.

Rosters

The Commission is aware that rosters are an integral part of health care. Let me confirm and say publicly once again that genuine rosters do not breach the Act. The Federal branch of the Australian Medical Association has been wrong in alarming regional or rural general practitioners that their roster arrangements may breach the Act. The purpose of a genuine roster is to ensure the availability and supply of medical services from general practitioners after hours and on weekends.

The primary boycott provisions of the Act are concerned with agreements between competitors that have the purpose 'of preventing, restricting or limiting the supply of services'. The purpose behind a genuine roster on the one hand, and primary boycott agreements on the other, are totally different. It is the purpose of the agreement that is central to determining whether or not there is a breach of the primary boycott provisions of the Act and the wording of the Act makes this clear.

I can confirm that the Commission has not been and is not investigating any rural or regional roster arrangements for breaches of the Act.

Boycotts

The Act prohibits two types of boycott: primary and secondary. Generally, any joint conduct by independent GPs that aims to exclude or limit dealings with purchasers or patients may breach the Act. Although collective boycotts are prohibited under the Act, individual boycotts are not. Any GP is free to individually decide whether or not to supply or withdraw their services. What the Act prohibits is the agreement with competitors to supply or withdraw services.

Let me illustrate the boycott issues with two examples.

> Three GPs in a country town provide obstetric services at the local public hospital. Each GP has formed the view, individually, that they can no longer afford to provide this service. They get together and, knowing that it is really only profitable for one to continue, decide that two of them will withdraw their obstetric services and only one will continue to provide obstetric services to the town.

This agreement would be likely to constitute a primary boycott because its purpose is to restrict, limit or prevent the provision of obstetric services by the two GPs who previously provided them.

Such an agreement may, however, be authorised by the Commission if it can be shown that the conduct results in a benefit to the public such that the conduct should be allowed to occur. On the facts provided, the public benefit of such an agreement would ensure obstetric services would remain in an area where they would otherwise be withdrawn. There is obviously great public benefit in ensuring obstetric services are provided in country areas. In my view, if the purpose of the agreement really was to ensure that obstetric or other medical services continue to be provided to town or country areas, it is highly likely the Commission would authorise the agreement.

> Four independent doctors in a small rural town collectively agree to not bulk bill. Is this a breach?

It probably is. The agreement will probably breach the primary boycott provisions as its purpose is to prevent the supply of medical services in circumstances under which the fees for the services would be processed by bulk billing. That is, but for the agreement, all or certain categories of patients might have been bulk billed. Because of the potentially significant consumer detriment to members of rural communities — a complaint about such a matter is likely to be pursued by the Commission.

Fee setting

Price fixing

To ensure compliance with the Act and to minimise legal risks, doctors should set their fees to be consistent with the business structure they have chosen. For example, GPs in legal partnerships can set fees collectively. However, a doctor choosing to practise as an independent practitioner must set fees individually; that is, independently of competitors.

On 31 August 2001, the Royal Australian College of General Practitioners applied for authorisation to allow GPs to agree on fees if they operated within certain business structures, including corporations, partnerships and, subject to certain conditions, associateships (GPs practising in associateships are independent businesses under the Trade Practices Act). The Commission granted interim authorisation on 19 September 2001.

Although an agreement between practitioners to bulk bill all patients would constitute a technical breach of the price fixing provisions of the Act, the Commission would exercise its discretion not to take action in such a matter, unless it could be demonstrated that a consumer detriment exists, or that it would be in the public interest to take enforcement action. The reason for this is because an agreement to bulk bill would result in lower prices for consumers, whereas an agreement to set a common fee between competitors, or an agreement not to bulk bill, would be to increase prices.

Fee schedules

The Commission has consistently taken a strong stance against 'recommended fee schedules' that are often circulated by a trade or representative organisation. Many such fee schedule agreements have come before the Commission and its predecessor, the Trade Practices Commission, for authorisation or informal approval and in the main these have been refused. This is because few public benefits flow from such agreements. The Commission considers that one of the inevitable purposes of a representative organisation issuing recommended fee scales is that the organisation expects many, if not all, of its members to follow the recommendation.

For a recommended fee schedule to be seen as a genuine guide only, you would expect to see:

- there is no obligation or undertaking to comply with the recommendations made;
- there is no attempt to police or follow up the recommendations made;
- the fees are recommended by a representative organisation and individual members have no direct hand in the calculation of the recommended fees; or
- the prices are recommended by a representative organisation on the basis of costing or other calculations by an outside party.

However, representative organisations can help members by publishing costing information and formulas that allow individual members to determine and set their own fee levels with regard to their own costs and expected level of profit. An example of where the Commission worked with an organisation to achieve such a process/ structure was the Australian Dental Association (NSW), which developed a model to help members with fee setting issues. Members were supplied with a formula to calculate a fee for their services, after taking all the costs that a particular dentist wants to take into account, as well as their expected returns.

