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VHIA

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To:	Adjudication Branch Australian Competition & Consumer Commission	**From:**	Alec Ojoneff
Fax:	02 6243 1199	**Pages:**	19 Including cover
Phone:		**Date:**	04/02/08
Re:	Application for Authorisation A91078	**CC:**	

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Dear Ms. Arnaud,

Please find attached submission with respect to the above application for authorisation by the RDAA.

VHIA
Victorian Hospitals' Industrial Association
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4 February 2008

Ms. Isabelle Arnaud
Director
Adjudication Branch
Australian Competition &
Consumer Commission
GPO Box 3131
Canberra ACT 2601

Fax: (02) 6243 1199

Dear Ms. Arnaud

Re: Application for authorization A91078

Please find attached the Victorian Hospitals' Industrial Association submission with respect to the above application for authorisation by the Rural Doctors Association of Australia Ltd ("RDAA").

In summary form we submit that this application should be rejected by the ACCC as it lacks merit in regards to the information relied on as well as being at odds with the Act in so far as the VHIA contents that the public detriment far outstrips any public benefit.

By way of moving forward, the VHIA submits that there maybe merit in a different approach, but this cannot nor should be based on a fee for service approach. Nor can it be the subject of this application.

Should the ACCC require any further information please contact Mr. I. Oostermeyer at the VHIA.

Yours sincerely
VICTORIAN HOSPITALS' INDUSTRIAL ASSOCIATION

Alec Djoneff
Chief Executive Officer
101L/4507J

VICTORIAN HOSPITALS' INDUSTRIAL ASSOCIATION SUBMISSION

RDAA APPLICATION FOR AUTHORISATION ACCC

RURAL MEDICAL GENERAL PRACTITIONERS (FEE FOR SERVICE CONTRACTORS)

4 FEBRUARY 2008

The VHIA confirmed that this document may be placed on the PR. SC 25/2/08.

Executive Summary

The ACCC's only function in considering the RDAA's application is to apply the test set out in Section 90 (1) of the Act. The test is whether the applicant has established the fact that the agreement or outcome achieved as a result of the application results in a benefit to the public that outweighs any anti-competitive effect.

The VHIA submits that the ACCC should dismiss the application as provided under Section 90 (1) of the Act. The reasons are simply that the detriments to the public far outweigh the benefits to the public.

The VHIA submits that the application would result in the following:

1. An increase in the cost of delivering medical services to in-patients;

2. An increase in the cost of delivering on-call services to both in-patients and out-patients as well as "private" patients including on call payments for GP's and Specialist VMO's in those Health Services that currently do not receive the REP Payments;

3. Fewer medical services being provided to the public;

4. A dysfunctional relationship between GP VMO's and hospitals;

5. A role for the RDAA and its constituents which it will be unable to perform;

6. Fewer bulk billing arrangements;

7. Immediate flow on to VMO Specialist 'Fee for Service' Payments.

The concept of a common Schedule of fees is attractive as such. It would provide certainty and obviate the need for local negotiations. However this would come at a cost. The detriments include funding uncertainty, a loss of direct relationships with the medical workforce, a lack of flexibility for local conditions, and an inability to ensure that the Schedule is 'enforced'. Unlike the previous 'Fee-For-Service' Award in Victoria, a common schedule cannot ensure uniformity. It would be an opt-in and opt-out system lending itself to uncertainty.

In any event, a common schedule is impractical at this stage without first doing the preparatory work required. This work would centre on the funding arrangements and maintenance of services and the quality of medical services to the public among other things apart from the aforementioned issues.

The Current Environment

1. In terms of the application there are approximately 60 – 70 health services that would engage VMO's on a 'fee for service' basis. These would range from large and complex services to small rural hospitals with as few as 12 acute beds. The General Practitioner VMO is largely concentrated however in the smaller rural hospital.

2. All of these health services supply after hours services by way of emergency departments. None of the smaller hospitals (commonly referred to as Group C, D and E) are funded by the State for out patient services. An annual sum is provided by the State to these health services, but only to supply on-call services (i.e. availability at the end of the phone and for possible recall). Any emergency services supplied at these smaller hospitals on site after hours are supplied on a private provider basis by the General Practitioner(s) where the patient is either bulk-billed or a fee is levied in accordance with the billing practice of the VMO GP or relevant Medical Practice. The larger rural hospitals (commonly classified as Group B Hospitals) all have funded emergency or outpatient (ambulatory) services.

