



Victorian Healthcare Association

18 January 2008

Ms Isabelle Arnaud
Director
Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
CANBERRA ACT 2601

Dear Ms Arnaud

Application for authorisation A91078 lodged by the Rural Doctors Association of Australia (RDAA) Limited

I note the current consultation period regarding the application of the Rural Doctors Association seeking authorisation to collectively negotiate with state/territory health departments the terms of contracts for visiting medical officers in rural areas.

Hospitals in Victoria are registered corporations through the Health Services Act 1988. Community Health Services are registered corporations through the Associations Incorporation Act 1981. These individual legal entities are in most part members of the Victorian Healthcare Association. Amongst the various functions of VHA is to act as an industry body in advocating position in relation to health policy impacting service delivery within Victoria, thus our interest in this matter.

Both Hospitals and Community Health Services engage GPs, although principally, this application by the RDAA will impact upon the arrangements in place within rural hospitals. As noted in the RDAA application, within Victoria the arrangements in place are negotiated directly between the legal entity (the hospital) and the medical practice providing the service. As such, it is somewhat surprising that the individual legal entities that may be impacted by this application have not been listed as interested parties despite the acknowledgement of the RDAA in their application of the unique status within Victoria.

The following comments are provided in relation to the specifics of the application:

1. Public benefit claims:

The RDAA make the following public benefit claims:

1.1 Effective representation of rural doctors to the State health authorities.

This may provide a benefit to the rural doctors, but I am unable to identify evidence within the Victorian context to support the notion that this would provide a public benefit.

1.2 The granting of an authorisation would positively influence the retention of rural VMOs by removing the 'red tape' and reducing transaction times and costs currently associated with contracting VMOs.



I am unable to identify evidence within the Victorian context to support the notion that the current process of negotiating VMO contracts represents a retention issue. While the notion of a collective agreement intuitively supports the contention of removing 'red tape', this would appear to be a business benefit as opposed to a public benefit. Further, I am not convinced that the reduction in so called 'red tape' would be significant as some form of document will still need to be reviewed and agreed.

In addition to noting the absence of evidence supporting this contention can be added our own anecdotal observation. That is that the current arrangements within Victoria provide a sense of 'partnership' between general practitioners and the local hospital, resulting from the interface in negotiating contractual arrangements. Any centralised approach may remove this sense of 'partnership', creating a risk of equal merit to the advantage argued by the RDAA. This risk is that the 'new red tape' disenfranchises the partnership currently existing and may create further retention concern.

- 1.3 That the improved process of contracting will realise a small increase in the number of VMOs providing services to public patients in rural hospitals and at very least that it will assist in retaining current VMOs.

As noted in 1.2 above, I am unable to identify evidence to support this contention within the Victorian context. If this were to occur, then public benefit may be argued.

- 1.4 That in the absence of an authorisation to collectively negotiate, that doctors will over time reduce the services that they provide to rural hospitals and may withdraw from rural practice altogether.

Some examples exist where local negotiations have broken down and resulted in a short-term withdrawal of service. These are isolated incidents that may or may not arise through a collective agreement.

Of concern to VHA is that in negotiating a collective agreement, collective action may be encouraged resulting in the members of RDAA withdrawing service 'en-masse' until their remuneration objective is agreed.

2. Public detriments:

The RDAA acknowledge the following potential detriment to the public:

- 2.1 It is possible that the granting of an authorisation may impact on the costs of labour in rural hospitals as the current arrangements may have had a distorting effect of reducing prices. It is not expected that any costs increases would be significant.

Significant concern has been expressed from amongst the membership of VHA that any collective agreement will drive costs up. As cost control is a concern to all involved in the delivery of public hospital services, VHA contends that this represents a major public detriment argument against this application. The application of the RDAA clearly identifies that the motive of the application is to achieve higher payments. This assertion is made in observation of the contention by RDAA that prices have been reduced through current arrangements.



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Within Australia, a collective guide to pricing medical services is expressed through the Medical Benefits Schedule (MBS). Previous exception to the value expressed within the MBS for medical services has seen the Australian Medical Association (AMA) publish their own fee guide, at rates significantly above those expressed through the MBS. If this outcome is a precursor to what the industry can expect from the RDAA collective outcome, then concern regarding price increases is further confirmed as a reasonable reaction.

3. Effect on competition:

VHA does not believe that a collective agreement will aid or hinder competition. Workforce shortages are relatively uniform across rural Australia, resulting in a 'sellers' market within the medical profession. This reality also provides opportunity for locally domiciled GPs to directly negotiate suitable terms for their services.

4. Current arrangements and processes for the negotiation of contracts:

The current arrangements within Victoria involve general practitioners entering into a fee for service contract with the hospital/community health centre to which they are to provide services.

Before doing so, GPs apply to be credentialed to practise at the rural agency, and once credentialed negotiate their remuneration arrangements.

The circumstances will vary according to location, but generally the GP will negotiate directly with the Chief Executive, the Director of Medical Services, or an externally engaged broker (such as the agencies legal counsel). Contracts vary in length from 1 – 3 years.

The Department of Human Services (DHS) is not involved in these negotiations, and agencies are expected to manage the cost of implementing the negotiated outcome within their available funding.

At present, a 'leap-frogging' effect applies. The AMA is active in promoting their fee schedule, and the industry grapevine ensures that favourable arrangements struck at one locality are communicated to the possible benefit of others currently negotiating.

At times, animosity may result from the negotiation process. This is a negative aspect of the current arrangements, and is generally short lived. However, it can be difficult in a cost-sensitive and fiscally pressured environment such as health to negotiate an outcome to the mutual satisfaction of the parties, and then to work cooperatively in the review of policy, process, and delivery of service.

5. The role of general practitioners in providing services in rural areas:

General practitioners are critically important to the provision of hospital services within rural areas. Smaller agencies (less than 50 acute beds) will in most cases be totally reliant upon local GPs to deliver accident and emergency and medical services. At smaller agencies, procedural GPs may also provide obstetric and surgical services.

Larger regional agencies will generally utilise GP services to support their resident medical officers in the provision of services. Although less reliant upon GP input to sustain the service model, they none-the-less play an important and integral role.



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Thank you for the opportunity to contribute to the deliberation of the ACCC in this matter.

Please do not hesitate to contact the undersigned on 03 9094 7777 should you require further information or clarification of any of the points made.

Regards

A handwritten signature in black ink, appearing to be 'Trevor Carr', with a long horizontal flourish extending to the right.

Trevor Carr
Chief Executive