16 April 2008

RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

Sharon Clancy
Assistant Director
Adjudication Branch
Australian Competition &
Consumer Commission
PO Box 1199
DICKSON ACT 2602

Dear Sharon,

Rural Doctors Association of Australia (RDAA) response to submissions from interested parties relating to the Australian Competition and Consumer Commission (ACCC) draft determination on the application for authorization by the RDAA to collectively negotiate the terms of contracts for visiting medical officers in rural areas

Further to our submission of 9 April 2008, please find attached a copy of our response to the submissions from the New South Wales Department of Health, the Victorian Healthcare Association Limited and the Victorian Hospitals' Industrial Association.

We welcome the opportunity to provide responses to those issues raised in relation to the draft determination by interested parties as part of the public consultation process.

We believe RDAA and the ACCC have satisfactorily identified and responded to the relevant issues raised by the interested parties with regard to the application for an exemption under the *Trade Practice Act 1974.*

I would be happy to provide any further information that may be required and can be contacted on (02) 6273 9303 or at ceo@rdaa.com.au.

Yours sincerely,

Steve Sant
Chief Executive Officer
Rural Doctors Association of Australia

RDAA Response to issues raised by NSW Department of Health, VHIA and VHA
15 April 2008

Stakeholder	Issue	RDAA Response
NSW Department of Health	The term 'rural hospital' is not defined which is a cause for difficulty and uncertainty. The term would be held to cover district and base hospitals where RDA currently has no role and would clearly lead to demarcation disputes with the NSW AMA who currently provide representative services	As noted in our previous submission: The definition of rural could be covered in negotiation of an agreement; however, there are several classification systems that define rural including • Rural, Remote and Metropolitan Area Classification System (RRMA1-7) • Accessibility/Remoteness Index of Australia (ARIA 1-5); and, • Australian Standard Geographical Classification (ASGC six interrelated classification structures.) Whilst RDAA would propose that hospitals in some RRMA3 and all RRMA4-7 areas would be considered within the scope of an agreement it would be appropriate to determine as a part of any negotiation the scope and coverage of the agreement. Furthermore, the RDAA has no objection of jointly negotiating with an appropriately authorised body such as a State AMA branch. An authorisation for the RDAA would not prevent genuine consultations with other bodies occurring, nor would it prevent other bodies seeking an authorisation.
NSW Department of Health	The term 'rural generalist' has no accepted meaning and seems likely to cause confusion	As noted in our submission of April 9 2008: The RDAA recognises that a large number of doctors who undertake generalist practice in rural areas consider themselves to be rural generalists. The RDAA also notes that a number of state health departments have implemented or are considering implementation of a rural generalist pathway. Qhealth notes on their website that on 24 August, 2005, the State Government announced recognition of rural generalists as a rural medical practitioner who is credentialed to serve in: 1. Hospital-based and community-based primary medical practice and 2. Hospital-based secondary medical practice: • in at least one specialist medical discipline (commonly, but not

Stakeholder	Issue	RDAA Response
		limited to obstetrics, anaesthetics and surgery) and • without supervision by a specialist medical practitioner in the relevant disciplines 3. and possibly, hospital and community-based public health practice – particularly in remote and indigenous communities. Rather than causing confusion the RDAA believes that using both terms will remove any confusion particularly in those states that recognise both terms.
NSW Department of Health	Voluntary nature of the arrangements - the draft determination misconstrues the nature of the relationship RDA NSW has with the NSW Department of Health. NSW Health notes it would not be practicable or in the public interest to opt out of negotiations.	The RDAA accepts that it would not be appropriate for the NSW Health to 'walk away' away from the current arrangements that exist and considers that the authorisation will assist in ensuring that the current arrangements have a firm legal foundation.
NSW Department of Health	Collective boycott activities may be of more limited significance than the draft determination would suggest given difficulty in establishing collusive conduct by VMOs should it occur.	The RDAA has noted that there is no intention to engage in any form of collective boycott and the application is made purely to enter into negotiations and an agreement. The RDAA also believes that if any collective boycott activity occurred it would be easily detected because of the large number of independent practitioners (businesses) that would have to participate and it is clearly impractical for this type of activity to be orchestrated without any 'noise'.
NSW Department of Health	Flow on potential – should authorisation be approved, a real prospect of further applications by other organisations which represent VMOs for similar authorisations.	RDAA considers that there could be some applications by other parties for similar authorisations and that the ACCC would consider them on their merits as has happened with the RDAA application. The RDAA does not consider that the possibility of other applications being made is relevant to the current application process.
NSW Department of Health	Public interest – the draft determination does not reflect the strong bargaining power that rural VMOs possess, nor the potential detriments of interrupting current arrangements. Arrangements are not of a contractual nature.	RDAA does not share the view of NSW Health that rural VMOs possess strong bargaining power. In fact, the bargaining power of any individual doctor in the NSW system is insignificant and they have little chance of having their voice heard. This is why the current arrangements in NSW must be supported by the granting of an authorisation that clarifies the capacity of the RDAA to undertake negotiations and enter into an agreement with NSW Health.

