Department of Human Services

Secretary

50 Lonsdale Street
GPO Box 4057
Melbourne Victoria 3001
DX210081
www.the
Department.vic.gov.au
Telephone: (03) 9096 8580
Facsimile: (03) 9096 9220

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Ms Isabelle Arnaud
Director, Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

Dear Ms Arnaud

Application for authorisation A91078 lodged by the Rural Doctors Association of Australia (RDAA) Limited – draft determination

I refer to your letter of 16 March 2008 inviting the Department of Human Services (the Department) to make a submission in response to the ACCC's draft determination to grant authorisation [limited to RDAA members who are rural generalists and general practitioners (GPs)] for a period of 5 years to the RDAA and its constituent State associations [in Victoria the Rural Doctors Association Victoria (RDAV)] to collectively negotiate, with State and Territory health departments, the terms of contracts for visiting medical officers (VMOs) in rural areas.

As you are aware, the Department has previously made a submission on 22 January 2008 to the ACCC as an Interested Party in response to the application for authorisation lodged by the RDAA on 7 December 2007. The Department again draws your attention to the concerns regarding authorisation addressed in that original submission and to the further concerns set out below.

In the State of Victoria, the Department has no direct involvement with setting contractual terms for VMOs, as this role has been devolved to individual hospitals. The Department is of the view that this devolved approach allows for a greater degree of flexibility and ultimately provides more efficient outcomes for Victoria than collective negotiations by rural generalists and GPs. In particular contracting at the hospital level allows:

- individual hospitals and VMOs to agree terms that reflect supply and demand conditions in that geographic area; and
- promotes a better level of understanding and cooperation between hospital administrators and VMOs.

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Voluntary Arrangements

The draft determination sets out that the proposed arrangements are voluntary and that a collectively negotiated agreement will only be reached if it is mutually beneficial to both the state health department and the RDAA. The Department considers that this voluntary approach will not hold in practice. The fact that the RDAV would be able to collectively negotiate is likely to create a significant pressure that they, in fact, do so, and the Department may not be able to decline such a request if it is supported by rural VMOs.

Capacity of RDAV to collectively negotiate on behalf of rural generalists and GPs

It is unclear to the Department whether the RDAV can negotiate on behalf of all rural generalists and rural GPs. The Department notes that even in New South Wales (NSW) and South Australia, where rates and conditions are established by the NSW Department of Health and Country Health SA respectively, there is prior consultation with organisations in addition to the state based association of RDAA. The NSW Department of Health collaborate with the Australian Medical Association and the RDA of both states and in the case of South Australia, there is collaboration also with the Australian Medical Association, the Rural Doctors Workforce Association, the Royal Australian College of GPs, and the Australian College of Rural and Remote Medicine.

The Department also notes that, in spite of having common rates and conditions, neither NSW nor South Australia supported authorisation (see Pages 5 and 6 of the Draft Determination of the ACCC).

Bargaining Power

Rural public hospitals, to a greater or lesser degree, suffer from a systemic shortage of supply of VMOs and demand conditions that are largely outside their control.

The shortfall of VMO services in rural areas has been acknowledged by the RDAA, both in its original Application (p. 3) and on its website where it notes:

> *'At least 1000 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush.'*[1]

Public hospitals have little discretionary control over their demand for VMO services. Rather, as public institutions, they are required to provide (non-specialist) medical services to the extent possible, subject primarily to resourcing and budgetary constraints. There is a competitive market for rural VMO services based upon the difficulty many rural based hospitals have in attracting VMO services and the fact that, for many GPs, VMO rights are not essential to their practice. The Department is aware of some rural GPs who have decided to withdraw their services to local hospitals in favour of focussing on their private practices despite additional payments offered by health services. Conversely, particularly for smaller more remote services, GPs who reside within those communities provide an essential core service to the local public hospitals. In all rural areas, but particularly in smaller more remote areas where there are few if any specialists, GPs are sought after and have a high degree of bargaining power.

The Department considers that there is no significant inequality of bargaining power between purchasers and suppliers of medical services (public rural hospitals and VMOs respectively) in rural areas so as to justify rural doctors being able to collectively negotiate terms and conditions, including price, as rural hospitals have no discretionary ability to reduce demand in order to depress price.

