RDAA Application (A91376) to the Australian Competition and Consumer Commission (ACCC)

Submission to ACCC Draft Determination (Issued 28 August 2013)

RDAA acknowledges receipt the draft determination issued by the ACCC in respect of the application for authorisation A91376.

RDAA notes that the draft determination allows RDAA and its constituent state associations to collectively negotiate with state and territory health departments, the terms of contracts for general practitioners or rural generalist visiting medical officers in rural areas, and that this authorisation does not extend to Medicare Locals and Local Hospital Networks.

The draft determination A91376 will maintain the existing arrangements in most States; however in South Australia and Western Australia, all rural hospitals in each State are now administered under a single Local Hospital Network - the Country Health SA Local Health Network (CHSALHN) in South Australia, and the WA Country Health Service in Western Australia.

RDAA requests that the draft determination be extended to include collective negotiations with those rural LHNs which are operating on a state-wide basis, namely the Country Health SA Local Health Network (CHSALHN), and the WA Country Health Service.

In seeking an extension to the draft determination as outlined, RDAA and its constituent state associations are seeking to maintain the existing arrangements and negotiating environments which have been working well and which the ACCC has acknowledged, have provided public benefits with minimal public detriments.

Local Hospital Networks.

Under the health reform process Local Hospital Networks (LHNs) have been established across all states and territories. The majority of these are geographically based networks and but there are also state or territory-wide networks that will deliver specialised hospital services across some jurisdictions.

Every Australian public hospital is part of a local hospital network.

LHNs are separate legal entities which are intended to devolve operational management for public hospitals, and accountability for local delivery to the local level. As such, they are direct managers of groups of public hospital services and the associated budgets, and are held directly accountable for hospital performance under the Performance and Accountability Framework outlined in Schedule D of the COAG National Health and Hospital Agreement.

Under the arrangements, State governments are the single purchasers of all public hospital services through purchase agreements with the LHNs.

There are a range of State-specific arrangements with respect to LHNs. In addition to continuing to make funding contributions to their LHNs, State governments will generally continue to be responsible for system-wide public hospital performance; for management, planning and policy development; the planning, funding and delivery of teaching, training and research; and in determining service delivery and state-wide planning.

As described in RDAA's previous submissions, negotiations on industrial issues, including the terms and conditions of Visiting Medical Officer (VMO) contracts, are carried out at the state level in all states except Victoria.

a. ***Queensland -*** Seventeen Hospital and Health Services (HHS) were established on 1 July 2012. Industrial awards, including Visiting Medical Officer and other industrial awards, are determined on a state-wide basis.

b. ***NSW –*** There are 15 Local Health Districts (LHDs) and two specialist networks, with seven of these classified as comprising rural areas. VMO arrangements for rural doctors are negotiated under the state-based NSW Rural Settlement Package.

c. ***Victoria –*** The governance and catchment of health services in Victoria has not changed as a result of the reform agreement. The local board structure which applies to the 19 public health services, 13 metropolitan and six regional boards, 56 rural public hospitals, 7 multi purpose services, and the state-wide ambulance service, Ambulance Victoria and Health Purchasing Victoria, has been retained.
There is are no state-wide arrangements and contracts for rural VMO and other services are negotiated by each Rural Hospital Board with individual medical practitioners or practice entities.

d. ***Tasmania –*** There are three Tasmanian Health Organisations (THOs) based in the north-west, the north and the south of Tasmania. VMO arrangements for rural doctors are negotiated on a state-wide basis.

e. ***Northern Territory –*** The five public hospitals in the Northern Territory are grouped into two Hospital Networks: the Top End Hospital Network and the Central Australian Hospital Network. Both Northern Territory Hospital Networks are run as Government Business Divisions sitting within the Department of Health (DoH), and state-wide industrial arrangements will be maintained.

f. ***South Australia –*** There are five Local Health Networks in South Australia, including the Country Health SA Local Health Network (CHSALHN). This network oversees the rural health system in South Australia.
The CHSALHN and the Rural Doctors Association of South Australia (RDASA) have been involved in industrial negotiations and agreements under the previous RDAA authorisation for the past five years.

g. ***Western Australia –*** There are four Health Services in Western Australia: the Child and Adolescent Health Service; North Metropolitan Health Service; South Metropolitan Health Service and the WA Country Health Service.
As is the case in South Australia, the WA Country Health Service is responsible for the rural health system in Western Australia. The Rural Doctors Association of Western Australia (RDAWA) has been involved in the past with the Australian Medical Association's Western Australian branch in the negotiation of broad terms and conditions for the State's rural doctors.

