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Medical practitioners and competition law in Australia and New Zealand

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Abstract

There is a lack of awareness among Australian and New Zealand medical practitioners about how competition law applies to them. In this article, basic legal issues relating to interaction between medical practitioners (which all medical practitioners should be aware of) are discussed. The New Zealand *Ophthalmologists Case* and some relevant Australian and United States cases are analysed. Three key areas of competition law (of relevance to medical practitioners) are identified as being important and relevant. In conclusion, medical practitioners must be able to distinguish between legal and illegal activities; and guidelines outlined in this paper provide some clarification.

Is there anything different about medical practitioners in relation to competition law which should excite the interest of national competition enforcers? Surely competition-law principles are the same for everyone?

The principles of competition law are the same for everyone. So, this makes the asking of the question *is there anything different about medicos?* appear somewhat illogical. And answering the question is even more illogical. Nevertheless there are areas in which medical practitioners have unique problems with competition law.

In general terms, competition law mandates individual decision-making about prices charged and parties dealt with. Problems occur in relation to joint activity engaged in by practitioners or their respective professional associations. Some of these problems (e.g. general activities relating to price-fixing) have no specific issues unique to medical practitioners.

However, it seems to me that there are three areas where medical practitioners do face specific problems (or where their exposure, actual or potential, is greater than that of other businesses or professions).

The three critical competition areas are conduct relating to:

- **Joint negotiations—**Medical fees, as a function of the society in which we live, frequently require Government policy input. Medical fees are often recovered from health funds and are reimbursed by compensation tribunals. Some type of joint negotiation (about the level of fees) is often necessary. Yet the essence of competition policy is that each market participant must ‘compete’ with his or her colleague and make individual decisions. Where are the respective boundaries?;
- **Exclusionary activities—**Law reports (particularly in the United States) are replete with cases of doctors trying to exclude other practitioners from their patch—either their hospital (access to which is essential to practice), their specialist accreditation college, or their geographic practising area; and

- **Breaches of professional ethics and the 'right' of 'self regulation' to enforce these ethics—**By necessity, society has to have professional standards. No-one believes that brain surgery should be performed on a park bench. But who sets the standards and how are they enforced? Obviously, a competitor judging the ethics and competence of their colleague is actual or potential competition dynamite. Unless there are appropriate safeguards, this process can become a method of excluding new entrant medicos from the turf of present practitioners. How does one ensure that proper ethical standards are observed without using standards of competency as an exclusionary device?

In Australasia (Australia and New Zealand), these issues are daily becoming of greater relevance. In Australia, individuals trading totally within State borders have enjoyed immunity from the Federal competition writ (for constitutional reasons). It was only with the enactment of supplementary State legislation in 1995 and 1996 that individuals were totally covered by the Australian Trade Practices Act. Although the Australian Act is now three decades old, for two of those three decades medical practitioners have enjoyed considerable immunity from the reach of the Federal Commissars.

New Zealand, thankfully, has no such constitutional difficulties but the whole issue of competition law and medical practitioners has recently leapt into prominence because of the *New Zealand Ophthalmologists Case*[1] decided in March 2004. As Justice Gendall remarked in his penalty decision of 30 June 2004,[2] the *New Zealand Ophthalmologists Case* was not a 'test case' but it was a 'first-time' case involving professional persons and their Society.

Applicable competition principles

Past experience of New Zealand, Australian, and United States law is taken as the basis of the discussion which follows. Each of the three critical competition areas identified above is discussed below.

Joint negotiations—In relation to medical practitioners, the Australian Competition and Consumer Commission ('ACCC') gives the view of a competition enforcer. It has taken a very strong line against the employment of a negotiator to represent competitor parties. It takes the view that a negotiator in this event sets a background level around which the individual's fees will be established. Furthermore, it takes the view that there will, therefore, be an anticompetitive arrangement between competitors even if the parties represented by the negotiator decide individually whether or not to supply their services at the negotiated price.[3]

Obviously, the joint appointment of a negotiator may be a cloak for a price fixing arrangement. In particular, parties must expect problems when they give the negotiator the power to bind them to the negotiated result or where the parties, or any two of them, agree (pre or post the negotiation) to implement the results of it.