3. There are four broad categories of medical staff working in Victorian public hospitals and community health organizations:

   (i) hospital medical officers (HMO) consisting of interns, residents and registrars;
   (ii) specialists (full time or visiting);
   (iii) clinical academics; and
   (iv) general practitioners.

4. All medical practitioners in Victorian public hospitals were covered by State awards until they were abolished in 1993. This included 'fee for service' medical practitioners. These awards were regularly reviewed until 1992.

5. The current VMO arrangements in this state are as follows:

   (i) Large Metropolitan and regional hospitals primarily staffed by full-time salaried specialists and part time sessional visiting specialist;

   (ii) Some rural base hospitals which engage 'fee for service' visiting specialist to provide specialist services with limited resident medical staff support; and

   (iii) Rural hospitals which engage general practitioners to provide the core of medical care and where visiting specialists visit only on a regular or occasional basis paid on a fee for service basis.

6. The 'fee for service' VMO is either engaged by the Health Service as a contractor or in a small number of cases as an employee pursuant to Australian Work Place Agreements or on an Enterprise Bargaining Agreement. None of the 'fee for service' Practitioners engaged as contractors or working as employees receive the benefits of the regular Enterprise Bargaining Agreements between the AMA and VHIA which cover employed doctors.

7. The fee for service contracts in most cases are negotiated between the Hospital and the Medical Practice or the Medical Practitioner. In most cases the AMA (Vic) represents an individual Practitioner or Practice depending on who has approached them for assistance. They have a sophisticated protocol to ensure that their representation is not in breach of the Trade Practices Act. The VHIA would in most cases represent the Health Service and the outcome is a local agreement and a Schedule setting out the remuneration based in large part on the CMBS Schedule. On an infrequent and occasional basis, the RDA represents the medical practitioner and assists in the negotiation of a new contract with the Health Service.

8. Increases in the fees paid or additional payments for non-patient activity by general practitioners are commonly negotiated on a three-yearly basis, and any increases in fees are based on the percentage increases in public sector medical staff wages. The reliance on the CMBS increases has ceased in large part as these are often less than the relevant CPI. In fact the AMA in its List of Medical Services and Fees 2006 sets out this difference in their 'Fee Gaps Chart' the *Indices of CPI, AWE & Medical Fees (AMA & MBS (p.438)*. This List has its origins in 1973 and has been published every year since except in 1983. It originates from the establishment of the Gorton Government's medical benefits scheme in 1970.

9. The outcome of the various negotiations in most rural hospitals is a Schedule of Fees, based in large part on the CMBS, but specifying radically different percentages. The % of the CMBS variation is between 100% CMBS to 130%CMBS and in some cases up to 150% CMBS for recall after hours. The Schedule of fees attached to contracts with General Practitioners may contain the following:

- CMBS % for Consultations;
- CMBS % for Minor Surgery (usually paid at Specialist level);
- ASA RVG fee (range of $20 RVU - $26 RVG);
- CMBS RVG (Similar range but different weightings);
- CMBS % for Obstetrics;
- Health Service Fees List for Specific Items such as multiple consultations;
- Additional % CMBS for Recall after hours;

- On-Call fees based on REP Payment (DHS Rural Enhancement Package currently at about and regional hospitals0;
- Fee for Telephone Consultation;
- Fee for attendances at Meetings (between $100 p.h. - $140 p.h.)
- Practice Payment fee of up to $20,000 p.a.;
- Medical Indemnity part payment;
- Arrangements for payment of support staff and IT systems;
- Requirement in all cases to provide on-call services for 24/7;
- Minimum increase – usually 3% guaranteed p.a.

In some cases, low cost or no-cost housing is also made available, but normally for a new GP first arriving in town. In other cases Hospital owned Consulting Rooms and General Practice Buildings are made available for no or a nominal rent. Facility fees are not paid by any Practitioners as far as we are aware.

10. The contract used in most cases is a standard contract agreed some time ago between the VHIA, AMA (Vic), RDA and VMIA. There are different contracts in place with different detail, but most are based or stem from the Lochtenberg Report which first set out a 'Model Employment Agreement for Visiting Specialists' in 1995.

