APPLICATION FOR REVOCATION OF A NON-MERGER AUTHORISATION AND SUBSTITUTION OF A NEW AUTHORISATION

1. Applicant

(a) Name of applicant:
Rural Doctors Association of Australia Limited (ABN 57 062 176 863).

(b) Description of business carried on by applicant:

The Rural Doctors Association of Australia (RDAA) is the peak organisation representing the interests of doctors working in rural medical practice throughout Australia. RDAA represents the full range of rural doctors, including specialists, rural generalists, general practitioners, and doctors working in both the public and private sectors.

The objects of RDAA focus on acquiring the highest standard of medical care for people living in rural and remote Australia. This includes advocating for a highly skilled and motivated rural medical workforce, which is appropriately trained, remunerated and supported.

(c) Address in Australia for service of documents on the applicant:

Postal address: PO Box 3636, Manuka, ACT 2603

Suite 5 Level 2 Endeavour House

2-10 Captain Cook Cres

MANUKA ACT 2603

Email Contact: ceo@rdaa.com.au

2. Revocation of authorisation

(a) Description of the authorisation, for which revocation is sought, including but not limited to the registration number assigned to that authorisation:

Authorisation no: A91376 to the Rural Doctors Association of Australia (RDAA) and its constituent State associations to collectively negotiate with state/territory health departments, Country Health South Australia Local Hospital Network, and Western Australia Country Health Service Local Hospital Network regarding the terms of contracts for general practitioner or rural generalist visiting medical officers (VMOs) in rural areas.

This authorisation was granted for a period of five years and will expire on 21 November 2018.

(b) Provide details of the basis upon which revocation is sought:

The existing authorisation (A91376) is still relevant and necessary with respect to collective negotiations between RDAA and its constituent state associations and State and Territory Health Departments, Western Australia Country Health Service Local Hospital Network.

However the cessation of Medicare Locals, which have been superseded, by Primary Health Networks and Country Health South Australia Local Hospital Network, at a date to be advised, will transition to six new Local Hospital Networks has resulted in the need to extend the scope of the new authorisation to include those organisations.

In addition, due to the feedback of members and increasing challenges with rural medical workforce in Victoria, RDAA is requesting that this authorisation extend to cover the individual Local Health Networks within Victoria, as listed in this application.

With the emergence of the Hospital and Health Services in Queensland, RDAA also requests the authorisation extends to the HHS' listed as part of this application, as currently there is no current statewide VMO contract, and individual doctors have bee required to negotiate with the HHS' and been provided with only the former statewide contract as the standard. If the statewide VMO contract arrangement recommences, the negotiations with Queensland Health will be reinstated.

3. Substitution of authorisation

(a) Provide a description of the contract, arrangement, understanding or conduct whether proposed or actual, for which substitution of authorisation is sought:

The Rural Doctors Association of Australia (RDAA) seeks a substitution of authorisation for the Association and its constituent members (being the Rural Doctors Associations in each State) to enter into agreements with State Health

Departments; Local Hospital Networks (or by known other name) and Primary Health Networks where applicable, regarding the contracting of rural doctors, otherwise in local or other practice, as Visiting Medical Officers (VMOs) or for the provision of primary health care services, including after-hours services, by these Departments and Authorities.

RDAA is seeking this authorisation, for coverage of our members under the following provisions:

- Section 45 *Competition and Consumer Act* non-price – enable negotiations on the terms and conditions of employment, not relevant to a specific dollar value.
- Division 1 of Part 4 regarding price fixing – to have the approval for RDAA or its constituent state associations to negotiate pay rates and/or fees with employers regarding VMO medical practitioner services.

These agreements could include payments for services provided to public patients or services provided within the hospital/facility, including payments for on-call and arrangements for rosters and on-call and other broader aspects of support and remuneration. They could also include payments for the provision of primary care services, including after-hours services in the general practice or other primary care setting. They may also include broader terms and conditions such as, but not limited to, fatigue management, clinical governance processes and professional development support.

Industry Description:

Rural health services provide essential and critical access to over 4 million people living in rural and remote Australia (excludes major cities and regional centres).[ii] The state health system through the hospital is often one of the major employers of people living in these communities, and therefore critical to the economy of the community. Other than in the Northern Territory or Queensland, the majority of the medical workforce employed at the hospital is employed through Visiting Medical Officer (VMO) contract arrangements. A smaller percentage of the workforce in rural Queensland and Northern Territory are also engaged under VMO employment arrangements.

