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Subject: **APPLICATION FOR AUTHORISATION A91078 LODGED BY THE RURAL DOCTORS ASSOCIATION OF AUSTRALIA LIMTIED – INTERESTED PARTY CONSULTATION**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply**

AUST. COMPETITION & CONSUMER COMMISSION CANBERRA
20 FEB 2008

Department of Health
Government of **Western Australia**

OFFICE OF THE DIRECTOR GENERAL

Ms I Arnaud
Director
Adjudication Branch
Australian Competition & Consumer Commission
GPO Box 3131
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Dear Ms Arnaud

Application for Authorisation A91078 lodged by the Rural Doctors' Association of Australia Ltd - interested party consultation

I refer to your letter to the Director General of Health dated 17 December 2007 inviting a submission in relation to the above application for authorisation. The Department of Health submits that the application for authorisation lodged by the Rural Doctors Association of Australia Limited to collectively negotiate terms of contracts for VMPs not be granted. The following information in relation to the engagement of visiting medical practitioners (VMPs) in rural areas of Western Australia together with comment on the likely public benefits and detriments associated with the application is provided for your consideration.

Current Arrangements for the provision of medical services in WA rural hospitals

There are 71 public hospitals in rural WA, ranging from small hospitals (6 to 8 beds) serving a small rural community to large regional hospitals with more than 100 beds providing a range of specialist services to a regional catchment. Medical services are provided to these hospitals by a mix of salaried and contracted specialist and non specialist medical practitioners, the mix depending on factors such as hospital size, location, and the range of services provided.

The basis of engagement of medical practitioners is varied, and includes:

- Full time salaried employment
- Part time salaried employment
- Sessional employment
- Fixed price per examination (applies to radiology)
- Annual fixed contract (ie a set annual amount for whatever services are required for pubic patients)
- Fee for service
- A blend of 2 or more of the above

Salaried Employment

Full time salaried employment is the predominant mechanism of engagement in hospitals in the north of the state where economic and lifestyle factors are perceived by many doctors as not conducive to private practice. In these locations, salaried employment offers income security combined with access to additional amenities such as employer-provided accommodation, motor vehicles, professional development and travel costs.

During the past 5 years, salaried employment has been introduced in some regional hospitals in the south of the state in order to secure a guaranteed on site medical presence in Emergency Departments, and due to the lack of doctors willing to take up private practice opportunities afforded by the departure or retirement of rural specialists such as surgeons, anaesthetists and physicians. This latter scenario represents the State's acceptance of a role as provider of last resort in instances of market failure rather than a preferred option.

Non Salaried Engagement

Despite the increase in the number of doctors employed on a salaried basis, most country doctors in the southern half of the state remain in private practice, and provide services to their local public hospitals under contract. Most of these doctors are general practitioners, many of whom have specialized skills in areas such as obstetrics, anaesthetics and surgery.

The contractual arrangements for such doctors are negotiated on an individual basis, and may entail:

- payment for public hospital sessions to deliver specific services;
- payment of a fixed annual fee for delivery of services on an 'as required' basis;
- payment on a fee for service basis;
- payment partly on fee for service and partly on a fixed fee;

Payments to individual GP's for services to public patients in hospitals range from $20,000 or less per annum for those who see a relatively small number of patients, to over $100,000 per annum for those who undertake a greater volume of hospital work. Those with specialist skills in areas such as anaesthetics, and who provide frequent services to larger hospitals may spend much of their time doing so and may receive in excess of $200,000 per annum.

Fee for Service
Where payments are wholly or partly on the basis of fee for service, item rates prescribed in the WA Government Medical Services Schedule (WAGMSS) are utilized. This schedule is based largely on the Commonwealth Medicare Benefits Schedule, supplemented by a small number of additional items to accommodate specific hospital services not adequately dealt with in the latter document.

WAGMSS rates are adjusted in accordance with an annual medical cost index each year.

Contracting Processes
VMPs are engaged on the basis of a Medical Services Agreement (MSA). The body of the MSA sets out the conditions of the appointment and the obligations of both parties, with remuneration details contained in a series of schedules. The term of each MSA is ordinarily three years, after which a new agreement is negotiated. A Memorandum of Understanding between the Minister for Health and the Australian Medical Association (WA) establishes processes for the granting of clinical privileges, reviewing clinical conduct and dealing with disputes.

The terms and conditions component of the MSA is largely non negotiable, as it deals with essential issues of governance, accountability, legal obligation, and commercial arrangement. The content of the schedules is negotiated individually, taking into account the skills of the doctor concerned, the service requirements of the hospital/s, the volume of services anticipated to be purchased, and the payment models preferred by both parties. Where doctors are unwilling to undertake direct negotiation, they are able to use an agent to conduct negotiations on their behalf.

While most GP's are contracted to provide services at a single hospital, this is not exclusively the case, especially in areas where a number of small hospitals are located relatively close together, Thus there are instances where after hours medical coverage is shared between doctors in a group of nearby towns.

The role of General Practitioners in providing VMP services

GP's play a wide range of roles within the public hospital system. These include:

- Provision of medical care to public hospital inpatients;
- In the case of GP's with procedural training and skills, provision of specialised care in areas such as obstetrics, anaesthetics, surgery, and psychiatry;
- Provision of emergency care to patients presenting at hospital Emergency Departments, including stabilising of critically ill patients prior to transfer to secondary or tertiary hospital facilities;
- Provision of medical advice to hospital management;

- Participation in programs of clinical governance;
- Coordination of medical rosters;
- Participation in clinical reform programs;
- Provision of medical advice and instruction to nursing staff working in remote nursing posts or in small hospitals without immediate access to medical coverage.