Fee for Service VMO

11. The Fee For Service Medical Officer Award (abolished in 1993) in Victoria, a system to which this application in effect, seeks to return (i.e. a common schedule), applied to both specialists and general practitioners appointed to the medical staff of a hospital to provide medical services on a fee for service basis. The award was rather straight forward and simple. It only provided for appointment, duties, powers and obligations, locums, facilities, termination, and appeals procedures as well as a schedule of fees to be paid according to the service provided. There were no provisions for paid leave, nor for superannuation for VMO's engaged on a fee for service basis.

12. The Award was updated regularly including frequent decisions to grant percentage increases. The last increase in the Award was on 1 December 1991. The Award was quite extensive in so far as it encompassed a large number of 'item numbers' which are also found, and are comparable to the Commonwealth Medical Benefits Schedule ("CMBS"). The latter commenced in 1970 and is updated annually and item numbers commonly adjusted on 1 November of each year. The CMBS has replaced the Award in Victoria and is now the basis of payment of fees to General Practitioners who deliver services to rural hospitals. There are some exceptions to this 'norm' where in some cases hospitals use both the CMBS as well as their own list of fees.

13. The other 'item list' that is used by rural hospitals and others is in the case of anaesthetic procedures. In this case the majority of rural hospitals use the Australian Society of Anaesthetists ("ASA") list and determines, through negotiations with the VMO, a local dollar amount per Relative Value Unit (RVU). Currently the RVU range in Victoria is between $20 and $26.

14. The major advantages of fee-for-service GP medical practitioners are perceived as being:

- Flexibility as payment is limited and linked to services actually performed;
- Consistent with case-mix funding in terms of complexity of work actually performed;

The disadvantages are perceived as follows:

- With specialist it may compromise continuity of care in terms of 'after care' where the specialist attends rural hospitals on an infrequent basis or 'fly-in fly-out' arrangement;
- Not conducive for other activities (i.e. attendances at meetings; on call services; training; non-patient care activities generally);
- Limited ability to control costs;
- Difficulty monitoring services actually supplied;
- Casual type of engagement

15. As a result, the *Ministerial Review of Medical Staffing in Victoria Public Hospital System* published in June 1995 and commonly known as the 'Lochtenberg Report' strongly recommended 'fractional appointments' as the way forward. This it was felt envisaged a system whereby in lieu of fee for service medical practitioners will be engaged *"for that fraction (or proportion) of a true full-time commitment expected to be necessary to meet the responsibilities associated with a defined group of public patients or related activities"* (p.47). The fraction would reflect both the expected number of patients and the complexity of their treatment and the extend to which medical practitioners would be expected to carry out related activities and be available or provide services outside normal working hours.

16. The advantage of this system, rather than fee-for-service were perceived as follows:

- Continuity of Care;
- All-up care;
- Flexibility;
- Capacity to budget and predict annual medical costs;
- Identifying the full range of activities up front;

- Recognise management responsibilities by medical practitioners;
- Capable of recognizing 'quality' of service unlike a common fee schedule;
- Capable of recognising of distant and rural location;
- Capacity for adjustment quarterly, bi-annually or annually;
- Control by the Health Service of remuneration and relative value supplied.

17. Clearly fractional appointments must recognize realistic allocations for the work expected to be carried out. Auditing would be on the basis of clinical and peer review of work carried out rather than external auditing that is required in the case of fee-for-service arrangements.

    It should be noted that fee for service arrangements were, as a result of the Lochtenberg Report, phased out in metropolitan health services but retained in rural health services.

Role of the GP VMO in rural Victoria & the Market

18. The role of the GP VMO in rural Victoria is crucial. In a number of cases, they are the primary provider of medical services to the Hospital. The exceptions are the base and large regional hospitals that employ Medical Practitioners on staff.

19. The smaller rural hospitals do not employ medical staff, and solely rely on the GP VMO. In most cases, the GP VMO is a local medical practitioner that is credentialed at the Hospital to supply a range of services. These services always include consultations for in-patients and may also include obstetric, anaesthetic and minor surgery services. The Hospital is extremely dependant on their services and their qualifications which in large part determines the range of medical services the Hospital can deliver.

20. The rural GP is different and distinct from the metropolitan GP. It is rare for GP's to be credentialed or have admitting rights to metropolitan or large base hospitals. These hospitals are staffed by HMO's, Registrars and Specialists. It is also rare for a GP based in large metropolitan centres to have qualifications in areas such as obstetrics and anaesthetics. The rural GP therefore is unique and delivers a vital and essential service in rural towns. They are the 'gatekeepers' to the system. They are essential in any local setting.