But what is the position when parties jointly agree to appoint a negotiator but:

- Expressly provide that the negotiator has no power to bind them but merely a power to probe alternatives, ascertain attitudes, seek a range of prices within which individuals may further negotiate, or even ascertain a particular price at which another party is prepared to stand in the market; and

- Expressly provide that the parties between themselves do not agree and will not agree to adopt the result of any negotiations, that each party reserves the right to make his or her own decision, and that no concerted action will be taken to implement the negotiated result.

In such an event, assuming it represents the actuality,[4] what is the 'arrangement' between competitors? The joint arrangement is only that the parties will appoint a negotiator. There is no arrangement that the parties will adopt or implement anything the negotiator reports back. This remains a matter for individual decision. If the parties individually decide to adopt the result of the negotiation, this may mean that the negotiation gives rise to economic consequences. But this does not prove that such consequences stem from the joint appointment of a negotiator or what has been negotiated by the appointee.

Economic consequences are not the same thing as anticompetitive effect. Economic consequences can follow from individual decisions to adopt (or not adopt) a negotiated position. Indeed, if decisions (whatever their consequences) are made individually, the requirement of mutuality, which is fundamental to illegality, is not present. The issue of whether a party would (as a result of communication) regard himself or herself as bound, at least in honour, to act in a certain way is crucial to identifying what the subject of an 'arrangement' is. Indeed, consensus and expectation are the key issues. If there is no consensus and no expectation by one party *vis a vis* another as to what each will do pursuant to the arrangement, there is no arrangement to do that thing.[5]

Obviously competition authorities will watch joint negotiation procedures carefully. However, the views expressed are (in my view) backed by the authority of the Western Australian Medical Association Case in Australia[6] and the Hawaiian Medical Association Case in the United States.[7]

I believe, therefore, that medical practitioners must be careful (perhaps more careful than most other professions) in their conduct of joint negotiations. But the nature of the profession virtually necessitates the joint appointment of negotiators when arrangements are being entered into with Government, with health funds or with hospitals. The competition law mandates individual decision-making but, in my view, does not outlaw the joint appointment of negotiators.

I believe that the approach of competition authorities may, to date, have deterred the joint appointment of negotiators when this can clearly benefit both the medical practitioners involved (in the saving of time and the acquisition of negotiating expertise) and also benefit the party with whom negotiations are conducted (in perhaps not having to negotiate with individual practitioners on many issues, saving time because of this limitation and being able to negotiate with a party of expertise on the other side). The benefits to each party are clearly shown when all parties want to deal with jointly appointed negotiators, do so willingly and regard the alternative of multiple individual negotiations as inefficient in the extreme.

The line between legality and illegality in the joint appointment of a negotiator is a fine one. For this reason, competent legal advice should always be sought if any such appointment is contemplated. But there is, in my view, no reason why such a joint appointment necessarily breaches competition law and, if specific steps are taken, it can be ensured that no breach will occur.

Exclusionary activity—Since 1880, when a group of Irish tenants organised and refused to work on the estate managed by Captain Charles Cunningham Boycott (who perhaps not so willingly loaned his name to the tactic), the concerted refusal to deal or the collective boycott, has been recognised as an effective way of achieving certain types of economic and political goals. To invoke Captain Boycott's name in the context of competition law is, however, generally a prelude to condemnation.

Both Australian and New Zealand law have specific provisions dealing with collective boycotts; although they are (in both pieces of legislation) more antiseptically described as exclusionary provisions. The philosophy behind the legislation dealing with exclusionary provisions is to make it clear that collective activity (whereby competitors agree not to deal with others) is to be regarded harshly under competition law. For example, the Australian Trade Practices Act prohibits all arrangements between competitors which have the purpose of 'preventing, restricting, or limiting' the supply of services to, or the acquisition of services from, particular persons or classes of persons.

In Australia, the ban is absolute.[8] It matters not who the 'target' of the arrangement is (provided the target is a particular person or class of persons), and there is no defence that 'the arrangement does not substantially lessen competition'.

