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

Response to Submissions and Supplementary Information.

Australian Medicare Local Alliance.

RDAA notes the concerns raised by the Australian Medicare Local Alliance (AMLA) in its submission dated June 6, 2013.

Medicare Local Objectives and Services:
RDAA agrees with the AMLA statement that access to health care services in rural Australia is already inequitable. As outlined in RDAA's original application, one of the key objectives of RDAA's application is to promote rural workforce recruitment and retention, through supporting its members where necessary in their negotiations with Medicare Locals for the provision of primary health care services. Any measure which will promote workforce recruitment and retention will improve access to health care services and improve health outcomes in these areas.

One of the key elements in improving health services and health outcomes in rural areas is timely access to appropriate primary care services. RDAA contends that its members are more likely to enter agreements to provide these services on a contractual basis to Medical Locals if they have the option of accessing support from the RDAA or their State RDA in the negotiation of these contracts.

Strengthening relationships between Medicare Locals and GPs:
RDAA accepts that it is important that Medicare Locals develop and retain a strong understanding of, and working relationship with, their constituent general practitioners and general practices. The Association does not seek to compromise or replace the direct relationship that Medicare Locals have with their GPs and practices. RDAA's objective is to support its members in their negotiations with Medicare Locals, rather than take over or assume the primary role in these negotiations. RDAA's application notes that any arrangements would be entirely voluntary, so RDAA could and would only become involved at the specific request of a member.

If relationships between a Medicare Local and its GP constituents are strong, it is highly unlikely that RDAA members in that particular Medicare Local's constituency would request that RDAA become involved in any negotiations, or that RDAA involvement would compromise this relationship.

However, there may be circumstances in which RDAA involvement can facilitate the best outcomes for the community, especially if this means that agreements can be reached regarding the provision of primary health care services when it might otherwise not have been possible to do so.

Retaining a competitive local negotiating environment and the potential for increased costs for the delivery of primary health care services affecting service delivery sustainability:

As noted by the AMLA, the RDAA application states that any negotiations or 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'.

The geographic spread, demographics, health profiles and medical workforce characteristics of each Medicare Local varies significantly. Medicare Locals with a significant rural constituency tend to cover a relatively large geographic area and are therefore even more likely to contain communities of varying sizes and with different health care needs. Given that the brief of Medicare Locals is to 'deliver national initiatives through locally tailored solutions', RDAA accepts that it is appropriate that most agreements with rural general practitioners for the provision of primary care services would have a local focus, and that those agreements would need to take into account local circumstances, including the health care services that are needed; the skill sets of the medical workforce which is available to deliver those services; and the infrastructure and other support which may be required. This will contribute to retaining a competitive local negotiating environment, as there will most likely be variations in the nature of the agreements offered to individual doctors and practices.

RDAA believes that the potential for limiting a competitive local negotiating environment and increased costs for the delivery of primary health care services in rural areas is small.

Rural Health Workforce Australia estimates that there were a total of 6,467 doctors practising mainly in the general practice setting in areas ranging from inner regional to very remote areas of Australia in 2010. *(Health Workforce Queensland and New South Wales Rural Doctors Network (2010). Medical practice in rural and remote Australia: Combined Rural Workforce Agencies National Minimum Data Set report as at 30th November 2010. Brisbane: HWQ).*

Under RDAA's proposal, the Association would only be acting on behalf of financial members of the RDAA or its constituent State Rural Doctors Associations. The percentage of rural doctors who are RDA members varies from State to State and within communities, and RDA members include doctors working in the public and private sectors (or a mixture of both); rural specialists; doctors-in-training and medical students, so it is difficult to estimate the number of members to whom the proposed authorisation would be relevant.

However, as the total number of RDA members is less than half of the total number of doctors quoted above, it could be assumed that there would be a significant number of regional and rural communities in which not every doctor is an RDA member. There would not be the potential for RDAA to become involved in every negotiated agreement, thus maintaining a competitive local negotiating environment.