21. The GP VMO who is credentialed at the Hospital delivers such medical services as required pursuant to a contract. This contract is an agreed or standard contract in terms of the content. They usually last for three years following which they are renegotiated between the Hospital and the relevant Practice or individual GP. The AMA (Vic.) is often involved in the negotiations, as is the VHIA acting on behalf of the Hospital. The

major subject of negotiations is the Schedule of Fees attached to the contract, and any specific local requirements.

22. The local nature of negotiations is not necessarily time consuming and is often completed within a reasonable time frame. Major disputes rarely erupt, although some of the relationships are not as robust as others.

23. The market for GP's is a local market despite the fact that there is a Victorian wide shortage. Victoria had 120 GP vacancies listed as at January 2007. Twenty three per cent of these vacancies are in regional cities of Ballarat, Bendigo, Shepparton and Wodonga. This coupled with population growth in rural Victoria of 1.2% annually and an aging population means that the demand for GP services in Australia is projected to grow by 11.8% between 2000-2010.

24. AMWAC has estimated that Australia will need to recruit 1100 to 1200 GPs each year to 2013 to achieve a balance in supply, but has only 700 Australian GP trainees and Overseas Trained Doctors ("OTDs") entering the workforce each year. There is an increasing reliance on OTDs in rural Victoria where RWAV recruits about 45-65 OTDs to rural Victoria each year.

25. The GP Workforce is also aging. Thirty percent are aged over 50 and the numbers approaching retirement are set to rise exponentially over the next decade. Rural GP work an average of 49 hours per week, although RWAV reports a trend towards reduced hours. This is in part supported by a number of rural GPs either limiting or refusing to work after hours.

26. Furthermore it should also be noted that between 1983 and 2005, 82 small rural obstetric services have closed in Victoria, leaving 32 small rural services open, nine larger centres and six regional centres. In March 2005, there were 173 practicing GP Obstetricians in rural Victoria, mostly aged 40 to 55 with 32 resident obstetricians, 12 of whom are aged 50 to 54 years and six over 60 years of age.

27. All these factors impact on the market and rates paid for medical services in various localities. A common Schedule, for example would fail to take account of local market conditions and different demands for medical services. Attraction for example to more remote or less attractive rural places could become even more difficult should a common schedule prevail. It would reduce flexibility in the market by not necessarily taking account of local requirements and conditions.

Application by RDAA

28. The RDAA's application seeks to negotiate, through its constituents, with State Health Departments regarding the contracting of rural

doctors as VMOs for services provided to public patients including on-call arrangements for rosters and on-call. The application ignores the fundamental fact that in Victoria, the Principal contractor is the individual hospital or community health organisation. There is no common contract in place, and the Department of Human Services ("DHS") plays no role. Therefore the assertion that "*...State health department unilaterally determine the arrangements for contracting of doctors in state hospitals and facilities*" is not only misleading but shows that RDAA is either unaware of, or indifferent to the role of the Victorian Dept of Human Services as it relates to the engagement of VMO's.

29. In Victoria, as already stated, the Hospitals are the Principal Contractors, and the arrangements, including the method of engagement vary from locality to locality. The provision of medical services, including surgery, obstetrics, anaesthetics, emergency services and medical consultations by rural GP VMOs vary. Both the price charged and the services delivered differ between Hospitals. There is certainly no common fee schedule.

30. The RDAA seeks authorization for a period of five years. This ignores the fact that all contracts in Victoria are of three years duration. It also ignores the fact that credentialing is an important part of clinical governance. There can be no contract for the delivery of services without the GP being credentialed. The process of credentialing ensures the quality of services through peer review. This must be done on a frequent basis, and certainly, an appropriate period would be three years.

31. It is not apparent from the application whether the outcomes, described in the application as "contracts with the State Health Authorities..." are opting in or opt out. What occurs for example should a rural GP VMO elect to negotiate a separate arrangement? What happens should the local conditions be such that a more attractive package is required in order to attract the General Practitioner. How do these separate arrangements, if negotiated fit into the common schedule? How do they impact of the Schedule? What will the flow-on affects be when separate agreements are reached between contracting parties?

