RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Ms Gina D'Ettore
Assistant Director
Adjucation Branch
Australian Competition and Consumer Commission
Level 35/360 Elizabeth Street
MELBOURNE VIC 3000

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Dear Ms D'Ettore

Thank you for the opportunity to respond to the submission made by the Australian Medicare Local Alliance (AMLA) regarding RDAA's current application (No 91376) to the Commission.

One of RDAA's key objects is to attain the highest standard of health care for the people of rural Australia, and this is a key driver for the Association's current application to the Commission.

RDAA considers that this objective can be achieved through the provision of a medical workforce that is numerically adeqeuate, and which has the necessary training and support to be able to deliver the services that are needed, in the communities where they are needed.

In most States, rural doctors are responsible for community, pre-hospital and hospital care as are well as advanced medical care in the home. This work spans both the public and private sectors, primary and acute care, and State and Federal jurisdictions, and is fully integrated on an everyday basis.

It is important that the policies and decisions pursued by rural Medicare Locals, in the interests of public well being, take this factor into account. It is therefore highly desirable that RDAA be in a position to assist such doctors and groups of doctors to negotiate with their Medicare Locals, in the interests of fully integrated best patient care, to preserve and foster such care.

In applying for this revocation and substitution, RDAA is seeking to support its members in their negotiations with Medicare Locals, but only when members request that support be provided. In these circumstances, RDAA involvement would potentially contribute to the retention of primary health care services in rural and remote areas, as RDAA members may be more likely to enter into agreements with Medicare Locals, knowing that they can call on the support of their national and state representative organisation during negotiations with Medicare Locals, if they feel that this is necessary.

RDAA believes that the potential for cost increases as a result of this authorisation would be minimal, and will be offset by the potential benefit as outlined above.

In larger communities where there is more that one rural medical practice, there will be sufficient competition to maintain stable pricing structures. There may be less competition in those communities where there is only one medical practice, but the involvement of RDAA is not going to change this circumstance. As funding administrators, Medicare Locals will still be in a strong bargaining position.

In any case, it is unlikely that RDAA or State RDA involvement would contribute to any significant increase to the cost of services, given that one of the key objectives of any involvement would be the maintenance and enhancement of primary health care services in these situations, for the benefit of the both the local community and for the wider public good.

In reality, the amount of income which a rural practice might derive from contracts with Medicare Locals is likely to be relatively small compared to the practice income derived from other sources. There is a greater danger that services will be lost through rural practices not taking up contracts with Medicare Locals for the provision of primary care services such as after-hours services, with a resultant loss to the community.

It must be stressed that the arrangements proposed under the RDAA application will be entirely voluntary. RDAA or its constitutent State RDAs would only become involved in any negotiations between Medicare Locals and rural practices at the request of members, and this is not likely to happen where satisfactory working relationships and negotiating arrangements between Medicare Locals and practice entities are in place at the local level. The proposed authorisation will not delay negotiations or service delivery to rural communities in those situations.

It is likely that RDA members will only request support from RDAA where there are difficulties in negotiations with Medicare Locals. In this case, negotiations are likely to be protacted regardless of whether RDAA is involved or not. It may well be that RDAA is able to assist in achieving a suitable agreement which will result in a positive outcome for the parties involved, and for rural communities.

RDAA does not seek to influence the relationship between General Practitioners and their respective Medicare Locals, unless this is in a positive manner. Where sound relationships already exist or are developed, it is highy unlikely that RDA members will seek the involvement or support of RDAA in any negotiations with their respective Medicare Locals in the first place.

Negotiations between rural general practices and Medicare Locals with respect to the provision of after-hours services are already taking place, with the bulk of these agreements to be finalised by 30 June 2013. RDAA is well aware of the importance of after-hours services to rural and remote communities, and has been closely involved in discussions at the policy level to promote the maintenance of these services.

I hope that this clarifies the Association's position with respect to the issues raised by the Australian Medicare Local Alliance. I would be happy to provide further information or clarification.

Yours sincerely

Jenny Johnson

Jenny Johnson
Chief Executive Officer