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RDA RURAL DOCTORS ASSOCIATION OF VICTORIA

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RDAV Submission: Collective Bargaining notification CB00004 lodged by AMA (Vic)

The RDAV has been invited to make comment. It has no intrinsic objection to the submission. As part of its remit, the RDAV represents rural general practitioners who are trained in and provide services to rural Public Hospitals (GP VMOs). It is noted that the names of a number of GP VMOs are included in the application, along with specialists from sundry locations. These doctors are from a number of locations including Sale, Korrumburra and Foster, where they also provide such services.

The Latrobe Regional Hospital is situated just outside the town boundary of Traralgon and represents an attempt to consolidate area services into one campus, which was achieved by closing Moe hospital. The town of Traralgon does not have the critical mass of population, services or amenities to generate the cohort of resident doctors and specialists necessary to support a Base Hospital. For this reason it is forced to depend on specialists visiting from Melbourne and has ongoing problems filling its rosters for acute and emergency services including obstetrics. Even in the early 90s, prior to the 'amalgamation' Traralgon was forced to import GPs from South Gippsland for example to provide a Caesarean service.

GP VMOs form a logical, able and experienced workforce to support such services. The RDAV has submitted to thee State Ministerial Public Medical Workforce Inquiry (www.rdav.com.au) that the GP VMO workforce should be given status and support to put it on a permanent footing in rural public hospitals. These doctors are far more likely to be settled in the local area and to provide stable round the clock services in suitable roster arrangements.

GP VMOs were not included in the HMO agreement concluded by the AMA with the State in 2006, which presumably set agreed levels for remuneration throughout public hospitals. As a consequence, VMO rates continue to be set through contract negotiations. The ACCC (Authorisation no A91024) has in 2007 approved such negotiations between individual hospitals and GP practice entities on behalf of their members supplying VMO services. The submission for authorization was made by the RACGP. The AMA did not support the application, unable to perceive "a public benefit……in respect of a limited group of general practitioners". The RDAV supported the application, saying that it was a vital step to slow the current near-catastrophic decline in rural GP VMO services.

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The RDAV holds that the public benefit would be served by a uniform award throughout the State for GP VMOs, and this would support a viable generalist teams in rural hospitals, as it does in Queensland, NSW and SA, allowing such hospitals to provide effective urgent services appropriate to their distance from tertiary services.

In the interim the RDAV supports arrangements which foster team harmony within and between visiting doctors and hospital staff and create a flow on effect into clinical operation and governance. Individual contract agreements fragment rather than foster such team arrangements, create disparities between locations where VMOs carry similar responsibilities and workloads, detract from rural procedural work as a career pathway, and are part of processes which appear to be progressively eliminating GP VMOs from rural medicine in Victoria and with them the vital urgent services that they provide.

Reports to us indicate that Latrobe RH would like to replace GP VMOs with specialists and does not have a policy to train and foster GP VMO services. We do not see this as being in the best interests of the needs of the local population. The Obstetric workforce at LRH especially remains depleted. All indications are that the supply of Australian trained obstetricians is diminishing. It is to be noted that procedural GPs work effectively as equal rostered partners in anaesthetics and obstetrics in locations such as Hamilton and Horsham.

The RDAV considers that the importation of often third world obstetricians and other specialists to acquire often unsupervised experience in larger rural Victorian hospitals, prior to moving to metropolitan hospitals, runs a poor second to trained GP VMOs in terms of effectiveness, and encourages a flow of specialists from countries where they are trained and vitally needed.

Latrobe RH hospital covers about 50,000 (Traralgon, Moe, Morwell, Churchill) population and provides limited services to the rest of the region. It would never be able to provide satisfactory services to the whole of Gippsland. It is vital that other hospitals remain open and provide urgent services. A recent UK study suggests that mortality rises by 1% for every extra 10Km (http://emj.bmj.com/cgi/content/abstract/24/9/665) traveled by ambulance**.**

In East Gippsland, events in Traralgon have little effect on **Bairnsdale** (Pop 17,500 East Gippsland News prime circulation area), a GP VMO hospital serving the Eastern end of the State, which tends to transfer by air to Melbourne at this time. **Sale** serves a population of around 20,000 (East Gippsland Times PCA 22,000) and needs an active hospital and acute services including obstetrics. There is every indication that policy is to downgrade Sale in favour of LRH and the hospital is facing substantial difficulties with effective urgent cover. In that sense allowing Tralalgon to build up would not favour provision of services in Sale, but this is a matter for hospital provision rather

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than any competition between doctors. Substantial services have been lost in **Heyfield** (Pop 2000) and **Maffra** (Pop 4500)

In the West **Warragul** serves 19,5000 RRMA 5 population (Warragul Gazette PCA), at 60 Km from Traralgon and 70Km from Dandenong. Downgrading or closing Warragul would impose severe impost on the population. Warragul refers patients to Melbourne.

Any reference to **South Gippsland** is irrelevant since it is geographically isolated from Traralgon and relates directly to Melbourne for transfer of patients. Some doctors travel to LRH to work more for their own interest and upskilling than for necessity or part of a health services process, and as mentioned LRH and Traralgon BH before it have had good value from these doctors over the years.

Of the doctors listed, XXXXX are GP VMOs from Locations in Traralgon, Sale, Moe, Korumburra, Foster and Wonthaggi. The AMA is proposing to jointly negotiate terms and conditions for both GP and Specialist VMOs. Work involved would be in obstetrics, anaesthetics and presumably emergency. Added to the specialists involved, this involves a disparate number of fields with quite a degree of complexity of negotiation.

The wide spread of addresses of those represented by the AMA in the submission indicates that LRH is dependent on non-resident doctors for its services and must be paying shift rates. This differs from the usual fee-for-service arrangements for GP VMOs, and is a much more expensive option than for locally resident on-call doctors.

The willingness of specialists to travel out from Melbourne sometimes reflects an over-supply there. On other occasions specialists can be difficult to find, and additional funds are provided from the Medical Specialist Outreach Assistance Program (**MSOAP**). This varies between the specialities. At present for rural, orthopaedic surgeons are in better supply and ENT surgeons are scarce.

The AMA however is familiar with terms and conditions in other Base hospitals where GP VMOs are involved, for example emergency in Wangaratta and Obstetrics in Wodonga, and with the rates of pay agreed to for HMOs. This exercise has the potential to put procedural GP VMOs on a proper footing in the hospital vis a vis their specialist colleagues.

Yours sincerely,

Mike Moynihan, President

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