32. The application states that the RDAA does not intend to negotiate on behalf of medical specialists. The reasons for this are not provided. It needs to be acknowledged that the market for Specialists is a different market to that of VMO GPs. Specialist services are regional as well as State wide. However, there is little doubt that a common schedule of fees for rural GPs will impact on Specialist fees. The latter of which are often different and sometimes less than those paid to GP VMO's.

Public benefits of the Application

33. The RDAA argues that a common schedule of fees achieved through central negotiations with the RDAA being the 'bargaining agent' will result in ensuring the following:

    (i) Provide certainty with respect to the Trade Practices Act;
    (ii) Provide a third party expert (i.e. RDAA) in ensuring that the needs of rural GPs are met across the State;
    (iii) Provide a common schedule of fees and price for services;
    (iv) Provide an efficient method of negotiating fees and conditions;
    (v) Improve retention of rural GPs VMOs by reducing red tape.

34. The public benefits of the application appear to apply unilaterally to the applicant and its members. It ignores the fact that the current situation in Victoria takes account of market conditions within specific rural areas. It fails to take account of the fact that the TPA has not been a major impediment to the negotiations between individual GPs or Practices with the Hospitals. It takes no account of the fact that in almost all cases GPs are represented by a third party which is normally the AMA (vic.) It is only in one instance over the last three years where the RDA (Vic) represented a member GP in negotiations with the Hospital. In all other cases, the AMA represented the rural GPs.

35. The application also ignores the fact, that local negotiations serve a useful purpose. It maintains an ongoing and close relationship with the Hospital. Removing such negotiations may alienate the parties to an extend which is undesirable. Local issues are discussed at these negotiations, including the retention and recruitment of GPs to local practices. The Health Service often provides funds to the local practice to ensure it can recruit. The Hospital may provide staff and facilities. The Health Service may also supply IT and other support services to make the practice more economic and functional.

Public Detriment & Effect on Competition

36. To centralize the negotiations therefore will have a major detrimental effect. It will de-sensitise the health service and the GPs to local needs and requirements. It could become dysfunctional in terms of relationships between the parties. This may well have a negative impact on recruitment and retention of rural GPs in specific communities.

37. The primary effect however will be an increase in the price of medical services. This is admitted by the Applicant when the RDAA states that *"... it is possible that the granting of authorization may act on the costs of labour in rural hospitals as the monopsonistic purchasing arrangements practiced by State Health Departments may have had a distorting effect of reducing prices for VMO services."*

38. This assertion is a complete and utter nonsense and a fabrication of the facts. In Victoria the so called *"purchasing arrangements"* are not *"monopsonistic"*. In fact they are the direct opposite. The arrangements are diverse and bound up with the particular hospital and other local arrangements. The price varies as a result, and certainly the diverse form of negotiations has not reduced prices. Indeed, the opposite has been the case. Prices vary between hospitals and localities. They vary between VMO Specialists and VMO GPs. To that extend there is competition. The more remote areas are in a position to attract GPs by 'meeting the market'. Most contracts also contain an arrangement whereby the price increases either by a set percentage, or by increases in the CMBS.

39. It is submitted that the effect of a centralized method of fixing prices will have the immediate effect of requiring the 'highest common denominator' to prevail. That is no-one will take a pay cut, Rather, the highest price currently paid by a rural health service for a particular range of services will become the norm. This will mean a substantial hike in the price of medical services.

40. The impact will also be felt on the prices currently paid to Specialists 'fee for service' work. A common schedule of fees will inevitable result, albeit unintended, in an increase in Specialist VMO fee-for-service payments. At the moment, most of these fees are separate and distinct. That is Specialist VMOs do not necessarily know or are aware of the price or remuneration received by VMO GPs. The common fee schedule for GP VMOs will be a public document. Not just a matter for private contractual arrangements as they are now. As stated before, the fees paid to Specialists are very often no more than 100% CMBS, whereas those for GPs vary considerably with more than 130% CMBS being paid in some localities.

41. Similarly, on call payments could also flow on to Specialists. At the moment, on call fees or payments are largely made to VMO GPs in rural areas only. The exception would be the larger hospitals where local Specialists maybe on-call for specialized services such as anaesthetics and obstetrics. It is submitted that anything that is part of the 'common Schedule of fees' will have an impact and flow on effect on other medical services.