The doctors who work across both private general practice and the hospital are essential to ensure the sustainability of both services in these communities, as there is often not sufficient work to have two separate medical workforces employed in each location without impacting on the provision of services or significant cost implications.

An integrated model of the rural medical workforce across hospital and general practice is one that has been in operation for many generations. The hospital work provides additional revenue to the individual and the practice and forms a large portion of the remuneration package, which is critical for the successful recruitment and retention of rural doctors.

The state health department, or the Local Health District has the monopoly as the "owner" of rural hospitals and therefore is the employer of rural doctors who provide hospital services. There are only a small number of private hospitals in rural and remote Australia, and they are not included in scope of this authorisation application.

General Practice bulk billing rates, where the medical practitioner accepts the Medicare rebate as the payment in full for the services provided is only higher in very remote locations at 87.2% than the national average of 84.3%. Outer regional and remote have bulk billing rates of 82.6% and remote 82.1%, this is reflective of the impact of the Medicare freeze on rebates of the past five years, and is an indication of the delicate viability and escalating costs for rural general practice.[iii] Some states such as Victoria, in its rural hospitals have implemented outpatient models of service, which access Medicare rebates for the remuneration of the medical workforce, in particular GP VMOs.

VMO Services: VMO agreements are expected to be made on a state-by-state basis, or with individual Local Hospital Networks in some circumstances. They would continue or develop arrangements already in place in those States where the State Health Department unilaterally elects to determine the arrangements for the contracting of doctors to state hospitals and facilities.

The nature of negotiations, which take place at the State level, and the extent of RDA involvement in these negotiations, varies widely between States.

National agreements concerning pay and conditions of rural VMOs are not expected at this time but remain a possibility for the future. With work currently being progressed on the development of a National Rural Generalist Pathway, this may have implications for parts of the rural medical workforce either in training years (Post Graduate Years 1-7), or once Fellowed with one of the general practice specialty colleges.

It may also be that responsibility for more of these agreements be devolved to Local Hospital Networks (LHNs) in the future. Circumstances may arise in which all parties, including health consumers, would benefit if RDAA and its constituent state associations were able to provide advice, or become involved in these negotiations. Once again, it is not expected that national agreements could or would be put in place.

Under current arrangements, VMO fees for rural doctors in all States except Victoria are set on a state-wide basis by State Departments of Health. In Queensland, HHS currently use the previous statewide contract as the guide for employment arrangements of current rural GP VMOs. Under authorisation A91376, the Rural Doctors Association of Australia and its State constituent associations have been authorised by the ACCC to participate in the negotiation of these agreements with State Departments of Health on behalf of rural doctors.

In Victoria, General Practitioner VMO arrangements are negotiated directly between medical practitioners and practices and Local Hospital Networks Boards in rural areas. The Rural Doctors Association of Victoria (RDAV) had continued to encourage the State Government under authorisation A91376 to implement a State-wide arrangement, which it believes to be allowed under the 1987 Health Services Act, as being in the best interests for the rural public.

Negotiations with Primary Health Networks: With respect to Primary Health Networks, the proposed substitution of authorisation would allow RDAA and its constituent State Associations to become involved in negotiations between rural doctors and practice entities for the provision of a range of primary health care services, including after-hours services and mental health services, with their respective Primary Health Networks, where RDAA involvement is appropriate. 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.

This application does not extend to rural specialists working in specialist areas other than general practice (the Australian Health Practitioner Regulation Agency recognises general practice as a specialist discipline).

The proposed arrangements would be entirely voluntary. Parties to the application would not be bound to participate in the proposed arrangements and there is no provision or intention for any boycott arrangements as part of this application.

On 28 February 2018, the ACCC granted authorisation (No: A91599) to general practitioners who operate within certain team-based practice structures to engage in collective bargaining with purchasers of VMO and primary care services. This authorisation is necessary and relevant; however it refers to single practice entities and therefore does not cover broader negotiations between purchasers of VMO or primary health care services on the one hand and organisations such as the RDAA on the other.

Under the proposed arrangements for this application for revocation and substitution, and further to any arrangements under ACCC authorisation A91376, rural doctors and practices will be able to have contracts with purchasers of VMO and other hospital services, and/or their respective Primary Health Networks, where the content may be determined with input from RDAA or State RDAs.

