Public Accounts Committee
Parliament of New South Wales

Report on Payments to Visiting Medical Officers

Report Number 45 June 1989

1988-89
Parliament of New South Wales

Public Accounts Committee of the Forty-ninth Parliament

Forty-Fifth Report

Inquiry pursuant to Section 57 (1) of the Public Finance and Audit Act 1983, concerning Payments to Visiting Medical Officers.

(Transcripts of Evidence are printed in a separate volume to this Report.)

June 1989

3119-1

Committee Members. From left: Wendy Machin*, Allan Walsh. Phillip Smiles (Chairman), Terry Griffiths, John Murray

* Ms Macbin was appointed Chairman of Committees and her place on the Committee has been taken by Mr G Souris, M.P., Member for Upper Hunter, on 23rd February. 1989

MEMBERS OF THE PUBLIC ACCOUNTS COMMITTEE

The members of the Public Accounts Committee are:

Mr Phillip Smiles, LL.B., B.Ec., M.B.A., Dip. Ed., M.P., Chairman

Mr Phillip Smiles was elected Member for Mosman in March, 1984. A management and marketing consultant since 1974, Phillip Smiles has been involved with entrepreneurial business activities since his teens. Since entering Parliament he has been actively interested in the areas of small business, emergency services, welfare and financial analysis. He was appointed a Member of the Public Accounts Committee in 1984 and was elected Chairman in 1988.

MS Wendy Machin, B.A., M.P.*

Wendy Macbin was elected Member for Gloucester in 1985. Following completion of a Bachelor of Arts (Communications) Degree she worked in public relations for the National Party and later established her own public relations consultancy business specialising in the rural sector. She also served as an independent alderman on North Sydney Council prior to becoming a Member of Parliament In 1988, following a redistribution, she became Member for Manning.

Mr John Murray, B.A., M.P.

John Murray, formerly a teacher', was elected Member for Drummoyne in April. 1982. An alderman on Drummoyne Council for three terms, John Murray was Mayor of the Council for five years and served four years as Councillor on Sydney County Council. He has served as a member of the Prostitution Committee and the House Committee, and is a former Chairman of the Public Accounts Committee.

Mr Allan Walsh, B.A.(Hons), Dip. Ed, M.P.

Allan Walsh was elected Member for Maitland m September, 1981. Following eight years as a Mirage fighter pilot with the RAAF, he was involved in business management. Allan Walsh has also taught industrial relations, management and history at technical colleges.

Mr Terence Allan Griffiths, M.P.

Terry Griffiths was elected Member for Georges River in 1988. Prior to being elected to Parliament he was the Chief Executive of the Scout Association of Australia. Before this he was an Army Officer. He is a graduate of the Officer Cadet School. Portsea, a graduate of the School of Military Engineering and a Fellow of the Australian Institute of Management. He has been actively involved in Lions, Rotary and other community organisations.

---

* Ms Machin was .appointed Chairman of Committees and her place on the Committee has been taken by Mr G. Souris, M.P., Member for Upper Hunter, on 23rd February, 1989.

Secretariat

John Horder, LLB., AASA, CPA, Clerk to the Committee

Amanda Bowden, B.A., Dip. Ed., LL.B., Senior Project Officer

Tim Nieuwendyk, B.Bus., Adviser on secondment from the Treasury

Maria Hagispiro, Secretary/Word Processor Operator

Sandra Brien, Secretary/Word Processor Operator

N.S.W. Public Accounts Committee

Parliament House
Macquarie Street
Sydney, N.S.W. 2000

Telephone: (02) 230 2631
Fax: (02) 230 2831

REPORT ON PAYMENTS TO VISITING MEDICAL OFFICERS

CONTENTS

CHAIRMAN'S FOREWORD

In June 1988, the Committee undertook preliminary inquiries concerning the rising cost of Visiting Medical Officers (VMOs). On 24th October, 1988 the Minister for Health, The Hon. Peter Collins, MP, gave a formal reference to the Committee to inquire into payments to VMOs in New South Wales (NSW) Public Hospitals.