Negotiating fees with hospitals

Under the Act, competitors such as GPs cannot make agreements about the price they will charge for their services. Negotiations on fees or allowances by groups of competing GPs and/or their representative organisations with hospitals would also be at serious risk of breaching the Act. A hospital can consult or hold discussions with groups of practitioners and their representative organisations, and then choose to make its own independent decision about the terms and conditions for contracting doctors.

The law allows representative organisations to make policy statements and give advice to their members. The Commission's view is that such organisations are able to provide guidance on the negotiation process with State governments and hospitals to their members to ensure their members consider all the relevant contract issues, but they cannot reach an agreement on behalf of their members. While competing GPs are able to make an individual decision not to enter into contracts, they are not permitted under the Act to collectively agree not to sign contracts.

Representative organisations should note that any agreement between competitor GPs not to accept contracts offered to them by hospitals would be likely to constitute a breach of the primary boycott provisions of the Act. This means that organisations can inform, advise and make recommendations to their members about particular hospital negotiations as long as there is no agreement between competing GPs. Organisations should be careful when advising their members on remuneration. There is a fine line between lobbying and encouraging or inducing a boycott.

Collective negotiations may, however, be authorised by the Commission upon application by the parties if it can be shown the public benefit outweighs the detriment caused by the anti-competitive conduct. It is also possible for representative organisations to apply for authorisation on behalf of their members to enable negotiations to occur. The important issue is to focus on the public benefits flowing from any such conduct.

Corporatisation

When we refer to corporatisation in the health sector, we have generally meant doctors being engaged, either as employees and paid a salary, or as independent contractors, on some form of profit-share arrangement, by a company. Note that, contrary to other professions such as the legal profession, GPs have never been legally restricted from incorporating their practices, and therefore the concept of doctors adopting the business structure of a company for their practice is not new. It is the most common business structure for GPs with 53 per cent of all GP business units being limited liability companies.

However, when corporatisation is being discussed these days, what is generally being referred to is the development of at least one of the following.

- Horizontal integration — in certain metropolitan areas, large numbers of individual general practices are being bought to form large GP corporations.
- Vertical integration — emergence of large corporations including GPs, specialists, diagnostic imaging and/or pathology.
- Non-medical ownership — the shareholders of GP corporations or corporations including GP practices are not general practitioners themselves.

Potential issues

Referrals

Concerns have been raised that corporate owners may require GPs to refer their patients to certain specialists. Depending on the circumstance, and without overriding the clinical independence of GPs, such conduct may constitute third line forcing or full line forcing in breach of the Act. Full line forcing occurs where a company requires their employees to make referrals to certain businesses owned by that company. Full line forcing is a breach of the Act if it can be shown that these referrals substantially lessen competition.

Disclosure

To guard against the possibility of becoming liable for misleading or deceptive conduct it may be wise for GPs to disclose to patients that they are part of a corporation and/or that the corporation has a policy of referring within the corporation. While the Act does not impose a general duty to disclose information, the courts have held that silence, or the failure to disclose relevant material infor-mation may, in some circumstances, amount to misleading or deceptive conduct.

Interferences with clinical independence

Some GPs have expressed concern that pressure from corporate owners may decrease their clinical independence, for example in relation to consultation targets, inappropriate ordering of diagnostics, and/or the inappropriate prescription of medicine. If a corporation is imposing clauses in a contract with a GP, or has policies that interfere with the GP's clinical independence, such conduct may raise issues under the unconscionable conduct provisions of the Act. Many factors may be used to determine if a particular conduct is unconscionable including:

- the relative bargaining strengths of the parties;
- whether as the result of the stronger party's conduct, the other was required to meet conditions not reasonably necessary to protect the stronger party's legitimate interests;
- the use of undue influence, pressure or unfair tactics on the part of the stronger party; and
- the extent to which the stronger party was willing to negotiate.

Whether the unconscionable conduct provisions apply to conduct by the corporate owner towards a GP will depend on the nature of the contract or the relationship. If it is a straight employer–employee relationship, the conduct is not likely to breach the Act.

Authorisation

I would now like to provide a very brief overview of the authorisation process. The authorisation provisions give the Commission the power to

grant immunity from legal proceedings for conduct that might otherwise breach the restrictive trade practices provisions of the Act (except for misuse of market power). Decisions of the Commission can be reviewed by an independent body — the Australian Competition Tribunal. A judge of the Federal Court of Australia presides at hearings of that Tribunal. It is a truly independent review process.

You should also note that authorisation is a public process, not one conducted behind closed doors. The Commission will approach all interested parties to enable them to make submissions on the application for authorisation. For authorisation to be granted, the applicant must satisfy the Commission that the conduct in question will result in a benefit to the public that outweighs any anti-competitive effect. So, it is a balancing exercise between public benefits and anti-competitive detriment.

Public benefit is not defined in the Act, rather the Commission recognises a range of matters as constituting a public benefit. The authorisation guide gives examples including:

- expansion of employment or prevention of unemployment in efficient industries;
- industrial harmony;
- improvement in the quality and safety of goods and services and expansion of consumer choice;
- supply of better information to consumers and business;
- promotion of equitable dealings in the market; and
- promotion of industry cost savings.