(b) Description of the goods or services to which the contract, arrangement, understanding or conduct (whether proposed or actual) relate:

Provision of medical services including surgery, obstetrics, anaesthetics, emergency services and broad inpatient care and medical consultations by rural generalists and rural general practitioners in rural public hospitals and health facilities.

Primary medical care and related services, including after-hours services, and mental health, which may be provided under agreement to Primary Health Networks.

(c) The term for which substitute authorisation of the contract, arrangement or understanding (whether proposed or actual), or conduct, is being sought and grounds supporting this period of authorisation:

The substitute authorisation is requested for a period 5 years. The negotiation of the arrangements relating to the provision of services in rural hospitals and health services is an ongoing process with fees and arrangements being reviewed/indexed usually on a yearly basis.

RDAA anticipates that there will be a continuing need for this authorisation, as the nature and demands of rural medical practice are unlikely to change in the short to medium term.

The current authorisation (no A91376) for which revocation and substitution is applied, was granted for a period of 5 years. Given that this authorisation has worked effectively, a similar time frame would be appropriate for this application.

On 28 February 2018, the ACCC granted authorisation (No: A91599) through the Australian Medical Association to general practitioners who operate within certain team-based practice structures to engage in collective bargaining with VMO service purchasers. This authorisation has duration of 10 years, expires 22 March 2028.

4. Parties to the contract, arrangement or understanding (whether proposed or actual), or relevant conduct, for which substitution of authorisation is sought

(a) Names, addresses and description of business carried on by those other parties to the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct:

Members of RDAA and its Constituent State Associations: The individual doctors who would be a party to contracts with the State Health Authorities would be current and future members of the RDAA and its constituent State Associations. These doctors are rural general practitioners (including GP Registrars and locums) and rural generalists who provide services in public hospitals and health facilities as Visiting Medical Officers, and primary care services, including after-hours services, which may be contracted by Medicare Locals.

It is not intended for the RDAA or its constituent State Associations to negotiate on behalf of rural medical specialists who are not engaged in the specialty of general practice as a part of this authorisation.

State Health Departments/Authorities in each State, as listed below:

Party	Postal Address
Department of Health - New South Wales	Locked Mail Bag 961 NORTH SYDNEY NSW 2059
Department of Health and Community Services – Northern Territory	PO Box 40596 CASUARINA NT 0811
Department of Health – South Australia	PO Box 287 Rundell Mall ADELAIDE SA 5000
Department of Health and Human Services – Tasmania	GPO Box 125 HOBART TAS 7001
Department of Health and Human Services – Victoria	GPO Box 4057 MELBOURNE VIC 3001
Department of Health – Western Australia	PO Box 8172 Perth Business Centre PERTH WA 6849

The nature of negotiations for VMO and other hospital-based services varies from State to State, as does the level of RDA involvement in these negotiations. More information on these negotiations is included in Section (5).

Local Hospital Networks (LHNs): LHNs are separate statutory authorities, which are responsible for the management of public hospitals. The boundaries for the 137 LHNs include 124 geographically-based networks, together with 13 state-wide networks which will deliver some specialised services across some jurisdictions.

LHNs are made up of small groups of local hospitals that collaborate to deliver patient care and manage their own budget. LHNs will be held directly accountable for their performance. The size and scope of responsibility for LHNs varies from State to State.

Although it is likely that current arrangements for the negotiation of VMO fees and conditions will continue at the State level for all States except Victoria, this may change in the future, and the role of LHNs may possibly evolve to include direct negotiations with organisations such as RDAA and its constituent state associations, as well as with individual doctors, regarding the provision of these and other services.

In Victoria, the Local Health Networks are the employer of the medical workforce at the local rural hospital. In hospitals located in Modified Monash Model[v] 3 – 7 areas, doctors are generally employed under VMO arrangements. At this point in time, the governance and catchments of health services in Victoria are not expected to change, and hospital boards (which will be referred to as LHNs) will continue to individually negotiate VMO fees and conditions directly with doctors. The Rural Doctors Association of Victoria (RDAV) wishes to continue advocate for State-wide arrangements in Victoria, believing these to be beneficial in other States. However, due to limited reception on state-wide arrangements to date, RDAV is also seeking to negotiate on behalf of GP VMOs with each LHN, if they elect to engage in a more centralised LHN wide approach, while maintaining their independence from a state wide system.