New Zealand, having initially adopted the strong Australian *per se* ban in s.29 of the Commerce Act, has subsequently amended that section to provide that the 'targeted' entity must be a competitor (actual or potential) of the parties to the arrangement and that the defendant parties have a defence, on a reverse onus basis, if they can demonstrate that, even though they come presumptively within the ban, the arrangement does not substantially lessen competition.[9]

The New Zealand law is by far the more logical in my view and equates to the judicially decided United States position. The Australian law, on the other hand, is a mistranslation of the Sherman Act downunder because it encompasses neither of the above two important provisions incorporated into the New Zealand law.

Even though the New Zealand section is not as all embracing as the Australian provisions, the defences in s.29 of the Commerce Act will not, in my view, be (in the case of medical practitioners) as useful as first thought. Boycotts by doctors are usually (but not solely) aimed at other doctors and it is with these types of boycotts that the case law has primarily been concerned.

In these cases, the target of the conduct will be a competitor of those in the arrangement and this criterion of s.29 will be satisfied. Once a collective refusal to deal is found in this circumstance it is, in my view, unlikely that a competition defence will be successful in any but the unusual case. This is because the history of medical boycotts shows that they are, except rarely, aimed at excluding new entry doctors. New entry has been held to be the most important factor in competition and its inhibition or exclusion to be the major anticompetitive sin.[10] Thus it is important (under either Australian or New Zealand law) to address the issue of what can and cannot be done in the medical field without running foul of the applicable exclusionary provision legislation.

At first glance, it appears as if doctors can never exclude another doctor from hospital accreditation or admission to a learned medical college (even if the excluded doctor is

totally incompetent) without running into difficulties under the exclusionary provision laws. Clearly this is an arrangement between competitors to limit services (for example the services which go with hospital accreditation) and, when a specific doctor is excluded, he or she becomes a particular targeted person. On the face of it, all the factors necessary to bring the conduct within the exclusionary provision prohibition are complied with.

In Australia, it appeared that even unimpeachably proper standards of conduct and training had the real possibility of being illegal under the Australian ban on exclusionary provisions. This was especially so when objective standards for admission to the *National Rugby League (NRL)* competition were ruled invalid by the Full Federal Court.

The *NRL* is the result of an arrangement between competitors[11] who have combined their prior separate rugby league competitions but limited the numbers of participating clubs to 14. There was a total of 22 teams playing in the two separate competitions (media magnate Rupert Murdoch's *Super League* and the original *Australian Rugby League [ARL]*). Objective standards were set down and impartially administered to determine which clubs, if any, would miss out on admission to the new single *NRL* competition. Fifteen clubs applied for admission to the *NRL* but only 14 places were available. The *South Sydney Rabbitohs* were refused admission after application of the admission criteria. However, the Full Federal Court held that the *Rabbitohs* were within a relevant 'class of persons' as they had previously been a competition participating club[12] and that the *Rabbitohs* were, therefore, illegally excluded from the combined competition.

The High Court reversed[13] the decision (and the *Rabbitohs* were subsequently admitted to the *NRL*). The essence of the High Court decision, and particularly the strong views expressed by Chief Justice Gleeson and Justice Callinan, was that, as the criteria were objective and impartially applied, there was no identifiable club or any identifiable excluded class of clubs 'aimed at', and thus there was no exclusionary conduct involved. The time to evaluate the conduct is when it is engaged in i.e. at the time the criteria were put in place and, at that time, it could not be ascertained which club or clubs would be excluded. A particular class of excluded entities cannot be held to exist merely because the application of objective criteria results in non-supply or exclusion at a future time.

The High Court decision in the *South Sydney Case* is a victory for standards setting.

In setting criteria for medical accreditation, one cannot know who is being excluded and a class of persons cannot be defined by, or ascertained only by, the fact of a future exclusion itself. Hence genuinely set standards do not run the risk (by their application) of being illegal as an exclusionary provision. It must be stressed, however, that, in the *South Sydney Case*, the standards were, in fact, objective and impartially administered and no objection was taken to them on this basis. In my view, the same criteria must apply to any standards, which rely on this case as establishing that medical standards are not within the exclusionary provisions definition.

If medical standards are set which are aimed at particular practitioners or other particular identifiable groups, or if seemingly 'objective' standards are administered

arbitrarily or capriciously, the courts will assuredly have little difficulty in finding them to be a sham behind which exclusion is practised.

