Rural Doctors' Association of Victoria
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9.4.07

The Commissioner
Australian Competition and Consumer Commission
PO 1199 Dickson ACT 2602
Attn Scott Gregson, General Manager Adjudication Branch

<u>Submission re: RACGP Application for revocation and Substitution A 91024</u>

The RDAV thanks the Commission for this opportunity for late comment on the application. This submission concerns and is confined to the additional component of collective bargaining by GPs, in some form of legal association, with their local hospitals. Contract bargaining at a local level is currently the norm throughout rural Victoria as opposed to other States. The RDAV supports renewal of the 2002 determination to allow eligible Associateships to set fees charged to patients attending their rural community General Practice, together with the proposed extension to include negotiation with local hospitals.

In summary, the RDAV supports the application of the RACGP as being in the public good for the following reasons.

1. There is major and continuing rundown of Victorian rural hospital services with resulting lack of access to basic hospital services for many Victorian rural communities
2. This can only be having a negative impact on the health and well being of rural residents and the rural economy as a whole.
3. Diminishing supply and retention of appropriately skilled rural medical practitioners is a principal reason for this
4. Equitable Rural Hospital VMO payments are essential for recruitment and retention of doctors.
5. VMO payments have become uncompetitive with HIC funded community practice. Current low levels work against rural recruitment and retention.
6. Collective bargaining by legally associated practice entities, with legal advice, often using AMA negotiators, is currently the norm throughout the State.
7. Individual negotiation would place a substantial impost on both doctors and hospitals.
8. Currently in rural Victoria, no single medical associateship would supply in excess of $3m services to its local hospital under the Dawson Legislation.
9. It is assumed that the outcome of the RACGP submission will either be for collective bargaining with notice to the ACCC or blanket exemption, rather than a reversion to negotiations by individual doctors.
10. Statutory obligations for rural doctors, which have an inexorable tendency to proliferate, should be minimized in the interests of their effective function as clinicians responsible for advanced practice.

11. Approval will allow Collective bargaining by legally associated practice entities to proceed without the need for a large number of notifications under the Dawson regulations.
12. Approval will facilitate the role of rural practice entities across the State in the recruitment and retention of other appropriately qualified and skilled doctors thus improving rural community access to local medical services.
13. Approval will help accommodate a major trend in the younger workforce towards shorter and more flexible working hours, with the creation of more GP associateships to facilitate the necessary practice structure arrangements.

Workforce, recruitment and retention summary.

Role of rural GPs. Rural communities in Victoria are served by generalist medical practitioners with emergency and procedural capability working both in local hospitals and in their own community general practices. Table 1 is a brief overview of hospital arrangements by State. Fees to community practice and hospital emergency attendees in Victoria, (except in a few instances) are reimbursed by the Federal Government through the Medicare. Except where by accident of history there is no hospital, the presence of a GP serviced hospital implies isolation and the necessity to supply advanced medical services to the local community by local doctors.

A list of rural locations with hospitals in Victoria is attached (Table 2), together with practice and practitioner totals The available information, from our databases as they stand is reasonably accurate but subject to fluctuation and change. Of the larger locations some are omitted because of nil or minor involvement in hospital based practice. Others are included because of as yet significant involvement. The list is not identical to the Department of Human Services (DHS) Victoria list of ‘Rural Enhancement Package’ locations as this is considerably out of date. There is a total of 93 Hospitals, with 37 solo practices and 105 group practices, and a total of 525 practitioners. Except in the larger locations, where a smaller proportion of GPs work in the hospitals, most but not entirely all of these practitioners will be VMOs. The total number of doctors covered by this submission might not exceed 450.

Loss of facilities. From 1985 in Victorian smaller towns, community access to local medical services has progressively reduced through loss of obstetrics (<90 locations) and theatre facilities, reduced number of days in residence by doctor, participation in on-call rosters with other often distant towns, loss of specialist visiting service, loss of local doctors, loss of acute beds, reduction to aged care facility, weekly branch surgery to no medical presence. A number of towns now without services have been excluded from the list provided . Currently 5 rural communities in Victoria are known to be without resident doctors and an additional 25 have lost all their acute beds since 1991 (Table 3 also details obstetric closure).