In Queensland, where previously VMOs had been able to negotiate contracts at a state level, with the establishment of Hospital and Health Services(HHS), VMO arrangements no longer continue to be negotiated statewide. RDAQ is seeking to be able to negotiate with individual HHS', if the HHS agrees.

Primary Health Networks: Primary Health Networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.[vi]

The Australian Government established the 31 Primary Health Networks across Australia in 2015. Each PHN is overseen by a board of directors, and is advised by a clinical council and a community advisory committee.[vii]

The PHNs are expected to commission external health care providers to meet regional needs. For example PHNs fund:

- After hours services
- Mental health services
- Health promotion programs
- Primary care support

(b) Names, addresses and descriptions of business carried on by parties and other persons on whose behalf this application is made:

Members of RDAA and its Constituent State Associations: The individual doctors, who would be a party to contracts with the State Health Authorities, would be current and future members of the RDAA and its constituent State Associations. These doctors are rural general practitioners and/or rural generalists (including GP Registrars and locums) who provide services in public hospitals and health facilities as Visiting Medical Officers, and primary care medical services, including after-hours services and mental health, which may be contracted by Primary Health Networks.

(c) Where those parties on whose behalf the application is made are not known - description of the class of business carried on by those possible parties to the contract or proposed contract, arrangement or understanding:
n/a

5. Public benefit claims

(a) Arguments in support of application for substitution of authorisation:
(See Direction 6 of this Form)

RDAA is applying for this substitution of authorisation on the grounds that, if granted, it will support rural doctors and facilitate their participation in the provision of VMO and other services. This in turn 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.

The inclusion of Victorian LHNs and Queensland HHSs recognises the associated costs to the health system in contract negotiation, contract management and sustaining expertise in medical workforce management, and aims to provide a more cost efficient process for the engagement of VMO GPs in rural and remote hospitals across all of Australia.

Continuity of Existing Negotiations and Arrangements: The granting of this application for revocation and substitution of A91376 would enable the RDAA and its State members to continue to effectively negotiate with the State health authorities regarding VMO services provided by rural doctors. This is especially necessary in States such as South Australia, where these negotiations are ongoing.

It would also enable RDAA and the State RDAs to support their rural doctor members in any negotiations with LHNs and Primary Health Networks, which are carried out at the regional or local level.

The existing authorisation (A91376) has facilitated effective negotiations and agreements in a number of States and it is anticipated that these arrangements would continue under this application.

New South Wales - A series of state-wide agreements has been made between the NSW Department of Health (NSWDOH) and the Rural Doctors Association of New South Wales (RDANSW) and/or the Australian Medical Association (NSW) and that define the terms and conditions of individual VMO service contracts.

South Australia – the South Australian Department of Health (SADOH), through Country Health SA Local Hospital Network (CHSA LHN), until recently operated as a single agency covering all health units in country SA. The South Australian government, through CHSA LHN, has adopted a collaborative model in negotiating the South Australian Rural Medical Engagement Schedule and the South Australian Medical Schedule of Fees. This involves consultation with Rural Doctors Association of South Australia (RDA SA) to work through the industrial process in a collaborative manner. In the last round of negotiations in 2017 for the Rural General Practitioner Fee for Service Agreement, the AMA South Australia lead the negotiations for 16 case mix funded hospitals, with RDASA providing critical support. RDASA lead the negotiations in relation to the provisions for the 48 smaller grant funded hospitals.

Queensland - In Queensland, 'VMO' refers to Visiting Senior Specialists, Visiting Specialists and Visiting Medical Officers (GPs including Rural GPs/Rural Generalists). While not directly represented, the Rural Doctors Association of Queensland (RDAQ) has been involved in these negotiations. Rural Doctors Association of Queensland seeks to negotiate on behalf of Visiting Medical Officers (including rural GPs and Rural Generalists) contracting to rural and remote services with the State Government (acting through Queensland Health, the Department of Corrective Services and the Department of Communities) and each of the Health and Hospital Services (LHNs) as listed.

Prior to devolvement to individual Health and Hospital Services the State government (acting through Queensland Health, the Department of Corrective Services and the Department of Communities) negotiates an agreement with the Queensland Branch of the Australian Medical Association concerning the supply of VMO services. In Queensland, 'VMO' refers to Visiting Senior Specialists, Visiting Specialists and Visiting Medical Officers (GPs including Rural GPs/Rural Generalists). While not directly represented, the Rural Doctors Association of Queensland (RDAQ) has been involved in these negotiations.