Negotiations with State-wide Rural Local Hospital Networks.

RDAA is requesting that the draft determination to its application A91376 be extended to include those rural Local Hospital Networks which are operating on a state-wide basis, namely the Country Health SA Local Health Network (CHSALHN), and the WA Country Health Service.

Both these LHNs have a significant geographic spread and are responsible for relatively large populations and hospitals. Their operating structure and negotiating arrangements are essentially the same in nature as the negotiations with state health departments which have been granted under the draft determination, and with similar public benefits and detriments.

Country Health South Australia Local Health Network: The Country Health SA Local Health Network is the local hospital network covering the Riverina and regional areas of South Australia. It has a geographic spread of almost one million square kilometres, making up almost 99.8% of the state, and it contains almost one-third of the state's residents. CHSALHN contains over 40 public hospitals.

WA Country Health Services: WACHS covers over 2.5 million square kilometres. This area accounts for approximately 22% of the state population across 70 hospitals and a large number of smaller health services.

Public Benefit: In the draft determination A91376, the ACCC considers that there are public benefits resulting from RDAA and its constituent state associations being able to continue to collectively negotiate state-wide agreements with state and territory health departments. The benefits of cost savings; providing effective representation of rural doctors and promoting retention of doctors in rural areas were noted, with the conclusion being:

The ACCC accepts that the proposed collective bargaining arrangements with state and territory health departments are likely to result in cost savings and enable rural doctors to have more effective input into contracts resulting in more efficient outcomes. However, when negotiating tailored solutions at the local level with Medicare Locals and LHNs, transaction cost savings are likely to be lower compared to state-wide negotiations, and rural doctors negotiating at the local level already have a greater input into the terms and conditions of their agreements. (P11, para 68)

RDAA submits that collective bargaining arrangements with those LHNs which are operating at a state-wide level will result in the same level of benefits as negotiations with state and territory health departments. Although negotiations will be aimed at 'negotiating tailored solutions' in the sense that they relate rural VMO and other services rather than VMO services generally, they will cover a very wide geographic area and range of hospital services. They will generally not be tailored to specific areas and rural doctors will not have the same opportunities to negotiate at the local level.

That bargaining arrangements are taking place on a state-wide basis was identified by the ACCC as one of the key factors in generating cost savings and in producing more efficient outcomes. RDAA submits that the public benefits which have been documented in the draft determination will be similar if collective bargaining arrangements are extended to those LHNs which are operating on a state-wide basis.

Public detriment

Public Detriment: The ACCC, in its draft determination, has noted some factors which may constitute a public detriment with respect to collective negotiations with LHNs. These include the relative bargaining power of the parties; and smaller cost savings and efficiencies resulting from smaller and more tailored and localised negotiations as opposed to a state-wide agreement.

While it Country Health SA Local Health Network (CHSALHN), and the WA Country Health Service provide coordinated hospital services which are, to some extent, tailored to a geographically defined area, both entities are relatively large, and they provide services for hospitals and health services which have a significant variation in both size and the nature of services provided. In this respect their operation is far similar to a State health department than to that of a smaller and more regionalised Local Hospital Network.

Because of their size and the large number of doctors they employ, these LHNs will remain in a strong bargaining position relative to rural doctors. Under the draft determination, the proposed negotiating arrangements will remain entirely voluntary and there are no provisions for collective boycott. As noted in the draft determination, *the ACCC would expect that a collectively negotiated agreement will only be reached if it is in the interests of both parties to do so. (P16. Para 100).*

It should also be noted that both Country Health South Australia and the WA Country Health Service were well-established organisations before they became Local Hospital Networks. Negotiations under RDAA's previous authorisation (A91078) had been undertaken with these organisations. Including them in the final determination would represent a continuation of arrangements which are already in place, and for which the public benefits and detriments have been noted.