The precise role of individual GP's depends on their skills and qualifications, the extent of clinical privileges associated with their clinical appointment, the role delineation of the hospital, the number of other GP's and specialists available to provide services, and their own clinical interests and availability.

As a consequence of the lack of resident specialist obstetricians and anaesthetists in many locations, obstetric and surgical services are only made available through the work of GP's with training in these procedural areas.

Public Health requirements for GP services

The availability of public hospital services in many locations is wholly reliant on the services provided by GP's. The shortage of doctors and difficulties in recruitment are well recognised, and any measure that is likely to improve the attraction and retention of GP's to rural areas will result in significant improvements in public health.

A number of factors have been identified as inhibiting the attraction and retention of GP's to rural areas. These include:

- Security of income
- Professional isolation
- Continuous after hours demands and expectations
- Family issues, including access to educational facilities.

It is submitted that addressing these concerns requires an approach that is flexible to needs and circumstances of each individual doctor. For example, under a fee for service system, a doctor's income is directly related to the number of patients admitted to hospital or seen in the emergency department. These numbers are subject to variation, and in the case of communities with a declining population, a downward trend in both patient numbers and doctor income is likely to occur. An arrangement such as a fully or partially fixed fee contract provides a buffer against income fluctuation and is therefore more likely to retain the services of a GP who might otherwise decide to seek more viable opportunities elsewhere.

Lack of public benefit and detriments arising from the Rural Doctors' Association application

It is submitted that a number of detriments would be likely to result from the implementation of the collective bargaining strategy advanced by the RDAA. In brief, these are:

- Reliance on a fee for service model links doctor's incomes (and hospital costs) to public patient activity levels. Greater certainty of income and costs is provided by a system that incorporates other arrangements such as fixed fee components;

- The economic incentive in a fee for service system is to maximise the number of patients treated in hospital. By having the capacity to implement a payment structure that is not totally volume reliant, more appropriate strategies such as health promotion and community based care can be encouraged.

- GP's are not evenly distributed across locations where there is a need to secure medical services for public hospitals. In some locations (typically southern coastal centres) there are more GP's resident (or willing to take up residence) that in more remote inland locations. In some larger regional centres, there are more GP's than are required to provide hospital services, and as a consequence not all opt for hospital appointments. In other locations it is difficult to secure sufficient GP services to meet hospital needs. The imposition of a standardised fee for service structure on a statewide or national basis risks escalating prices in locations where GP's are more readily available without providing any incentive in those locations where recruitment is difficult. This risk is recognized by RDAA at item 6 (a) of the application. The collective bargaining arrangement is unlikely to increase the supply of medical practitioners in areas of short supply or lead to increased competition in existing markets.

- The RDAA submission does not disclose the extent of membership among rural GP's. It is not clear how the interests of non members would be served or whether the arrangement would serve as an inducement pressure to non members to join in order to gain the benefit of and to have input to the proposed collective negotiations. In this respect the ACCC is referred to the determination in relation to the South Australian Branch of the AMA in July 1998.

- The current level of individual bargaining between members of the proposed group and hospitals is high. A mere change in the amount of bargaining power is not in itself a public benefit. Medical practitioners currently negotiate on terms and conditions of supply through a process of negotiation and are not constrained in their ability to provide input into terms and conditions of engagement. Collective bargaining will not assist in providing a mechanism which does not currently exist.

- The RDAA submission argues that individual negotiations are onerous for GP's, and that collective negotiation of a fee for service arrangement would therefore positively influence attraction and retention. The number of doctors working in rural WA has steadily increased over the past five years. The current contractual arrangements have not proven a barrier to recruitment. It is not accepted that the existing arrangements are detrimental to the attraction and retention of GP's or that collective

bargaining is likely to positively influence medical recruitment. There is no evidence to suggest that there are significant transactional costs in medical practitioners conducting an individual negotiating process rather than a collective bargaining arrangement. Accordingly there are no efficiency savings that constitute a public benefit in the present circumstances.

- Collective bargaining is likely to result in an averaging effect on conditions for country doctors. This would increase payments made to more established practices with stable staffing and where recruitment is less challenging, while potentially reducing payments to isolated doctors where recruitment and retention is difficult and where maximum flexibility is required. This may in turn adversely impact on access to services for isolated communities.

- As detailed earlier, GP's fulfill a range of different functions in rural public hospitals. The fee for service arrangement proposed by the RDAA can provide a mechanism for payment of doctors for direct clinical services delivered to hospital patients. It will not adequately provide for remuneration for other important services provided to public hospitals by GP's.

- In the present case it is submitted that collective bargaining arrangements will not improve the supply of information between the parties and that no public benefit in the form of improved access to information arises in the present circumstances.

- The RDAA proposal related only to GP's. It does not relate to rural specialists. GP's and specialists often work together as a clinical team providing services such as obstetrics and anaesthetics. Acceptance of the proposal would result in different contracting systems for GP's and specialists.

Should you require any further information or clarification of the matters set out above please contact Mr Kim Snowball, Chief Executive Officer, WA Country Health Service on (08) 92238526.

Yours sincerely

Dr Peter Flett
ACTING DIRECTOR GENERAL

20th February 2008