Current cases

The Commission is currently pursuing some important competition and consumer protection cases in the health and medical sector.

ACCC v Australian Medical Association (WA) and others

The Commission is alleging that the AMA (WA) and Mayne Nickless Ltd and various individuals were parties to, or knowingly concerned in, various breaches of the Trade Practices Act, including allegations of price fixing, primary boycott and agreements that substantially lessen competition.

ACCC v Medibank Private Ltd

In October 2000 the Commission instituted proceedings against Medibank Private Limited in the Federal Court, Melbourne, alleging false, misleading or deceptive conduct in two advertising campaigns. In one, the Commission alleges Medibank Private advertised 'no rate increase in 2000' for its Package Plus insurance products although the rates for those products increased on 1 July 2000. In a second, the Commission alleges that Medibank Private advertised an offer to consumers who switched from another fund to Medibank Private of 'any waiting periods waived' and 'get 30 days free if you change to Medibank Private' in newspaper advertisements in August 2000 but failed to disclose some conditions.

ACCC v Medical Benefits Fund of Australia Ltd & another

In February 2001 the Commission instituted legal proceedings against Medical Benefits Fund of Australia Limited in the Federal Court, Sydney, alleging false, misleading and deceptive advertising of its health insurance products. The Commission alleges MBF print and television advertisements contained pregnancy related images to entice consumers to transfer — on a no waiting period basis — to join MBF private health insurance but that, in fact, a 12 month waiting period for pregnancy related services existed. The Commission alleges the condition was contained in a very fine print disclaimer.

ACCC v Paul Storer and Mrs Linda Storer

Earlier this year the Federal Court handed down orders, by consent, that Mr Paul Storer and his wife, Linda, made false and misleading representations about Paul Storer's qualifications (in relation to claims he had a PhD) and the benefits of using the product Probiotics in isolation as a cure for chronic fatigue syndrome. The representations occurred in lectures and workshops conducted on the Gold Coast, Melbourne, Adelaide and Perth, and on the television programs, *Today Show* and *A Current Affair*.

Education and compliance

Of the 79 000 complaints and inquiries received by the Commission last financial year, it pursued over 4000 non-GST related complaints — of these over 99 per cent were dealt with administratively. That is, without going to court. Apart from administrative resolution of complaints

and some court cases — the Commission also regards very highly its role of education and guidance to help people better understand the application and implications of the Act.

The Commission initiatives have generally included:

- contacting relevant associations to inform them of the need for their articles, codes, and/or by-laws to be amended to comply with the Act;
- presenting addresses at health sector forums; and
- meeting with representatives of health sector participants to discuss issues particular to their members.

In November 1995 the Commission published a guide to the Trade Practices Act for the health sector, which was widely distributed, and it has since introduced other education initiatives.

Most recently, however, the Commission has been working with groups to develop a comprehensive guide on the Act for general practitioners. Discussions have so far been held with the Australian Division of General Practice, the Commonwealth Department of Health and Aged Care, the College of General Practitioners, the AMA (Federal), and the Rural Doctors Association of Australia. The Commission has also participated in workshops around Australia, including rural and regional areas, to ensure GPs are accurately informed about the implications of the Act and the Commission's priorities.

The draft guide is available on the Commission's website at <http://www.accc.gov.au> and is expected to be published within the next month or so.

The Commission is pleased with the constructive approach taken by many of those within the health sector and will continue to work with them to ensure a sensible outcome. Namely, that all participants in the health sector have a properly informed and better understanding of the application of Australia's competition and consumer protection laws to the sector.

Trade practices compliance — a regulator's perspective

Following is an edited version of an address by Sam Di Scerni to the Association of Compliance Professionals of Australia's Meet the Regulators *seminar on 28 August 2001.*

Introduction

Compliance is a word that is increasingly appearing in the lexicon of Australian business, and company directors and senior management will ignore it at their peril. There is a recognition that compliance, as a business practice, is an emerging discipline in its own right, as evidenced by the activities of the Association of Compliance Professionals and the publication of the *Australian Standard on Compliance Programs AS 3806* in 1998.

Regulators and enforcement agencies such as the Commission are placing more emphasis on making compliance happen in the marketplace by encouraging a greater understanding of the elements of effective compliance. At the same time, the Federal Court is looking at the effectiveness of corporate compliance systems in determining the appropriate level of penalty in trade practices cases.

Commission priorities

In deciding whether it will pursue an enforcement action the Commission will take account of factors such as:

- apparent blatant disregard of the law;
- a history of previous contraventions;
- significant public detriment and/or many complaints;
- a national or across-state-boundaries coverage;
- the potential for action to have a worthwhile educative or deterrent effect; and
- a significant new market issue.

Institutional framework for compliance

As you are aware, Commission Chairman, Professor Allan Fels, launched the *Australian Standard on Compliance Programs* in 1998 and