In its determination (A91334) which grants authorisation to general practitioners who operate within certain team based practice structures to engage in intra-practice price setting and collective bargaining with VMO service purchasers and Medicare Locals, the ACCC noted:

'VMO Services to public hospitals and Medicare Local Services to Medicare Locals are unlikely to be affected by reduced competition or services from collective bargaining over service provision since:

1. *the relevant VMO Service Purchasers and Medicare Locals are not obliged to negotiate with a practice collectively;*
2. *each bargaining group will be small, and except in some remote areas, will not represent all the GPs who may supply VMO Services to a particular hospital or Medicare Local Services to a Medicare Local; and*
3. *public hospitals and Medicare Locals operate within the constraints of health budgets, which will provide a consistent and limited cost framework in which the negotiating parties will have to operate.*

While RDAA's application is for the Association and its constituent State RDAs to engage in collective bargaining rather than the team based practice entities to which the quoted determination refers, there is still relevance to RDAA's application, in that:

- under the terms of RDAA's application, there will be no obligation on the part of VMO Service Purchasers and Medicare Locals to negotiate with RDAA;
- although RDAA will represent a larger bargaining group than practice entities, contracts with Medicare Locals in particular will still be negotiated at the local level. RDAA's application applies to members only, and this will not represent all the GPs who may supply services to Medicare Locals in any particular area, except perhaps in some remote areas; and
- negotiations will still take place under the constraints of health budgets, which will provide a consistent and limited cost framework for any negotiations.

Adding delays to negotiations and consequently to the delivery of services for rural communities and disruption to the negotiations that are currently in place in relation to after-hours services:
As previously outlined, RDAA's application states that arrangements would be entirely voluntary. There is a strong possibility that RDA members would only call on RDAA to become involved in their negotiations with Medicare Locals where there were difficulties with those negotiations. Under these circumstances, the negotiation process would most likely be delayed in any case.

Negotiations with State Health Departments.

RDAA notes the submission from the Northern Territory Department of Health, regarding negotiations of conditions for medical officers.

The Association fully accepts that the State Health Departments will continue to consider the needs and views of a number of groups during any negotiations which take place at the State level. RDAA's current authorisation does not include exclusivity with respect to negotiations at this level and the Association is not seeking to do so under its current application.

Impact of RDAA's Current Authorisation on the Availability and Cost of VMO Services:
The submission from the Northern Territory Department of Health (DOH) notes that 'The RDAA has had a collective negotiation authorisation since 2008 and DOH has not been negatively impacted by this collaboration'.

RDAA has described the negotiating arrangements in each State in its original application. The Association anticipates that these arrangements will largely continue, meaning that in most States, RDAA is not the only organisation with whom State Health Departments consult during negotiations for VMO and other arrangements. Given this involvement, it would be realistic to assume RDAA's existing authorisation has not been the sole, or even a significant contributing factor, to any cost increases which might have occurred.

RDAA's existing authorisation has resulted in community benefits in terms of access to VMO services. It has streamlined negotiating arrangements and provided some certainty for both rural doctors and for State Health Departments.

For example, in South Australia, it has allowed the Rural Doctors Association of South Australia (RDA SA) to negotiate with the State Health Department regarding a package for rural doctors for the provision of VMO, on-call and procedural services to country hospitals. Whilst this may have created a new arrangement and provided rural doctors in SA with access to a contractual package, it has provided certainty for rural doctors and for the State Health Department, who now have certainty regarding the availability of VMO and on-call services in rural areas of the State. This arrangement has improved the availability of health care services in rural communities.

Retaining Health Care Services in Rural Areas.

A key purpose of RDAA's application is to preserve rural medical networks, and to facilitate a working environment for rural generalist practice across both primary care and acute and procedural services, together with opportunities for a career in rural medicine that is attractive enough to compete with metropolitan practice.

Many rural hospitals remain in decline because of lack of rural doctors to staff them properly, and there has been a significant decline in procedural services during the past ten years, with Health Workforce Australia 2025 (3) reporting that proceduralists have declined by 50% since 2002 (P118)

RDAA contends that the community benefits outlined in its application, which are based around the importance of workforce supply to improved access to health services and better health outcomes in regional, rural and remote communities, are of significant importance to the people who live in these areas, and as such they also have a wider public benefit.

These benefits significantly outweigh any detriments.