Medium sized towns formerly thought immune to this process are starting to be affected, particularly by the loss of obstetrics, which is a major blow to any population catchment particularly over 3000. It is particularly urgent to halt the decline in towns over this size. In Victoria 37 Towns still with functional Obstetrics and Caesar capability are identified on the list. 12 currently have marginal viability. On current trends most of these will lose this capability by 5-10 years time as doctors retire. The question is whether Government can or will take effective action to prevent this happening Anecdotally, births before arrival at obstetric units are becoming increasingly common throughout rural Australia but there is no State register of these sentinel events in Victoria.

The **large town hospitals** of Hamilton, Horsham, Wodonga, Traralgon, Sale and Waragul still have considerable dependence on generalists. We have not included Wangaratta, Shepparton, Bendigo, Ballarat, Warrnambool and Mildura at this time but, given the greatly diminished supply of specialist obstetricians, and the plateauing of emergency physician supply, there is no guarantee that they will not have to attempt to revert in due course to greater use of generalist rural doctors. Of course closure of services in medium sized towns will alter equations in larger towns. The closure of small town services has put a lot of workload pressure on medium sized towns, particularly with patients presenting to medical services later and sicker.

The number of **Australian graduate recruitments** to rural has fallen steadily off in the last 15 years. The number of female Australian graduates working in rural is rising and currently in excess of 32%. The lure of specialist and metropolitan practice has been augmented by: failures in recognition of rural medicine (rectified by COAG in 2006), lack of appropriate training streams (scheduled for rectification in 2007), and proper remuneration. A reflection of the situation is seen in the size of age cohorts (Table 4) in the pivotal categories of GP Anaesthetists and Obstetricians. These cohorts now are retiring, giving urgency to the need for effective action to renew their numbers.

There is growing dependency on **doctors from overseas**, which is set to deepen prior to the coming availability of expanded training output in 6-10 years time. It takes 5 years of postgraduate experience to train rural doctors. The numbers are difficult to assess because there are many long standing immigrant GPs and 32% would be an underestimate, this rising to 60% in some areas like the Mallee. Established GPs will be assisted by rural registrars and residents but will have a substantial supervision and teaching burden. Rural medical 'teaching centres' are appearing, with medical students, post-graduate residents, junior and senior registrars and overseas doctors in training.

Rural recruitment is the responsibility of the doctors themselves, except in some single doctor locations where hospitals now also operate the community practice. Practices go to great lengths to find doctors, even traveling overseas to find suitably trained doctors. Once a potential recruit has been identified a long process commences of negotiation, agreement, settling in, tuition, and family and financial support which may take 5 years to complete. The Rural Workforce Agency of Victoria assists by finding doctors but lately seems to be having less success than the Warracknabeal-based corporate Tristar.

Victorian rural **corporate involvement** is limited to **Hazelwood** (Community only CO) in Churchill, Morwell,Wonthaggi, Phillip Island just closed (and Frankston); **Gemini** – Apollo Bay; and **Tristar** Horsham (CO), Portland (CO), Warracknabeal (Base), Penshurst, Nhill/Kaniva, Jeparit/Rainbow. The latter 2 have campuses in other states. The Government-supported introduction of Hazelwood into Phillip Island resulted in the loss of procedural medicine, an exodus of established GPs, current incipient closure of beds, and severe strain on Wonthaggi.

From internal surveys of our members conducted by RDAV **recruitment optimism** in Victoria hovers around 0-2/10 statewide. Practices with a genuine commitment to their community, usually with substantial infrastructure investment, are having huge difficulties finding doctors capable of conducting necessary hospital work. This has been compounded by greatly improved Medicare reimbursements, making hospital VMO practice uncompetitive with community medicine. This is further exacerbated by Federal Government policies designating fringe metropolitan zones as areas of need, reducing effectiveness of established rural incentives .

At the same time, with Federal and State support, rural doctors have been immensely active in creating **educational streams** for Australian graduates, forming the Australian College of Rural and Remote Medicine, regional training programs and rural medical schools, and fostering procedural training in the few positions available. With the responsible cohort of rural doctors rapidly ageing, coupled with a lack of workforce replenishment, there is a real danger of these initiatives failing in the not so distant future. The prospect of many more communities deprived of medical services is quite daunting.