42. The insidious part of the application relates to funding arrangements. Fee for service work is difficult to fund and anticipate. Salaries and sessional or fractional payments can be budgeted for. If there were a common method of payment or fee schedule, the best and most transparent method already exists. That is, to place all VMOs on sessional rates and ensure that the fractions that are allocated are appropriately loaded for location, services provided, on-call services and so on. In fact the Lochtenberg Report provided a recommendation to that effect. The reason that fee for service still exists is because it is simply the most lucrative and as well as the most efficient method of payment. You pay for what you get.

43. The result of an increase in price and a common schedule of fee will be to take flexibility, competition, and diversity out of the market. Rural and remote hospitals may find it difficult to recruit and retain GPs. At the end of the day, they will have to meet the market and this will not be resolved by a common fee schedule.

44. The uncertainty in the funding arrangements is also an issue as stated. Fee for Service work is in theory never ending. If the price should increase, and there is no reason to think otherwise, services could be reduced, and some services removed from local areas and concentrated in regional locations. The impact of such relocations of services would be significant on obstetric services for example. It could also have the unintended impact of deskilling rural GPs. If services are removed to other more efficient locations because of a hike in prices, the local GP proceduralist could no longer practice his/her craft except for general medicine.

The Way Forward

45. A common schedule of fees is best achieved by the GP VMO becoming an employee of the Health Service and being paid on a fractional basis. The fraction would take account of market factors including the remote location of the service. The fraction would be all inclusive except for superannuation.

46. Fractional appointments will overcome the issue of the Trade Practices Act and obviate the requirement to obtain authorization. The fractional method of payment permits the Health Service to budget for the costs of medical services supplied by Medical Practitioners. The Medical Practitioner receives a set income for services supplied to the health service and can access the benefits of salary packaging arrangements, thus increasing the after tax benefits to the individual GP.

47. As stated in this submission the *Ministerial Review of Medical Staffing in Victoria Public Hospital System* strongly recommended 'fractional appointments' as the way forward. It envisaged a system whereby in lieu of fee for service medical practitioners will be engaged *"for that fraction (or proportion) of a true full-time commitment expected to be necessary to meet the responsibilities associated with a defined group of public patients or related activities"*. The fraction would reflect the expected number of patients as well as the complexity of treatment and the extend to which medical practitioners would be expected to carry out related activities and be available or provide services outside normal working hours.

48. The advantage of this system, rather than fee-for-service can be summarised as follows:

- It would provide continuity of care;
- It would provide all-up care;
- Flexibility;
- Capacity to budget and predict annual medical costs;
- Identifying the full range of activities up front;
- Recognise management and other responsibilities of medical practitioners;
- Capable of recognizing 'quality' of service unlike a common fee schedule;
- Capable of recognising remote and rural location;
- Capacity for adjustment quarterly, bi-annually or annually;
- Control by the Health Service of remuneration and relative value supplied.

49. It would negate the need for common schedule of fees, cater for local needs, maintain the relationships between the Health Service and the GPs, and effectively deal with the issues associated with the Trade Practices Act in relation to competition.

10092SD/VHIA 2008©

SCHEDULE ONE

SELECTED FEEDBACK FROM SOME RURAL HEALTH SERVICES

"One of my concerns is if VMO's bargain collectively and agree on a price why would some VMO's choose remote locations ... when they can receive the same $$ by working in larger Rural townships.

The only way we could continue to attract VMO's (which is already difficult) would be to do what we do now - offer more $$$, incentives and benefits and continue to "sell our souls". So really nothing would change, we would still be negotiating but at higher and higher prices!!"

Chief Executive Officer
Rural Hospital

"I am very happy with the VHIA position paper. The proposal by RDAA appears quite ludicrous."

Chief Executive Officer
Regional Health Service

"Some comments on the application and it's impact on Small Rural Health Services. We currently have a very neat arrangement with our GP's who also provide an after hours service to the Health Service. We have a model known as the "Grumpy Old Docs" (GOD) whereby we manage the Medical Practice and employ 5 semi retired GP's to share a single EFT position. We have built strong relationships with all our GP's including having negotiated contracts and remuneration with which all parties are currently satisfied. Our model is unique and does not reflect the basis upon which these types of negotiations are usually based. The outcomes usually impact negatively on Small Rurals such as us without government support that recognises the costs involved and funds them.