The line between the acceptable and the non-acceptable may be a thin one in the administration of medical accreditation for hospitals or admission to specialist medical colleges. But the line is a real one and conduct must be aimed at being on the correct side of it.

Probably the major danger area in relation to exclusionary activity in the medical field is in the peer-review process for hospital accreditation. There are some common sense precautions which can be taken to avoid allegations of exclusionary conduct in this area and these principles can be elsewhere applied—for example in relation to admission to learned medical colleges.

The principles are:

- Have no two clinicians on the accreditation committee from the same field of practice. This means that the decision to admit, or reject, an applicant will not be made by his or her competitors. If this does not prove possible in particular cases (because, say the hospital is a local one and all practitioners are GPs), practitioners outside the local area should be called in to serve on the peer review board or the application should be referred for competent external evaluation.
- Have decisions made by the hospital involved rather than an accreditation committee. An accreditation committee's view should be put only as a recommendation to the hospital itself. If the final decision on accreditation is made by the hospital as an independent decision maker, the ultimate credentialling decision is made unilaterally and unilateral decisions do not a conspiracy make.
- Ensure that rules of credentialling are objectively expressed and not based on anticompetitive or exclusionary grounds. The short position from the competition case law is that rules must be genuinely medically based and not capable of being interpreted in an arbitrary or capricious manner.

  However, this does not preclude genuine policy decisions—for example:

  - Making a decision to terminate a medical practitioner's accreditation because a hospital has decided to amalgamate certain services with those of another hospital and to reduce its own services in a particular medical area. As a result of this, a peer review board may be compelled to make certain decisions which may result in the denial of future accreditation to presently accredited practitioners; or
  - A hospital making a policy decision to grant hospital accreditation only to employed anaesthetists because of a genuine belief that this policy gives rise to less professional friction, better rosters and more efficient patient assignment. As a result of this, a peer review committee is compelled to recommend for accreditation only doctors prepared to accept the hospital's policy decision.

The High Court of Australia has saved accreditation from exclusionary provision condemnation. But it is really not a satisfactory situation that saving from such condemnation is determined by the somewhat ethereal[14] legal evaluation of whether or not a 'particular person or class of persons' is involved. There is much to be said

for the enactment downunder of legislation akin to the United States Health Care Quality Improvement Act of 1986.

This Act provides immunity from action in relation to peer review decisions if:

The peer review concludes that there was a reasonable belief that the action was in the furtherance of quality health care; and

- After a reasonable attempt has been made to obtain all the facts; and
- Fair notice has been given to parties affected and a fair hearing conducted; and
- The reasonable belief was held that the action was warranted by the facts known after a reasonable effort was made to obtain the facts, after the giving of fair notice and after the conduct of a fair procedural hearing.[15]

Legislation of this kind has the advantage of requiring the court to make a substantive evaluation of the issues involved rather than engaging in semantics in trying to work out whether the target is a particular person or class of persons. The case for such legislation is far stronger in Australia than in New Zealand because of the *per se* nature of the exclusionary provision ban in Australia and because of the inability to argue a defence in Australia, as can now be done in New Zealand, that the conduct involved does not substantially lessen competition.

The New Zealand *Ophthalmologists Case* shows up the importance which exclusionary conduct plays in competition assessments. In brief, this case involved concerted action initiated by the sole ophthalmologist in Invercargill to inhibit or prevent Southern Health from employing Australian ophthalmologists to perform cataract operations at a cheaper rate in order to clear a two-year public patient backlog in Southland Province.

The Invercargill opthalmologist involved various other ophthalmologists and sought and obtained the assistance of The Ophthalmology Society of New Zealand in his efforts. His actions prevented the relevant Australian ophthalmologists carrying out the operations and included:

- Concerted non-cooperation,
- Concerted pressure being placed on Southern Health to reverse its decision, and
- Attempts to have the relevant Australian ophthalmologists denied New Zealand medical registration.