The structure of legally constituted rural medical practice entities has been changing away from legally constituted partnerships sharing profits, to associate arrangements sharing expenses, and to independent sole traders billed for expenses by a management entity. Associate structures are progressively becoming the norm because of their greater flexibility in accommodating differing skill and work levels between doctors. Younger, especially female, Australian and overseas-derived doctors favour **sole trader status** as it provides more flexibility for reduced working hours, improved lifestyle, and better ongoing career management. Practice management has remained the same, with shared patient records, practice policy, individual choice of bulk-billing, and organization of on-call rosters. Regrettably it carries with it less long-term commitment and often no infrastructure investment, but this is the reality for the 21st century. Ownership of rural surgeries may pass into the non medical sector, such as local investors, Shires or community groups, unless uptaken by hospitals. Anything but ownership by doctors threatens long term doctor residence, continuity of patient care, and the necessary balance between locally delivered acute and preventive care for the community.

Victorian Rural Hospitals: status and industrial negotiation.

Triennial contract negotiations were instituted by the Kennett administration. Since inception these have been between hospitals and practice entities. AMA negotiators have been involved in many negotiations. The RDAV also gives advice.

Victorian Hospitals are independent Crown Entities and are understood to differ in this respect from other States. The State therefore says that it is unable to negotiate on behalf of hospitals or to dictate to them levels of remuneration, and cannot introduce state-wide measures as in other States.

The **State has provided an on-call package** currently approximately $26,000 annually for 24/365 on-call arrangements. This was introduced for all hospital (101) locations in 1999 and indexed annually since then. 12 locations have since dropped off the list of providers of after hours care. This package was understood originally to be for availability for accident and emergency care, but has increasingly become absorbed into hospital budgets or otherwise made part of contractual packages. It is possibly going to be revised this year following a 2006 election promise by the incumbent Minister of Health to increase on call allowances to over $60,000 per annum. In this sense the State has taken a step towards uniform conditions for rural doctors. The State is also negotiating through COAG for the Commonwealth to provide more clearly designated payment for A&E services in all the vast majority of Victorian rural hospitals that have unfunded A&E services. The State has argued that A&E patients in unfunded locations are not its responsibility until admitted, but there are signs that it may be starting to accept that it has some responsibility for this service.

Rural doctors extend their **community vocation** into considerable unpaid voluntary hospital duties in clinical governance and administration. High standards of clinical care can only be established through solid clinical cooperation between visiting doctors and nursing or other staff, suitably evolved clinical protocols and a strong and amicable sense of team spirit. The high demands of rural practice, especially the need to juggle after-hours call-out with often just as urgent day-time practice based work, can take a high toll on the individual. Adequate rural manpower and resources are not available to ensure safe working hours, especially with an ageing diminishing workforce with increasing commitments to education and training, and greater statutory demands for continuing professional development. The Australian Council for Safety and Quality of Health Care Standards has recognized the need for governance to be shared with doctors in their published recommendations.

Triennial hospital negotiations are a major cause of dissatisfaction in rural VMOs. This message has been coming through loud and clear for several years from all over the State. Hospitals are under great budget pressure and seek to minimize the cost of medical practitioner services at every negotiation. The resultant ill-will severely hampers the operation of clinical governance and threatens good patient management. Representation from within associateships and partnerships limits to an extent the spread of such ill-will amongst the doctors involved. It is more than likely that hospital administrators find it as stressful as doctors. A reversion to negotiation by each individual doctor would in our opinion be highly destabilizing, and create far more tension, not only between doctors and hospitals but also within associateships and partnerships. It can be noted that the implementation of a satisfactory State Award in South Australia 2005 has according to our information greatly reduced the number of rural medical vacancies in that State.

Doctors are trained as clinicians not businessmen. Rural doctors especially have a heightened level of clinical responsibility but the same level of medicolegal responsibility as their metropolitan colleagues and prefer to concentrate on optimizing clinical outcomes, often life and death matters, rather than business matters. In the short term hospitals can take advantage of business-naïve doctors, but in the long run they will lose good will and the trend to seek shelter in Corporate practices or leave altogether will be accentuated.