Western Australia - most country doctors in the southern half of the state provide services to their local hospitals under contract. Visiting medical

practitioners are engaged on the basis of a medical service agreement (MSA). The terms and conditions component of the MSA is largely non-negotiable. The content of the schedules is negotiated individually (with doctors or their agents), taking into account the skills of the doctor concerned, the service requirements of the hospital(s), the volume of service anticipated to be purchased and the payment models preferred by both parties. The Rural Doctors Association of Western Australia (RDAWA) supports individual members in these negotiations.

Tasmania - VMOs operate predominantly under arrangements set by the State government, with some consultations regarding these arrangements taking place with rural doctors and the Australian Medical Association (Victorian Branch).

As a result of RDAA and its constituent State Association Rural Doctors Association of Tasmania (RDAT) being able to be involved in these negotiations, there has been more certainty for rural doctors. This in turn increases the possibility of doctors participating in VMO rosters in rural areas. In 2016/17, RDAT supported AMA Victoria in the negotiations for the new Rural Medical Practitioners (Public Sector) Agreement, which included a range of improvements for the employment conditions of the doctors working under this agreement.

Negotiations with Local Hospital Networks and Primary Health Networks: As previously outlined, there is the possibility that some VMO or other agreements could be negotiated directly with LHNs in the future. If this is the case, the proposed authorisation would provide support for doctors and practices in those negotiations.

Any initiative that facilitates rural workforce recruitment and retention, including the granting of this substitution of authorisation, will in turn improve health outcomes and result in considerable economic and social benefits for rural communities.

Health Outcomes in Rural Communities:
Rural Australians have poorer health outcomes than their urban counterparts.

Australia's Health 2016, the biennial report from the Australian Institute of Health and Welfare (AIHW), was released in June 2016. The report shows that:

- people who live in outer regional, rural and remote areas are in the disease prevalence reporting rate higher than major cities in nine of the ten diseases listed, the tenth disease the prevalence is equal.
- The report states, "*For nearly all causes of death, rates were higher for people living outside of Major cities, with people in Remote and Very remote areas faring the worst.*"[viii]

Additionally:

- life expectancy in rural and remote areas is up to 7 years less than the city,
- rural mortality rates are up to 3 times higher than city rates
- There is a higher prevalence of mental health problems in rural and remote areas, and
- Suicide rates in rural and remote areas are up to 30% higher than in cities.

With approximately 30% of people living outside the major cities, tthese poor health outcomes have a significant range of economic and social impacts, including lost productivity and increased health care costs, at both the local, regional and national level.

The Rural Medical Workforce:

The shortage of rural doctors appropriately skilled in advanced community and hospital medical care is a significant contributing factor to poor health outcomes in rural communities.

Australia's Health 2016 notes that there are 441.6 medical practitioners per 100,000 head of population in major cities and this decreases the more rural and remote you go. In remote and very remote communities this number drops to 262.8 medical practitioners per 100,000 head of population.

For General Practitioners the numbers do improve the more remote you go 111.6 GPs per 100,000 population in major cities to 135.5 per 100,000 population in remote and very remote.[xii] This however does not describe the complexity of medicine due to lack of specialists in the area, the impact on tyranny of distance to access the GP service, as the 100,000 population are spread over a much larger geographical area than people living in major cities. There is also evidence that people living in these locations access their General Practitioner less than half than people living in major cities.[xiv]

The General Practice workforce is an ageing workforce. In 2012 the average age was 50.8 years, and in 2015, the average age was 51.4 years. In 2015 40.5% of the workforce of 27,754 are over the age of 55 years, up from 37.9% of 25,958 GP work force in 2012. A real increase of 1,402 GPs in the over 55 years age bracket. This is also impacting on the interest and willingness of this workforce to provide services, particularly the after hours services at the hospitals.

Currently, Overseas Trained Doctors (OTDs) make up approximately 40% of the medical workforce in regional, rural and remote locations.[xviii] In many cases, those doctors only partially fill the rural general practice service gap because, starting often with training inadequate to the Australian rural context, they are compelled to work in rural and remote areas, due to Federal Government policy, where they face cultural and geographic isolation, with often limited opportunities for ongoing mentoring and training.