Although the Commerce Commission succeeded in the case on the basis that the conduct involved was substantially anticompetitive, the case would appear to be one clearly within the exclusionary provisions law in s.29 of the Commerce Act.[16]

In New Zealand, the effect of bringing the case under s.29 would have been for the Commerce Commission to have obtained the advantage of a per se breach on proof of the relevant arrangement as the competition defence now available under s.29(1A) of the Commerce Act was enacted after the relevant conduct occurred. Thus, the present Australian position would have applied then (but not now) in New Zealand, and all that would have had to be demonstrated would have been the facts and *per se* illegality would have automatically followed. That ‘anticompetitive purpose’ was so easily demonstrated by the Commission makes one wonder whether any specific

legislation dealing with exclusionary activity is really necessary. My view is that such provisions are not necessary; that exclusionary activity can be evaluated under general principles of whether or not they substantially lessen competition; and that specific statutory provisions complicate, rather than effectuate, competition policy.[17]

The 'right' of self regulation

The third area of vulnerability of medical practitioners under competition law is that of ethics and the 'right' of 'self regulation' to enforce these.

Ethics looms high in the psyche of all professions, and deservedly so. It is basic to understand that no competition law anywhere in the world prevents the setting of proper ethical standards and the enforcement of these. The issue, however, is what constitutes 'ethics' and what is the rationale behind permitting their extra judicial enforcement by way of professional self regulation.

I believe that the basic rationale of ethics has perhaps been most articulately put by a Report some years ago by a Royal Commission into Civil Rights in Ontario. This Report said:

> The granting of self government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The relevant question is not 'do the practitioners of this occupation desire the power of self government' but is 'is self government necessary for the protection of the public?' No right of self government should be claimed merely because the term 'profession' has been attached to the occupation.[18]

The question, therefore, is *what is necessary for the protection of the public?* The fact that a profession may, in its own self interest, want an exemption from competition law is not itself a matter of public protection. Neither is public protection served by 'ethical' restraints against giving fee reductions or in relation to advertising prohibitions provided that such advertising is both honest and appropriate.[19] But there is public protection in setting standards of competency and enforcing these by peer review—with the provision that such review must be on a fair 'due process' basis.

There have been several pronouncements made by competition authorities around the world as to the setting of ethical standards and the enforcement of these.[20] In essence, standards must serve a public protection purpose, be based on clear and non-discriminatory criteria (one of which is that suitably qualified overseas parties not be subject to discrimination on the basis of nationality or residence), and be enforced by independent and impartial evaluation. If this is done, then standards setting and enforcement will not run foul of competition law.

New Zealand's situation

The above sets out the relevant applicable competition principles. The result in New Zealand shows, however, the need for much more education of medical practitioners as to the application of competition law to them.

The recent *New Zealand Ophthalmologists Case* is notable because it so clearly illustrates the total misunderstanding by the medicos there involved of the role of professional ethics and competition law. In that case, the New Zealand ophthalmologists involved, and their professional association, sought to exclude qualified Australian ophthalmologists from operating in New Zealand. This was

effected by the invention of quite spurious “ethical” objections. So, they claimed that routine cataract operations required access to emergency post-operative care and that this was an important service, which could not be provided by itinerant surgeons. No doubt such access was important but it could be provided in other ways because cataract operations were standard ones with few complications. The ophthalmologists, however, took steps to seek to ensure that post-operative care would not be provided. The term “itinerant surgeon” was used in a derogatory manner in order to provide an ethical reason or justification for what the ophthalmologists did.

The court, however, held that this was:

> ‘A convenient label to which opposition could be expressed. But it was no more than an excuse’

The New Zealand ophthalmologists also attempted to have qualified Australian ophthalmologists not registered in New Zealand by not providing surgical ‘oversight’ required by New Zealand registration requirements. They alleged that the employment of an overseas ophthalmologist (rather than giving all such business to the sole Invercargill ophthalmologist) was ethically unacceptable because it would destroy:

> ‘A long-term relationship with the resident Invercargill ophthalmologist whose desire is to dedicate his professional life to the ophthalmic welfare of the Southland community’

But words are frequently a mask rarely expressing (and frequently hiding) their true meaning. So it was with the New Zealand ophthalmologists. The Court held that their ethical justifications had nothing to do with ethics. They simply demanded that additional surgery should be offered locally and that the sole Invercargill ophthalmologist, ethically, had a prior right to veto new entry or at least that there was an ethical requirement that no ophthalmic surgery be carried out unless he so agreed. This, of course, is the direct negation of a fundamental principle of competition policy, that is that competition should be preserved by preventing private blockades on new market entry.