Provision of rural services. The RDAV advocates the provision of appropriately resourced local medical services for rural communities. Wherever possible this should be by appropriately trained generalist rural medical practitioners supported by locally based health infrastructure. Emphatically rejected is the often expressed view that locally based rural services should be abandoned because of changes of economics, safe working hours or requirements to meet metropolitan standards of health care. Absent local health service means for the community poor health outcomes and often abandonment of the rural ideal. Australia has to accept the uncomfortable fact that the tyranny of distance means that alternative methods of health care delivery are necessary for rural communities. All the evidence has been that given appropriate resourcing and support, rural doctors can be extraordinarily effective in providing outcomes quite comparable with and sometimes better than metropolitan health services. This is particularly the case in urgent medicine and obstetrics.

Approved practices. If it is agreed that the maintenance of rural hospital services is desirable in Victoria then it will be necessary to provide a remuneration structure which is competitive with other sectors of medical practice. The model of private sector medical practices providing visiting medical services to rural hospitals has been durable for many years, but is currently threatened by a number of factors. Replacement of Visiting MOs by Resident MOs on contracts is hugely expensive, necessitates reduced numbers on roster and results in greatly increased time onus on incumbents, such as the 3 weeks' continuous solo on-call required of Queensland rural RMOs. To change over to an RMO model the State would have to first facilitate widespread shutdown of services still open.

The RDAV therefore supports the application by the RACGP as being a sensible continuation of the status quo. It would be seriously detrimental in terms of recruitment and retention to a workforce currently in crisis, to impose individual negotiations on each and every Visiting Medical Officer. Further negotiations could be held with the RDAA and its constituent State groups, with long experience of rural industrial matters, to facilitate awards which give predictability to a career in rural medicine in the same way as careers in metropolitan specialist and general practice. Published data on rural practice, in the Commonwealth funded Viable Models Project demonstrated that rural practice becomes more costly and complex from regional through rural and remote and that economic determinants are critical in determining retention of rural doctors.

It is noted that for practical purposes the term **'fee-setting'** fits the activity of adjusting community consultation fees to economic circumstances, whereas the contract

negotiations conducted with hospitals on a triennial basis in Victoria (annual in some inter-state locations), fixes fees for that period by bilateral agreement with hospitals.

If **certification of negotiating practice associateships** is unavoidable, as in the 2002 determination, then the RDAV recommends the AMA (already responsible for certifying incorporated practices) or RDAA as certifying body. Despite the AMA current reservations about the RACGP application, it is more appropriate for an industrial body to provide this role, rather than a medical college, in the best interests of General Practice academic standards, the proper domain of the RACGP. The recent approval of the Fellowship of the Australian College of Rural and Remote Medicine by the Australian Medical Council is noted, which endorses the ACRRM as an appropriate arbiter of academic standards for the rural regions discussed in this submission.

This submission has been prepared in a short space of time and can be further elaborated if necessary.

Table 1. National Overview of Rural Hospital arrangements
Based on a brief email survey of RDA Presidents
WA: negotiations in some locations. Resident Generalist Medical Officers in a number of locations. State wide package provided. Further information requested.
SA: State package since 2005. Like Victoria, most A&E services in small rural hospitals are not funded by the state.
Qld: Resident Generalist Medical Officers in most locations. GPs in larger towns have right of private admission and do in some instances conduct contract negotiations
NSW: State package since 1987. Negotiated annually with RDANSW. Very effective in improving retention. A handful of locations not in this award where negotiations probably take place
Vic: Individual contract negotiations in all locations
Tas: Not many locations. Basically State set contracts. At least one Corporate involved
NT: Mainly salaried positions

Table 2 Victorian rural hospitals	Total GP	Solo Practice	Group Practice	GP workforce	Procedural	Additional Specialists
Alexandra	3		2			
Apollo Bay	4		2			
Ararat	9		1		Obstetrics/Theatre	
Bacchus M	13		2		Obstetrics/Theatre	y
Bairnsdale	22	1	2		Obstetrics/Theatre	
Ballan	2		1			
Beaufort	1	1				
Beechworth	6		1			
Benalla	16		2		Obstetrics/Theatre	
Birchip	1	1				
Boort		0		no resident		
Bright	3		1		Obstetrics/Theatre	
Camperdown	8		2		Obstetrics/Theatre	