Stakeholder	Issue	RDAA Response
		As we have noted in previous correspondence, the application is not intended to undermine but instead it is intended to provide a firm legal foundation for the RDAA to enter into collaborative negotiations with the state health departments on arrangements for the contracting of GP VMOs in those States. It is likely that if an authorisation is not granted that there will potentially be no negotiation voice for rural doctors as the status of some arrangements under trade practices legislation is unclear to the RDAA. Therefore, the public benefit to be gained by granting the authorisation is significant in ensuring that reasonable agreements that benefit both parties are able to be put in place. The RDAA contends that these contractual arrangements are clearly of a commercial nature and that the hospitals in NSW are conducting a business in which they procure the services of rural doctors to provide services to their patients.
Victorian Hospitals' Industrial Association	RDAA will be able to bring sufficient pressure on government that may result in a common fee schedule and the likelihood of substantial increases in the cost of medical services	RDAA assert that the proposed collective bargaining arrangement is likely to result in a public benefit that will outweigh any public detriment. The RDAA have for many years be seeking the agreement of the Victorian DHS to put in place centralised arrangements that will benefit both the contracted doctors and the hospitals involved. To date this has not been agreed and the RDAA considers that if an authorisation is granted it will not add any significant weight to the arguments put by rural doctors, and a number of rural hospitals, to move to a centralised process it will merely remove a hurdle should there be an agreement to negotiate centrally. RE: increase in cost of medical services - As previously noted in correspondence to the ACCC, it is acknowledged that it is possible that in some cases the cost of purchasing VMO services could increase in Victoria where there are a variety of fees paid by individual hospitals. It is unlikely that the lowest common denominator would provide a basis for any fee schedule and that a mixture of pricing would result. That is, there are likely to be some trade-offs negotiated as part of the initial development of a Victorian agreement and this would might result in some higher fees and some lower fees compared to current fees in place in individual hospitals. Overall the changes in costs expected across the system in Victoria are likely to be totally insignificant in the context of the

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		average cost per inpatient separation and across Australia it is very unlikely that there would be any direct impact on hospital costs at all as a result of an authorisation. AIHW figures indicate that across Australia medical costs account for a small percentage of the total cost of a separation (payments to VMOs accounted for ~4% of recurrent expenditure in 2004-05). Even if there was a small increase in the costs of providing some VMO medical services in some hospitals in Victoria it is not accepted that this will lead to overall increased inpatient costs across the State and that a variety of actions can be taken by hospitals to control costs at a higher level as is the case with some 'unfunded' employee salary increases. Even if there are some increases in the cost of purchasing VMO services and if this results in a increase in the overall costs of providing inpatient services, the RDAA would contend that • these costs increases will be very minor in the overall context of the cost of providing an inpatient episode of care; and, • the public benefit that accrues through increased recruitment and retention of GP VMOs would outweigh any increase in costs that might occur.
Victorian Hospitals' Industrial Association	Due to different relationships between RDAA and Victorian hospitals, Victoria should be excluded from the authorisation	As previously noted, the ACCC in its draft decision agreed with the view of the RDAA that any agreement in Victoria is voluntary. The RDAA believes that benefits would flow from an agreement to all parties and the rural communities that they serve and as such there is a strong argument that can be put for a state-wide agreement with rural doctors and rural hospitals in Victoria. As such the RDAA believes that the Victorian State Government will come, in time, to appreciate the benefits of an agreement and agree to enter negotiations. The provision of an authorisation will not mandate this but will simply remove an obstacle to such negation occurring if both parties consider such negotiations appropriate.
Victorian Hospitals' Industrial	RDAA will use the authorisation to benefit its members and to accommodate its "structural weaknesses".	As previously noted, the RDAA does not expect to receive any direct or indirect organisational benefit from the granting of an authorization. The RDAA recognizes obtaining an authorisation and representing doctors will demand significant time, effort

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Association		and associated costs to be borne by the organisation. The RDAA has no idea what the VHIA is asserting in relation to 'structural weaknesses' and suggests that VHIA would serve its membership better by putting forward a well argued position around the issue relating to an authorisation rather than continually trying to 'run down' the RDAA and "bureaucratic decision makers".
Victorian Healthcare Association Ltd	Any agreement negotiated by the Victorian Department of Human Services be adequately funded	The RDAA whilst arguing that the effect of a centralised agreement should not significantly increase costs per separation agrees that as a general principle any change imposed on hospitals by a central agency that significantly increases costs should be fully funded.