

Gina D'Ettorre
Assistant Director
Adjudication Branch
Australian Competition and Consumer Commission
Level 35 / 360 Elizabeth Street
Melbourne 3000

6 June 2013

Dear Ms D'Ettorre

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

Please find attached the AML Alliance submission which details our concerns regarding the RDAA's recent application for revocation and substitution of authorisation number A91078.

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 in the interest of rural communities however the AML Alliance and our member organisations (Medicare Locals) have some concerns that if the full breath of authorisation outlined in the RDAA application were applied, it could have unintended consequences for primary health service delivery in rural areas. Details of these issues are outlined in our submission (refer to Attachment A).

AML Alliance appreciates the invitation by the ACCC to comment on this RDAA application. We trust that the concerns we have raised will be fully considered in the course of reaching a determination about this matter.

If you would like to further discuss these matters, please contact me on 02 6228 0854.

Yours sincerely



Claire Austin

Chief Executive Officer

Attachment A - AML Alliance submission to the ACCC regarding the RDAA application A91376

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**Australian Medicare Local (AML) Alliance submission to the Australian
Competition and Consumer Commission (ACCC) regarding the Rural Doctor's
Association of Australia's application to ACCC**

7 June 2013

About AML Alliance

The Australian Medicare Local Alliance (AML Alliance) is a national, government funded, not for profit Company. AML Alliance leads and supports 61 Medicare Locals (MLs) – regional primary health care (PHC) organisations which play a key role in planning and coordinating PHC services for their respective populations across Australia.

AML Alliance is an advocate for Australia's primary health care policy setting and system. It works with a variety of stakeholders including general practice, health, aged and social care proponents to promote continuous improvement and excellence in the ML sector through evidence-based and innovative quality practice.

Led by a skills-based board, the AML Alliance works with MLs to:

- deliver better health services with general practice at its core;
- ensure service innovations are well promoted and advocated;
- provide the national connections to improve links between service delivery across the nation and Government policy;
- encompass the broader health sectors, including the social care and aged care sectors, to ensure gaps in services are filled and services are functional locally;
- provide accountability in the primary health care system; and
- support strategic partnerships with Local Hospital Networks (LHNs), general practitioners (GPs), clinicians and local government to improve their region's health system.

About this submission

The purpose of this submission is to provide ACCC with information relevant to RDAA's recent application for revocation and substitution of Authorisation number A91078, granted in May 2008. In particular, AML Alliance seeks to provide information relevant to public benefit claims and the impact on delivery of PHC services to rural communities. AML Alliance understands that the previous authorisation enables RDAA to collectively negotiate with state/territory health departments regarding the terms of contracts for rural GPs and rural generalist visiting medical officers (VMOs). RDAA's current application seeks to expand this authorisation to include collective negotiation with MLs and LHNs on behalf of rural GPs and rural practices regarding the delivery of PHC services, including after

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hours services. AML Alliance understands that this application does not relate to rural medical specialists who are not engaged in the speciality of general practice.

Medicare Local objectives and services relevant to RDAA's application

AML Alliance notes that RDAA's submission cites public benefit claims in its application whereby granting the revocation and substitution of RDAA's application will "...promote more efficient delivery of health care services, better workforce recruitment and retention, and improved health outcomes for rural and regional communities in the longer term." AML Alliance, through the work of MLs, also functions to achieve these goals across Australia and generally supports activity which aligns with these goals. A key objective for MLs is to assist more equitable access to health care services whilst also supporting clinicians and service providers. Given that access to health care services in rural Australia is already inequitable, actions with the potential to impact on this are of particular concern to AML Alliance.

MLs currently deliver and coordinate a range of PHC services to their local communities. An initial priority for all MLs is to improve access to urgent after hours PHC services. From 1 July 2013 MLs will directly contract with general practitioners and general practices to deliver face to face after hours services within their region. Currently, MLs are negotiating directly with GPs and practices in relation to this work. This direct relationship is important to gain the support from GPs and practices to improved access to such services for rural communities. Negotiations with practices and with GPs to undertake this work as identified, are already been put in place in most MLs so are likely to be outside of the current RDAA authorisation within the 2013 – 2014 period. Some arrangements will however may be re-negotiated over the coming 6 months so may fall under any new authorisation that RDAA attains.