Casterton	5		1			
Castlemaine	15		4		Obstetrics/Theatre	
Charlton	1	1				
Cobram	10		2			
Cohuna	4		1		Obstetrics/Theatre	
Colac	13		2		Obstetrics/Theatre	
Coleraine	5		1			
Corryong	3		1		Theatre	
Creswick	4		1			
Daylesford	8		2		Obstetrics/Theatre	
Dimboola	2		1			
Donald	1		1			
Echuca	19		2		Obstetrics/Theatre	
Edenhope	2		1			
Euroa	5		1			
Foster	6	1	2		Obstetrics/Theatre	
Hamilton	11		1		Obstetrics/Theatre	y
Healesville	4		1		Obstetrics/Theatre	
Heathcote	2	1				
Heyfield	2		1			
Heywood	2	2				
Hopetoun	1	1				
Horsham	11		3		Obstetrics/Theatre	y
Inglewood	1		1			
Jeparit	1					
Kaniva				no resident		
Kerang	7		2		Obstetrics/Theatre	
Kilmore	8	1	2		Obstetrics/Theatre	
Korrumburra	8		1		Theatre	
Kyabram	10	1	1		Obstetrics/Theatre	
Kyneton	4	1	1		Obstetrics/Theatre	
Leongatha	11+		1		Obstetrics/Theatre	
Lorne	1	1				
Maffra	7		2			
Manangatang	1	1				
Mansfield	9		2		Obstetrics/Theatre	
Maryborough	6		2		Obstetrics/Theatre	
Mt Beauty	5	1	1		Obstetrics/Theatre	
Myrtleford	6		1		Obstetrics/Theatre	
Nagambie	1	1				
Nathalia	3		1			
Neerim	2		1			
Nhill	3		1			
Numurkah	7		2			
Omeo	4		1			
Orbost	2		1		Obstetrics/Theatre	
Ouyen	1	1				
Penshurst	1	1				

Phillip Island	5		1			
Port Fairy	5		1			
Portland	13	1	3		Obstetrics/Theatre	
Rainbow				no resident		
Robinvale	2	2				
Rochester	2	1				
Rosebud				no info		
Rupanyup	1			no resident		
Rushworth	1	1				
Sale	25		4		Obstetrics/Theatre	y
Sea Lake	2		1			
Seymour	11	1	2		Theatre	
Skipton	1	1				
St Arnaud	2		1		Obstetrics/Theatre	
Stawell	9		2		Obstetrics/Theatre	
Swan Hill	10		1		Obstetrics/Theatre	
Tallangatta	2		1			
Terang	4		1		Obstetrics/Theatre	
Timboon	2		1		Obstetrics/Theatre	
Traralgon	17	2	2		Obstetrics/Theatre	y
Walwa	1		1			
Warburton				inadequate info		
Warracknabeal	3	3			One practice closing	
Warragul	28	3	3	Few at hospital	Obstetrics/Theatre	y
Willaura				no resident		
Winchelsea	1	1				
Wodonga	Inadequate Info		>2	12 GP Obstetricians	Obstetrics/Theatre	y
Wonthaggi	17		2		Obstetrics/Theatre	
Wycheproof	1	1				
Yarram	2	2				
Yarrawonga	11		2		Obstetrics/Theatre	
Yea	4		2			
locations = 93	**525**	**37**	**103**		**Obstetrics 37**	