The upshot of this situation is that there has been and continues to be pressure on medical services in rural hospitals especially in terms of acute

medical, emergency, obstetric, after hours, and advanced community medical care. The Commonwealth Government's commitment to establish a National Rural Generalist Pathway is a key strategy to encourage and incentivise more Australian Trained Medical Graduates to work in rural and remote Australia.

Australian universities are now graduating over 3,000 medical students each year who have been supported by the Commonwealth Government. There are full fee paying students in addition. There is now an opportunity to build up the rural workforce, but this will only be achieved if there are support networks in place as well as mature industrial arrangements comparable to those available in major cities and large regional centres hospital systems. There are also trends of the emerging workforce working fewer hours, to do limited oncall after hours, and this is a risk to the future sustainability of services, if sufficient workforce numbers are not achieved.

(b) Facts and evidence relied upon in support of these claims:

Statistics relevant to the rural medical workforce and to the health of rural Australians are provided in the previous section.

6. Market definition

Provide a description of the market(s) in which the goods or services described at 3 (b) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):

(See Direction 7 of this Form)

The provision of VMO services to rural hospitals and health facilities: These services are provided by rural general practitioners to rural medical facilities within a defined geographic area, and usually in the community in which the practitioner is located in the vast majority of cases. There may be some instances where VMO services are provided to hospitals and facilities in other towns in the vicinity. These would usually relate to procedural services such as obstetrics or anaesthetics, or to services provided to facilities in nearby locations where there is no available medical practitioner. In a large number of rural and remote hospitals across Australia, the VMO GP workforce makes up the full complement of medical practitioner workforce.

Given the distances and associated travel time involved, it is not usual for a rural medical general practitioner to provide VMO or other services to multiple hospitals or facilities. Where this does happen, it is usual for individual negotiations to occur.

The provision of services to Primary Health Networks: These services would be provided by rural doctors within a defined geographic area and usually restricted to the community in which the doctor is located.

7. Public detriments

(a) Detriments to the public resulting or likely to result from the substitute authorisation, in particular the likely effect of the conduct on the prices of the goods or services described at 3 (b) above and the prices of goods or services in other affected markets:

(See Direction 8 of this Form)

The existing arrangements for the state-wide negotiation of VMO agreements have worked well to date with no evidence of public detriment. This application for revocation and substitution would see a continuation of these arrangements but with an extension to include Local Hospital Networks (LHNs) and Primary Health Networks.

(b) Facts and evidence relevant to these detriments:

With the exception of Victoria, the vast majority of rural doctors will have no choice but to accept the VMO fees and conditions, which have been negotiated on a state-wide basis, under existing arrangements and with RDA input.

In Victoria, the proposed arrangements are a continuation of those, which have been in place since the previous authorisation, which have not resulted in any known public detriment to date. However, a recent survey of RDAV members and other Victorian rural doctors, the issue of independent contract negotiations has been identified as a critical issue for the rural medical workforce, and RDAV has been requested to address.

In Queensland, with the success of the Rural Generalist Pathway, rural procedural hospital salaried medical workforce have benefited from improved provisions under the Award. However, the same outcomes for general practice have not been achieved. It is critical that GPs working in private practice and providing services to rural hospitals under VMO arrangements have the support and recognition to ensure private general practice is sustainable in Queensland rural and remote communities.

It should also be noted that there has not been and would be no compulsion associated with the proposed arrangements and that all parties can avail themselves of other arrangements.

8. Contracts, arrangements or understandings in similar terms

This application for substitute authorisation may also be expressed to be made in relation to other contracts, arrangements or understandings (whether proposed or actual) that are, or will be, in similar terms to the abovementioned contract, arrangement or understanding

(a)Is this application to be so expressed?

No

(b) If so, the following information is to be furnished:

(i) description of any variations between the contract, arrangement or understanding for which substitute authorisation has been sought and those contracts, arrangements or understandings that are stated to be in similar terms:
(See Direction 9 of this Form)

(ii) Where the parties to the similar term contract, arrangement or understanding(s) are known - names, addresses and description of business carried on by those other parties:
(See Direction 5 of this Form)

(iii) Where the parties to the similar term contract, arrangement or understanding(s) are not known — description of the class of business carried on by those possible parties:

9. Joint Ventures

(a) Does this application deal with a matter relating to a joint venture (See section 4J of the *Competition and Consumer Act 2010*)?