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[1] RDAA 'Rural Health – the facts at a glance'

Pricing Impact

It is highly likely that there will be a pricing impact from the proposed arrangements in that it will introduce an artificially high floor price for such services. Any state based collectively negotiated agreement is likely to use CMBS/existing terms and conditions as a starting point. The Department submits that, as it is unlikely that any doctors will be looking to lower their current remuneration, such an agreement is likely to increase the floor price to the upper level of current remuneration; that is the terms and price currently offered by hospitals in the least desirable locations. It would therefore create a new and increased floor price for services, with doctors likely to expect no less that the terms specified in any such centrally negotiated agreement. This view was also supported in the original Victorian Hospital Industrial Association (VHIA) and Victorian Healthcare Association (VHA) submission to the ACCC (see Page 6 of the Draft Determination of the ACCC).

'Burden of Negotiation' Claim

The Department does not agree that 'the burden of negotiation' and 'red tape' is a significant factor in either attracting or retaining rural based VMOs. Attracting and retaining doctors in regional and rural areas is a major ongoing challenge throughout Australia. Australian research into factors influencing decisions by medical practitioners to reside in rural areas suggests that professional satisfaction is the main reason for doctors staying in or leaving medical practice in rural and regional areas. The fact that many doctors prefer a metropolitan lifestyle and practice is not an issue that will be affected by the RDAA being able to collectively negotiate terms on behalf of rural doctors. Rather, the Department is of the view that flexibility and the ability to tailor contractual arrangements is a key factor in attracting and retaining rural VMOs and that this flexibility would be substantially lost under the proposed state based contracting system.

Further, the amount of VMO time involved in settling individual terms is not great. The Department reiterates the example of the recent collective bargaining notification lodged by the Australian Medical Association on behalf of a group of doctors at Werribee Mercy Hospital, the hospital stated that the process was to write to each doctor and invite them to enter into discussions. Negotiations were typically through a few telephone calls and possibly a further letter, with negotiations typically being finalised by a quick 15 minute to 45 minute meeting.[2] The Department submits that this level of negotiation would be typical of rural public hospitals. This amount of 'red tape' is not particularly burdensome and is likely to be no greater than would be required by any collective negotiation process run by the RDAA.

The Department therefore submits that the 'red tape' and transaction costs of individual negotiation are neither significant or a major factor behind the shortfall of VMOs in rural areas.

Relationship between rural hospitals and VMOs

Locally based negotiation also allows the medical practitioner and hospitals to recognise their mutual dependency and work more cooperatively. The Department considers that a system of state based collective negotiation would lessen the scope for cooperation between a hospital/health service and local doctors. This loss of a mutual cooperative commitment to the provision of health services, developed through localised contract negotiations, can only be detrimental to the level and quality of healthcare provided in rural areas. VHIA in its original submission to the ACCC also comments that *'a common fee agreement will.... result in a loss of existing direct relationship between hospitals and GP VMOs'* (see Page 10 of the Draft Determination of the ACCC).

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[2] ACCC Draft Objection Notice, 8 November 2007, para. 3.118.

Conclusion

The public detriments that will result from granting authorisation are therefore as follows:

- a decrease in competition between VMO providers;
- VMO terms no longer being as reflective of local market conditions;
- an overall increase in price, to a level above competitive pricing;
- rural based public hospitals facing additional budgetary pressures that may compromise the level of service they are able to provide to the community;
- a possible detrimental effect on the cooperative relationships between rural hospitals and VMOs; and
- rural hospitals being faced with the potential to lose, at the same time, all of the non specialist VMO providers, if collective negotiations fail. Hospitals do not face this risk under the current system where VMO agreements are negotiated individually with the Hospital.

The Department submits that centralised arrangements will impede competition and result in a less efficient pricing outcome. A key benefit to current decentralised Victorian bargaining is that individual hospitals can negotiate contracts with individual doctors that reflect both the doctor's circumstances and local supply and demand conditions.

Yours sincerely

FRAN THORN
Secretary