Table 3. Closures

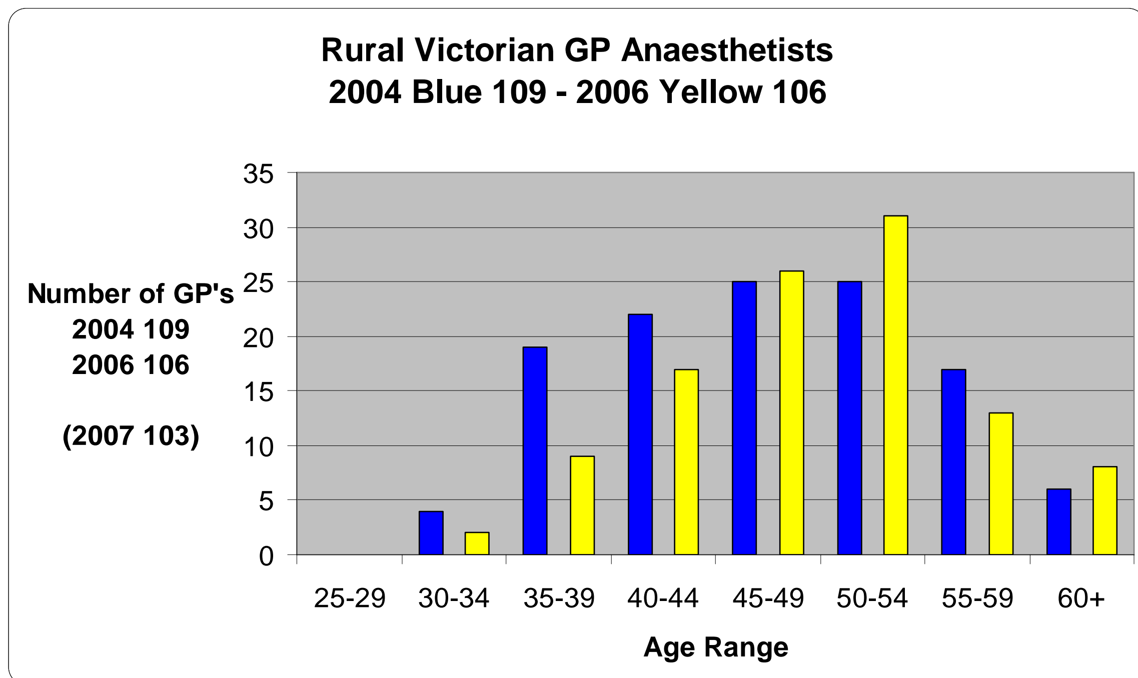
Locations (25) with full acute bed closure since 1990: Kooweerup, Rutherglen, Chiltern, Rutherglen, Eildon, Tongala, Rushworth, Maldon, Dunolly, Clunes, Trentham, Lismore, Mortlake, Cobden, Birregurra, Beeac, Koroit, Avoca, Lake Bolac, Beulah, Natimuk, Pyramid Hill, Wedderburn, Redcliffes, Murrayville.

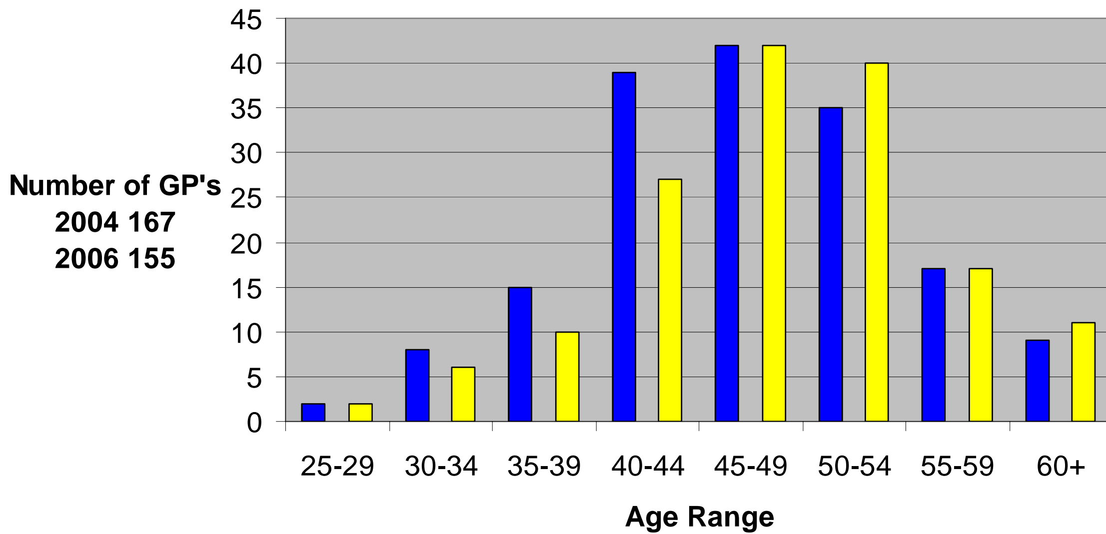
Obstetric Units closed since 1983: **(86)**: Alexander, Apollo Bay, Avoca, Ballan, Beechworth, Beulah, Beeac, Birchip. Birregurra, Boort, Casterton, Charlton, Clunes, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Dunolly, Eildon, Edenhope, Elmore, Euroa, Gisborne Heyfield, Heywood, Hopetoun, Inglewood, Jeparit, Kaniva, Kooweerup, Koroit, Korrumburra, Lancefield, Lismore, Lorne, MacCarthur,