The *New Zealand Ophthalmologists Case* shows that professionals cannot use ethics as subterfuge for anticompetitive activities. Case law clearly delineates the borders within which professional ethical conduct is to be confined. The Ophthalmologists Case was the first in New Zealand involving professionals and their professional association. A penalty of $NZ25,000 was imposed on the Invercargill instigator of the conduct and a penalty of $NZ100,000 imposed by the Ophthalmological Society of New Zealand. In assessing penalty, the Court specifically took into account the fact that the case was the first in New Zealand involving a professional association. Presumably the court is implying in this comment that future conduct of this kind will be regarded more seriously.

Discussion

There is nothing unique in the interaction of medical practice and competition law. The applicable principles are quite generally relevant to all professions and occupations. But, historically, throughout the world, there have been major conflicts between the views of competition-policy enforcers and what medical practitioners believe they should be entitled to do. All is not smooth in competition land as its territory expands over greater areas in the medical fiefdom. The *New Zealand Ophthalmologists Case* shows how basic the differing views can be. But there is

plenty of room for mutual harmonious accommodation and, hopefully, this article gives some indication of where this accommodation can occur.

We have to remember that it is the policy of both the Australian and New Zealand Governments, as set out in the Closer Economic Relations Treaty, that there be one market, not two, in Australasia. This necessarily involves freedom of entry by Australians into the New Zealand market, and vice versa.

There is no doubt that individual businesspersons or professionals can have their freedom of choice of what they will do, how they will do it, what prices they will charge, and the areas in which they will conduct their business taken away from them just as effectively by an anticompetitive private arrangement as by any government edict. Competition law is a sensible restraint which aims to preserve freedom of business decision making and freedom of market entry. It is these basic freedoms which were so endangered by the *Ophthalmologists Case*. This is why this case has importance, which far transcends its limited direct application to ophthalmology in Southland.

Despite the attempt to exclude Australian ophthalmologists from New Zealand, a comparative price evaluation of cataract operations is illuminating. In Invercargill, cataract operations were being performed initially at NZ$1,100 and, after the threat of new entry, at NZ$675. The price of cataracts in Australia, according to one newspaper survey, is about AU$2,090. That survey also concludes that there are close to 12,000 people waiting for cataract operations in New South Wales alone.[21]

So perhaps I can offer the following pro-competitive advice to New Zealand Kiwi ophthalmologists:

> Do not despair. Get on a plane to Aussie and do some itinerant cataract surgery across the Tasman. You have seen how competition law can assist you in this regard. Try using it to your advantage to make some money. No doubt one can cynically say that ready money is ready medicine. But, so what? Aussie needs you to move its two year cataract queue. The Australian Trade Practices Act protects your ability to practise in the Australian market in the same way as the *Ophthalmologists Case* shows that the New Zealand Commerce Act protects the ability of Australian surgeons to practise in yours. New Zealand ophthalmologists will be a blessing to help clear the unforgivable backlog of cataract queues in Australia. So don't complain. Get competitive!

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1. Commerce Commission v The Ophthalmological Society of New Zealand & Ors (High Court of New Zealand: Wellington Registry CIV – 1997 – H85-34; CP 354/97: Decision of Gendall J: 1 March 2004).
2. n.1 above. Penalty decision of Gendall J on 30 June 2004.
3. ACCC: Guide to the Trade Practices Act for the Health Sector (Nov. 1995) p.13.
4. It being assumed throughout this discussion that this represents the factual situation as well as that which is expressed.
5. For the concept of what is "an arrangement" see Re British Basic Slag Agreements [1963] 2 All ER 807; Gilltrap v Commerce Commission & McKenzie CA 235/01; CA 40/02; CA

41/02; Judgment 5 November 2003. Specifically in relation to the difference between an "arrangement" and the making of a statement in the hope that another will follow (this not being an "arrangement" within the prohibitions of competition law), see TPC v Email (1980) ATPR 40-172.