The three main ML models for contracting GPs and practices to deliver after hours services are:

- Incentive payments similar to the Medicare Australia Practice Incentive Program (PIP) payments for after hours services that will cease from 1 July 2013. These models generally pay an incentive payment to practices, rather than individual GPs, for achieving defined levels of after hours service. These payments generally do not directly purchase services (which continue to be funded through Medicare billings) but rather offer an incentive for GPs to be involved in after hours service delivery. It is unclear whether these payments would fall within scope of the RDAA authorisation. It is strongly recommended that they do not given the risks associate with perverse incentives.
- After hours clinics: these often take a co-operative model and/or are run like practices where doctors are independent contractors (usually not employees) to the ML. GPs are generally paid an agreed hourly rate, although less frequently, payment is made to GPs based on a percentage of clinic billings. In some cases, long standing agreements have been in place between GPs and the ML regarding their clinic payments based on payments negotiated between GPs and their previous Division of General Practice, from which MLs evolved.
- Some MLs have also funded other activities to support the provision of after hours services. Examples include the provision of grant payments to general practices, financial support for training and upskilling, and contracting of Medical Deputising Services in urban and outer metropolitan areas. It is unlikely that these types of activities would fall within the scope of the RDAA authorisation however clarification on this matter is sought from ACCC.

Potential impact of RDAA application on MLs and on rural PHC service delivery

MLs currently hold limited funding to support improved access to urgent after hours PHC services to their communities. Future changes to this funding and information about whether MLs will be required to contract with GPs and practices for the delivery of other health care services are yet to be determined.

AML Alliance is supportive of the overall aim of achieving better access to health services across Australia, including in rural Australia and is not aware that any significant public detriments have occurred as a result of RDAA's 2008 authorisation.

Strengthening relationships between MLs and GPs

AML Alliance does however have a concern that potential future RDAA negotiation on behalf of rural doctors and practices may intercede in the direct relationship that MLs have with their GPs and practices. This direct relationship is critical to MLs achieving their strategic goals. In many cases this relationship is already working well, in others, the relationship needs to be extended and strengthened. MLs are concerned that introduction of a third party may adversely affect relationships with GPs. In particular AML Alliance is concerned that collective negotiation by RDAA for rural GPs and practices may lead to a significant cost increase in the delivery of PHC services in rural Australia. Although not intended to, this may inadvertently impact on the sustainability of PHC service delivery in Australia. Some examples of such concerns that have been provided in ML feedback as follows:

- *'We currently have good relationships with our doctors, both within and external to [our ML region] and do not see the need for RDAA to be involved in any negotiations that are occurring within the ML for provision of primary health care services, including After Hours services'.*
- *'There is a possible negative impact on the direct relationship between MLs and rural General Practice if negotiations take place with a third party. It adds more formality, introduces added complexity and may distance the parties unnecessarily'.*
- *'Involvement of the RDAA may result in price increases for service delivery which may in turn, have a negative impact on the sustainability of these (medical) services'.*

Retaining a competitive local negotiating environment

A further area of concern is potential impact on local negotiations. A key factor in the establishment of MLs is their ability to deliver national initiatives through locally tailored solutions. Retaining a competitive negotiating environment is critical to achieving this. AML Alliance acknowledges that RDAA's application (page 3, last paragraph) states, in relation to "Negotiations with Medicare Locals" that "These arrangements would largely take place at the local level and it is not envisaged that any state or national agreements could or would be put in place." At the same time, MLs are concerned that if collective negotiation were permitted, it may reduce MLs' capacity to fund services and may not allow for the varying operating cost structures for the provision of PHC services in line with the differing needs and priorities of rural communities.

Adding delays to negotiations and consequently to service delivery for rural communities

A further consideration for MLs is that introducing a third party into negotiations between MLs and rural GPs/practices will add delays to negotiations which in turn could translate into delays in service

delivery. Given that rural communities already have less access to health services than their urban counterparts, any further delays to service delivery should be proactively avoided.

In Summary

This submission has been prepared to assist ACCC to assess the application by RDAA to revoke and substitute its 2008 application A91078, and to authorise RDAA to collectively negotiate with state/territory health departments, LHNs and MLs where applicable, the terms of contracts for rural generalist and GP VMOs in rural areas.

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. This aligns closely with the RDAA application's statement under point 5a: Public Benefits Claim.

AML Alliance believes that the intention of RDAA's application is to act in the interest of rural communities however AML Alliance and our member organisations, Medicare Locals, have some concerns that the substitution may inadvertently have in certain areas, such as:

- Potential increased costs for delivery of PHC services in rural 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 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 and risks in service delivery, particularly in areas that are already compromised in their access to health care services.
- Adversely affecting the direct relationship between MLs and rural 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. 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 months. MLs have concerns that these negotiations could be disrupted if RDAA are able to intercede between MLs and GP/practices. .

AML Alliance appreciates the opportunity to comment on this application by RDAA. We acknowledge general practice as central to the provision of PHC services in Australia and recognise the importance of ensuring that rural communities have equality of access to quality PHC services that are cost effective and efficient.