

Rural Doctors Fee for Service Working Party

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Dear Rural Doctor

The Rural Doctors Association of South Australia (RDASA) welcomes the opportunity to be involved in framing a draft agreement between Country Health SA and rural GPs and GP Registrars who are not employees of South Australian Health but who provide medical services at Country Health SA sites.

The RDASA supports the principle that the draft agreement will detail the terms of engagement in relation to their duties, responsibilities, rights, obligations and payment of all parties.

The RDASA believes that the framing of this agreement provides a unique opportunity for Country Health SA to show a true commitment to the rural GP and Registrar workforce and the important role that they play as visiting medical officers in Health Units in rural South Australia.

It is essential that this agreement recognises the unique role that visiting GPs and Registrars play in

- the service delivery of primary health care to rural communities;
- the provision of procedural services to many health units and
- 24 hour emergency cover for most rural health units across country South Australia.

The SAMSOF and SARMES agreements have provided a framework in the past for clarification of many issues; however it appears now that a more definitive contract arrangement is being envisaged by Country Health SA. There will now be documented responsibilities both on behalf of Country Health SA (and of course the respective Rural Health Units) and the doctors providing essential health services for those rural communities.

RDASA believes that it will be necessary to source further industrial advice and expertise in order to produce a contract that will be acceptable to the majority of rural doctors

The complexity and differences involved in many rural locations means that there may have to be a number of different models as far as remuneration support and workforce support are concerned, around rural South Australia. There are already in place a number of different types of remuneration models including the Iron Triangle Agreement, the Mount Gambier Salaried Doctors Agreement, South Coast Hospital Accident & Emergency Agreement, Wallaroo, Gawler, Mt Barker, Naracoorte Medical Practice Agreement and the standard SARMES Agreement which has led to many further complexities and much confusion around rural South Australia.

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The philosophy of different bands of support dependent on work load, locality and remoteness certainly are deserving of consideration in the formulation of a new rural doctors working agreement.

The RDASA believes that it is essential that adequate time be put into the crafting of such agreements, which it believes would have considerable benefits for retaining those doctors in those locations as well as providing a clear understanding for doctors considering working in these locations as to what their roles, responsibilities and benefits may be, depending on the location that they are working in. In particular, we believe that the following points are important.

1. TIME Frame

The RDASA believes that a three year contract would give Country Health SA, hospitals and doctors a clearer understanding of the time frame for each agreement and adequate time to review changes.

2. On Call Payment

As has been elucidated previously the varying amounts of on-call payments around the State is leading to disagreement and confusion in regards to the recruitment of doctors and Registrars and Locums to various locations, which also means that some rural practices' viability is dependent on their on-call payments and workload. This needs to be recognised in the agreement and as far as the different banding as it is discussed.

3. SAMSOF Item Definition

There continues to be considerable confusion in regards to SAMSOF items including the definition of whether to bill patients for treatment provided in the Emergency Department who are then subsequently admitted. The RDASA will argue strongly about the need for a clearer definition of after-hours including Saturday morning.

4. Fee for service Consultations

RDASA believes that FFS payments by CHSA have not kept up with the CMBS changes in recent years and that these need to be reviewed in the discussions

5. Emergency Treatment Item Numbers.

For many years rural doctors have argued that the SAMSOF item numbers for emergency treatment for longer than an hour should in fact involve payments of quarter hourly quanta, recognising the requirement in many of these critically ill patients for doctors to spend considerable amounts of time with the patient, stabilising them prior to transport or retrieval. The RDASA believes that the 15 minute quantum should be applied to these prolonged attendance items similar to the anaesthetic item numbers.

6. Quality Assurance Activities

The RDASA supports the proposal that quality and safety issues should be at the forefront of delivering health services however there are considerable deficits in the collection of adequate data and bench marking of these data with other health units.