No

(b) If so, are any other applications being made simultaneously with this application in relation to that joint venture?

(c) If so, by whom or on whose behalf are those other applications being made?

10. Further information

(a) Name, postal address and telephone contact details of the person authorised by the parties seeking revocation of authorisation and substitution of a replacement authorisation to provide additional information in relation to this application:

Peta Rutherford
Chief Executive Officer
Rural Doctors Association of Australia Limited
PO Box 3636

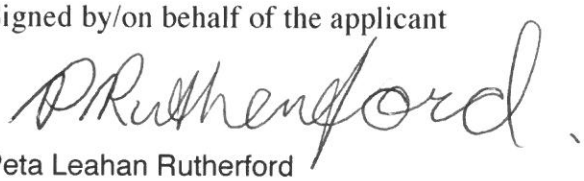
MANUKA ACT 2603

Email: ceo@rdaa.com.au
Telephone: 02 6239 7730

Dated 27 July 2018

To the best of my knowledge and belief, the information provided in this application in response to the questions in this form is true, accurate and complete.

Signed by/on behalf of the applicant



Peta Leahan Rutherford

Rural Doctors Association of Australia

Chief Executive Officer

DIRECTIONS

1. Where there is insufficient space on this form to furnish the required information, the information is to be shown on separate sheets, numbered consecutively and signed by or on behalf of the applicant.

2. Where the application is made by or on behalf of a corporation, the name of the corporation is to be inserted in item 1 (a), not the name of the person signing the application and the application is to be signed by a person authorised by the corporation to do so.

3. In item 1 (b), describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding, or the relevant conduct, in respect of which substitute authorisation is sought.

4. In completing this form, provide details of the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, in respect of which substitute authorisation is sought.

   (a) to the extent that the contract, arrangement or understanding, or the relevant conduct, has been reduced to writing — provide a true copy of the writing; and

   (b) to the extent that the contract, arrangement or understanding, or the relevant conduct, has not been reduced to writing — provide a full and correct description of the particulars that have not been reduced to writing; and

   (c) If substitute authorisation is sought for a contract, arrangement or understanding (whether proposed or actual) which may contain an exclusionary provision — provide details of that provision.

5. Where substitute authorisation is sought on behalf of other parties provide details of each of those parties including names, addresses, descriptions of the business activities engaged in relating to the subject matter of the authorisation, and evidence of the party's consent to authorisation being sought on their behalf.

6. Provide details of those public benefits claimed to result or to be likely to result from the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, including quantification of those benefits where possible.

7. Provide details of the market(s) likely to be affected by the contract, arrangement or understanding (whether proposed or actual), in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the application for substitute authorisation.

8. Provide details of the detriments to the public, including those resulting from the lessening of competition, which may result from the contract, arrangement or understanding (whether proposed or actual). Provide quantification of those detriments where possible.

9. Where the application is made also in respect of other contracts, arrangements or understandings, which are or will be in similar terms to the contract, arrangement or understanding referred to in item 2, furnish with the application details of the manner

in which those contracts, arrangements or understandings vary in their terms from the contract, arrangements or understanding referred to in item 2.

[ii] https://sarrah.org.au/demongraphy-and-population 2016 Census 24.13 million Aust pop.
[iii] http://www.health.gov.au/internet/main/publishing.nsf/Content/Annua-Medicare-Statistics
[v] http://www.health.gov.au/internet/main/publishing.nsf/content/modified-monash-model

[vi] http://www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

[vii] https://www.healthdirect.gov.au/primary-health-networks-phns
[viii] https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health
[xii] Australian Institute of Health and Welfare : Medical Practitioners workforce 2015 report
[xiv] https://www.myhealthycommunities.gov.au/our-reports/gp-and-speicalists-attendances-and-expenditure/june-2018
[xviii] Australian Government Department of Health, NWHDS Medical Practitioner 2013 and 2016

Primary Health Networks – rural service provision

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Wide Bay

Health Service Chief Executive

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RDA NSW Rural Doctors' Association *Caring for the Country*

RDAQ Rural Doctors Association of Queensland

rdasa Rural Doctors' Association of South Australia Inc.

rdav RURAL DOCTORS ASSOCIATION OF VICTORIA SUPPORTING RURAL DOCTORS

RURAL DOCTORS' ASSOCIATION OF WESTERN AUSTRALIA INC.

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