I can see a possible outcome that upsets the arrangement, the contracts and the relationships. The Health Service manages on a very small budget and any increase would definitely require support from government to avoid the negative impact of having to underwrite the service and to recognise the differences between large metro and small rural when negotiating if it gets that far."

Chief Executive Officer
District Health Service

"In reference to the Position Paper prepared I would like to make the following comments;

The Health Service certainly does not support the application by the RDAA's to have a common schedule of payments to VMO's working in public hospitals throughout Victoria.

An organsiation such as our Health Service should have the flexibility to negotiate its own fee for service fees to it's VMO's.

In some situations, negotiations with VMO's can also include salary packaging, housing, motor vehicle, etc.

An organisation such as our Health Service located in a rural area should have the flexibility to attract general practitioners in its own right without being tied to state-wide rates of pay.

For instance, the Health Service recruited three overseas trained doctors to the hospital and in negotiating their contract, we are only paying them 100% of the CMBS but provide them housing and a motor vehicle for two years.

How would a state-wide agreement deal with these issues?"

Chief Executive Officer
District Health Service

"I won't be able to make it to the meeting on Monday. I have signed and returned the authorisation for VHIA to act for the Hospital in this matter, but would like to point out that while I obviously would not like to see us have to pay the highest amount currently being paid in remote areas, I do think the idea of some common contract would be advantageous in many ways and avoid situations where hospitals are in competition with each other for the same doctor."

Chief Executive Officer / Director of Nursing
District Hospital

SCHEDULE TWO

Authority to Act ACCC& RDAA		
Organisation Name	**CEO**	**Acting CEO**
Alexandra District Hospital	Heather Byrne	
Bairnsdale Regional Health Service	Wayne Sullivan	
Ballarat Health Service		Dale Fraser
Barwon Health	Sue De Gilio	
Bass Coast Regional Health	Lea Pope	
Beechworth Health Service	E.Jan Webb	
Boort District Hospital	Peter Abraham	
Casterton Memorial Hospital		Mary- Anne Betson
Central Gippsland Health Service	Peter Craighead	
Cobram District Hospital	Chris Symmons	
Cohuna District Hospital	Alan Rickey	
Colac Area Health	M.Iles	
Djerriwarrh Health Service	Robert Bruce Marshall	
Dunmunkle Health Service	Chris Scott	
East Grampians Health Service	Victor J.Davies	
East Wimmera Health Service	R.J.Bulmer	
Edenhope & District Memorial Hospital	Kathy Huett	
Gippsland Southern Health Service	Gary Templeton	
Goulburn Valley Health	Greg Pullen	
Hepburn Health Service	David Lenehan	
Heywood Rural Health	Peter Starick	
Hesse Rural Health Service	Peter Birkett	
Inglewood & Districts Health Service	Michael A. Parker	
Kerang District Health	Robert Jarman	
Kilmore District Hospital		Amanda Edwards
Kooweerup Regional Health Service	Terrona Ramsay	
Kyabram District Health Service	Neil Cowen	
Kyneton District Health Service	Jennifer Gale	
Latrobe Regional Hospital	Felix Pintado	
Lorne Community Hospital	Janelle Bryce	
Mallee Track Health & Community Services	John Senior	
Mansfield District Hospital		Jennifer Fawkes
Mildura Base Hospital	Michael Kreig	
Mt Alexander Hospital		Graeme Hill
Nathalia District Hospital	Greg Pullen	
Northeast Health Wangaratta	Lisette Wilson	
Omeo District Health	Trevor Adem	
Portland District Health	John O'Neil	
Rochester & Elmore District Health Service	Duanne Attree	
Robinvale District Health Services	Graem Kelly	
Rural Northwest Health	L.Vause	

Seymour Hospital	Doreen Power	
South Gippsland Hospital	Ward Steet	
South West HealthCare	Graeme Mitchell	
Stawell Regional Health	Peter Edwards	
Swan Hill District Hospital	Roey Bice	
Terang & Mortlake Health Service	Mark Johnson	
Timboon & District Health Care Service	Elaine Collins	
West Gippsland Healthcare Group	Ormond Pearson	
West Wimmera Health Service	John Smith	
Western District Health Service	Jim Fletcher	
Wimmera HealthCare Group	Chris Scott	
Yarram & District Health Service	Colleen Boag	
Yarrawonga District Health Service	Andrew Freeman	
Yea & District Memorial	Greg Pullen	