7. Auditing and Review.

Appropriate auditing and review processes are needed and must be funded; these should involve discussing appropriate clinical issues amongst colleagues with peer review. This peer review and audit process, which often occurs now in an informal way during normal working days, should be adequately remunerated. There is a real and pressing need for the time that doctors spend attending these meetings and reviewing their clinical practice to be appropriately rewarded. It is essential that adequate data, with regard to the number of procedures (including anaesthetics,

surgical operations and deliveries) be provided electronically by the health units to assist doctors in peer review, audit processes and updating credentialing information and this process must be done by the health units.

8. Accident & Emergency Service Requirements

The RDASA understands that there may be a number of locations around the State where provision of 24 hour emergency medical services is problematic and that this situation may continue into the future. However there must be recognition by CHSA that rural doctors, especially those in one or two doctor towns who are providing emergency and on-call services, need appropriate supports. These supports include not only locum relief, but appropriate IT supports including video conferencing, and tele-radiological facilities, as well as doctors having ready access to their practice notes in emergency departments. These supports should be mandated across health units to improve information management and therefore patient management. The lack of these supports has a major and important impact on the provision of good patient care, especially for inpatients and those presenting from outlying practices, and is considered a key requirement for the improvement of quality assurance in hospital patient clinical management. The issue of IT supports and the provision of discharge summaries as a key part of the quality and safety agenda obviously need consideration in the new agreement.

9. Safe Working Hours

Since 2005 many rural doctors have highlighted the need to recognise that providing care at the hospital often has a considerable impact on their own ability to provide primary health care services to outpatients from their own practices and that this has not been adequately recognised by Country Health SA and the SA Government. This is especially so for recalls in the "unsocial hours" of 2400 to 0800 when even one recall can affect ability to practice next day safely. The RDASA requests that there be considerable thought into how this should be addressed and recognition by CHSA that this is one of the key issues expressed by rural doctors responding to RDASA questionnaires in the past.

10. Call Backs in Consulting Time

Many rural doctors have expressed the concern that being called away from their own private practice to provide hospital care is a considerable financial disadvantage to them. This is one of the key issues that must be addressed during the formulation of the new agreement.

11. PMO Role

It has been clearly highlighted in the past that many rural doctors is fulfilling this role in an unpaid capacity. This is no longer acceptable to rural doctors. CHSA must recognise and remunerate PMO's, who have a pivotal position in implementing changes and improvements in quality and safety issues within rural hospitals.

12. Information Management and IT Support

Many rural doctors and practices have clearly highlighted the deficiency in regards to information management and information technology in many centres around rural South Australia. There should be a much-improved and mandated level of access to appropriate IT clearly linking hospital wards to practice records, as well as to pathology and radiology services. The capacity to use tele-radiology and video conferencing at very short notice must be mandated as part of the conditions of service for rural doctors working in rural Health Units.

The RDASA believes that Country Health SA has a unique opportunity to provide a framework which will encourage future entrants to the rural health workforce and retain those doctors who are already providing these essential services in rural South Australia.

Any agreement that is brokered in the future needs to have a clear process of adequate consultation including the capacity for the RDASA and AMA negotiators to consult with their members as to any changes that are to be proposed. The success of the formulation of a draft agreement is dependent on input of the rural doctors who are providing these services as visiting medical officers as well as appropriate support from Clinical Consultants in Country Health SA, recognising the key role that rural doctors play in providing health services.

Such an agreement must be constructed with an appropriate timeframe to allow full, adequate and appropriate consultation between all parties.

RDASA has recently held an IMG teleconference meeting to hear of some of their particular issues that are confronting these doctors. More meetings are planned as well as appointing a Representative on the RDASA Management Committee.

We urge you to maintain an active membership and encourage your colleagues to join RDASA at this important time for rural health services. Working party members welcomes feedback and input from RDASA members into the process (including specific areas of contention around SAMSOF and the current Rural Health Enhancement Package).

Please contact the members by phone or email with your input.

Regards



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