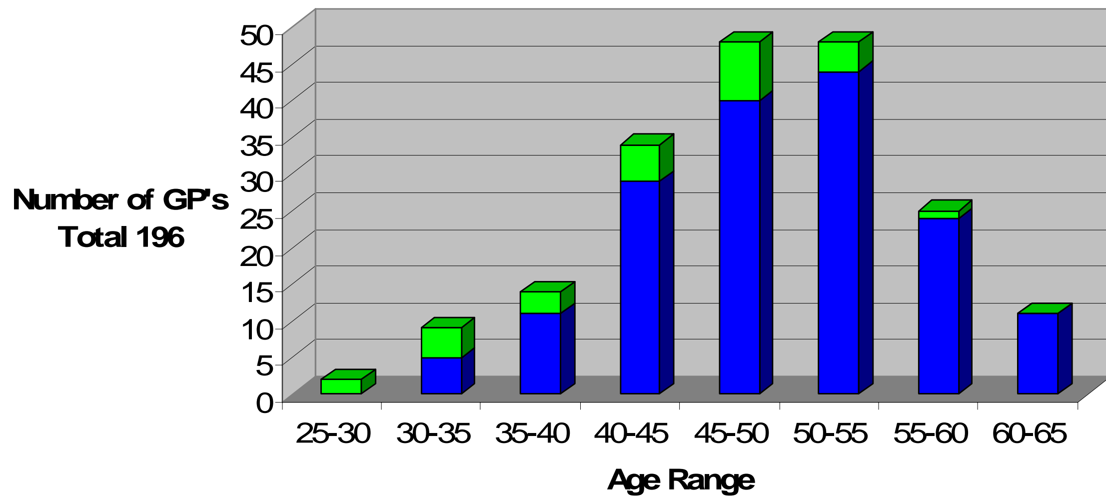
Maffra, Maldon, Manangatang, Minyip, Mirboo Nth, Moe, Mortlake, Murchison, Murrayville, Murtoa, Nagambie, Nathalia, Natimuk, Neerim South, Nhill, Numurkah, Nyah West, Omeo, Orbost, Ouyen, Penshurst, Port Fairy, Pyramid Hill, Rainbow, Redcliffes, Robinvale, Rochester, Rupanyip, Sea Lake, Seymour, Skipton, Sunbury, Talangatta, Tatura, Tongala, Trentham, Walwa, Warley, Warracknabeal, Wycheproof, Wedderburn, Willaura, Yackandanda, Yarra junction, Yarram, Yea.

Obstetric Units closed since 1997: (**35**): Alexander, Beechworth, Birchip, Boort, Casterton, Charlton, Cobram, Coleraine, Corryong, Cowes, Creswick, Dimboola, Donald, Edenhope, Hopetoun, Korrumburra, Lorne, Maffra, Maldon, Nathalia, Nhill, Numurka, Omeo, Ouyen, Penshurst, Port Fairy, Rosebud, Rupanyip, Seymour, Talangatta, Tatura, Warracknabeal, Wycheproof, Yarram, Yea,

Table 4. Rural Victorian Proceduralists: Attrition by age cohort.




Rural Victorian GP Obstetricians
2004 Blue - 2006 Yellow
Number of GP's
2004 167
2006 155
45
40
35
30
25
20
15
10
5
0
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60+
Age Range


Rural Victorian GP Obstetricians and Anaesthetists
2006 (single or dual capability)
Blue = 163 male, Green = 27 female
Number of GP's
Total 196
50
45
40
35
30
25
20
15
10
5
0
25-30
30-35
35-40
40-45
45-50
50-55
55-60
60-65
Age Range