australian medicare local alliance

Connecting health to meet local needs

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Australian Competition and Consumer Commission
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31.05.2013

Dear Ms D'Ettorre

Re: Rural Doctors' Association of Australia's (RDAA) application (A91376) to The Australian Competition and Consumer Commission (ACCC)

I write in relation to the RDAA's recent application to the ACCC for revocation and substitution of authorisation number A91078 (current application number A91376). AML Alliance understands that the substitute authorisation, if successful, would extend RDAA's current authorisation to include collective negotiation by RDAA on behalf of rural GPs and practices with Medicare Locals (MLs) and Local Hospital Networks (LHNs) in relation to primary health care service delivery, including after hours services.

The Australian Medicare Local (AML) Alliance will be making further written submission to ACCC by 7 June, 2013 regarding the RDAA's substantive application. This letter relates to RDAA's interim authorisation.

AML Alliance supports activities that promote more efficient delivery of health care services, better workforce recruitment and retention and improved and more equitable health outcomes for all Australians, including those in rural and regional communities. AML Alliance believes that the intention of RDAA's application is to act similarly in the interest of rural communities and also to ensure that RDAA are empowered to provide their members with advice in relation to new regional health infrastructure such as MLs and LHNs. However, MLs are concerned that if the full breadth of authorisation outlined in RDAA's application were to be applied, it could potentially impact on health service delivery for rural communities and on ML functions with the following consequences:

- Potential increased costs for delivery of primary health care services in rural and regional Australia subsequently affecting service delivery sustainability: Collective negotiation on behalf of rural GPs/practices by RDAA may increase costs for services rendering them less sustainable. As rural areas already have less access to health services than their urban counterparts such a result would be detrimental to rural communities.

- Difficulty retaining a competitive local negotiating environment: MLs were established to deliver national initiatives through locally tailored solutions. Retaining a competitive negotiating environment is critical to achieving this. Collective negotiations may reduce

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AML Alliance gratefully acknowledges the financial and other support from the Australian Government Department of Health and Ageing.

MLs' capacity to fund services and may also make it difficult to allow for the varying operating cost structures that affect practices in different rural communities.

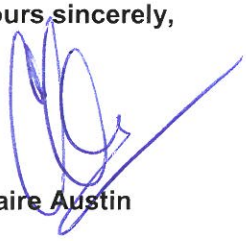
- Adding delays to negotiations and consequently to service delivery for rural communities: introducing a third party into negotiations between MLs and rural GPs/practices could add delays into negotiations which in turn could be translated into delays in service delivery in areas that are already compromised in their access to health care services.

- Adversely affecting the direct relationship between Medicare Locals and rural/regional GPs/practices: The direct relationship between MLs and GPs/general practices is critical to MLs delivering on their strategic objectives. In many cases, MLs' relationships with their GPs and practices are working well. Such relationships will need to continue to be extended and strengthened though. MLs have concerns that introducing a third party that can act on behalf of rural GPs and practices may adversely affect this relationship and therefore impact on MLs' ability to deliver their broader objectives.

- Disruption to negotiations that are currently in place in relation to afterhours services: From 1 July 2013, MLs nationally will, for the first time, have a direct funding relationship with GPs/practices for the delivery of After Hours face to face services. The nature of this funding varies from incentive payments (as distinct from billing for services provided through the Medicare Benefits Schedule) to hourly rates for After Hours Clinics to small grants. Although most of these payments are already agreed, some are still in negotiation and most will be reviewed in the next 12 - 18 month. MLs have concerns that these negotiations could be disrupted if RDAA are able to intercede between MLs and GP/practices.

AML Alliance requests that the above concerns raised by MLs be realistically considered in relation to this matter to prevent any unintended consequences of RDAA's application on rural health service delivery.

Yours sincerely,



Claire Austin

Chief Executive Officer