6. ACCC v The Australian Medical Association (Western Australian Branch) Inc. (2003) 199 ALR 423.

7. International Healthcare Management v Hawaii Coalition for Health & Others (9th Cir. C.A.): Opinion June 6, 2003.

8. Trade Practices Act s.45 and definition in s.4D.

9. Commerce Act s.29.

10. See Australian Trade Practices Tribunal Determination in Queensland Cooperative Milling Association (1976) ATPR 40-012 (followed in New Zealand in Tru Tone Ltd v Festival Records Retail Marketing Ltd [1988] 2 NZLR 352 and Auckland Regional Authority v Mutual Rental Cars [1987] 2 NZLR 647).

11. The Australian Rugby League and News Limited, each of which had previously run competing rugby league competitions – the Australian Rugby League competition and the "Super League" competition respectively.

12. South Sydney District Rugby League Football Club v News Ltd (2001) 111 FCR 456; [2001] FCA 862. For the writer's commentary on this decision see W.J. Pengilley: "Fifteen into fourteen will go: The Full Federal Court defies the laws of mathematics in the South Sydney Case" (2001) 17(4) ANZ Trade Practices Law Bulletin 25.

13. South Sydney District Rugby League Football Club v News Ltd 2003 HCA 45; (2003) 200 ALR 157. For the writer's commentary on this decision see W.J. Pengilley: "Rabbitohs not illegally excluded from the NRL competition" (2003) 19(6) ANZ Trade Practices Law Bulletin 73.

14. In the sense of "extremely delicate" and not in the sense of ethereal beauty or heavenly.

15. United States decisions are also frequently affected by the U.S. Local Government Antitrust Act 1984 giving pecuniary immunity to actions taken against local government entities. Hospitals have frequently been held to be entitled to take advantage of this immunity. See, for example, Crosby v Hospital Authority of Valdosta 1996 2 Trade Cases 71563 (11 CCA).

16. The reason why the New Zealand Commerce Commission brought the case under s.27 of the Commerce Act requiring it to prove a substantial lessening of competition instead of arguing an exclusionary provision per se breach under s.29 is not known to the writer. There are two possible reasons which present themselves. The first is technical. The Commission proved a geographic market limited to the Southland. Many of the participants in the arrangements were outside this area. The Commission may have taken the view that s.29 was not applicable as the section applies only in relation to arrangements between "competitors" and those outside the Southland area were not competitors for s.29 purposes. If this is the rationale of the Commission's approach, one can understand it but the writer believes it is wrong (see commentary in Gault on Commercial Law (Brookers NZ) Para 29.07(3)). On the other hand, the Commission may simply have taken the view that the case, being the first taken against a professional organisation, was one in which it should have, as a matter of principle, accepted the onus of demonstrating a substantial lessening of competition.

17. As stated in the text, this issue may well now be considered somewhat historical. The per se condemnation of exclusionary provisions in New Zealand was the law at the time of the conduct involved. The present law provides a competition defence on a "reverse onus" basis. Whether future cases are brought under s.27 or s.29, the question of illegality will substantially be a competition issue, albeit on a different onus of proof requirement.

18. Royal Commission into Civil Rights (Ontario) 1968 p.1162. This view has been reiterated by the Law Reform Commission of NSW – see NSW Law Reform Commission – The Legal Profession, Discussion Paper No. 1 (1979) p.45.

19. As regards the view of the New Zealand Commerce Commission in relation to the enforcement of advertising constraints see Re Chemists Guild of New Zealand Inc. (1967) 1 NZBLC (Com) 104058.
20. See Trade Practices Commission Guideline No. 9 (26 May 1995) re "Codes of Ethics"; ACCC Report to Australian Senate on Health Fund Practices 1 July 2000 – 30 June 2001, p.54; ACCC Determination in relation to Royal Australasian College of Surgeons (30 June 2003); U.S. Federal Trade Commission Advisory Opinion re National Standards Institute 78 FTC at 128-30; U.S. Federal Trade Commission Guideline 83 FTC 1849; New Zealand Commerce Commission decision on Chemists Guild Case (n.19).
21. See Sydney Daily Telegraph "Vision of Hope" 28 May 2004.