Initially the task seemed similar to other Inquiries of the Committee - investigate the situation and report to Parliament. The Committee was confronted, however, by a history of disputation in the State's public hospitals and the legacy of many heated battles with vested interest groups.

The contentious backdrop to this Inquiry includes the return of orthopaedic surgeons to public hospitals, the campaign for changes to the duties and training of resident medical officers, the country doctors' dispute, and the continuing resistance by some doctors to the changes wrought by Medicare. The recent public debate concerning VMO emergency rostering and closure of hospital beds was indicative of the low level of co-operation between, and conflicting interests of, the medical profession and hospital administrators.

Further, there is a long and complex history leading to the industrial Determination in 1985 under which sessional VMOs were granted increases of up to 90% in their hourly rate and on-call rates were tripled. Simple matters in the Determination became the subject of protracted debate and litigation initiated by the NSW Branch of the AMA in the Supreme Court.

The Committee also received submissions to the effect that the Department's case in the 1985 Macken Arbitration was ill-prepared or alternatively not forcefully argued at the behest of political instruction.

The inability of the Department of Health to provide comprehensive information considerably hampered the Committee's deliberations. The Committee recognises the Department's role is one of policy and planning. Nevertheless, these functions cannot be fulfilled and appropriate advice cannot be tendered to the Minister without an adequate information base. The Committee believes that a Department spending some $3.8 billion per annum should be capable .of developing an adequate management information system and strategic plan for the NSW health care system.

The Committee found the attitude of some members of the medical profession towards accountability for public expenditure most disturbing. The profession was reluctant to recognise that the expenditure of millions of taxpayers' dollars entails a high level of accountability, requiring monitoring and management by health administrators. Many VMOs place great emphasis on being *"independent contractors"* in relation to their public hospital work, yet seek the benefits of employee status, particularly financial security, through an industrial . determination.

Throughout this Inquiry, it became obvious that doctors have been reluctant to accept structural change in their profession in the same way as workers have been forced to in other industries. VMOs in NSW, more than in any other State, have sought compensation for the changes in the health care system at considerable cost to the public purse.

This Report presents a major challenge to the Government, the medical profession, the Department of Health and hospital managers. Failure to face this challenge and arrive at an adequate resolution will significantly endanger the public health system in NSW.

I wish to thank all who appeared before the Committee and provided information and submissions to the Inquiry. I also express my appreciation to my fellow Committee Members, and to former member Ms Wendy Machin, MP, who was promoted to Chairman of Committees during the course of the Inquiry. Thanks are also due to Committee staff members Mr John Horder, Miss Amanda Bowden and Mr Tim Nieuwendyk who made valuable contributions to research and drafting, and to Miss Maria Hagispiro and Ms Sandra Brien for secretarial support. I am also grateful for the significant contribution made to the Report by Ms Bronwyn Richardson in her capacity as the Committee's Senior Project Officer prior to her recent appointment to the Victorian Economic and Budget Review Committee.

Phillip Smiles, LL.B., B.Ec., M.B.A., Dip. Ed., M.P.,
CHAIRMAN.

EXECUTIVE SUMMARY

The history behind the provision of services by, and payments to, medical practitioners in public hospitals is complex. Protracted disputation involving the State and Federal governments and the Australian Medical Association has had a profound direct and indirect influence on the setting of rates of remuneration for VMOs and terms of their employment in public hospitals.

The Committee found that some members of the medical profession were reluctant to recognise that the expenditure of millions of dollars of public funds requires a high degree of accountability. Throughout the Inquiry it became clear that VMOs aim to remain *"independent contractors",* yet they have sought the benefits of employee status and have received substantial compensation from public funds for structural changes in the health care system.

Payments to VMOs increased from $46M in 1983/84 to an estimated $204M in 1988/89. This growth in payments represents an increase of 345% in total payments to VMOs and an increase of 402% in payments to VMOs on sessional contracts.

One of the chief causes of this increase was the 1985 arbitration of sessional rates of remuneration by Mr Justice Macken. Litigation arising from the arbitration, initiated by the AMA, led to further increased payments to sessional VMOs. Higher rates of sessional payment relative to other forms of remuneration were followed by a significant increase in the number of VMOs electing sessional appointments, the decline of the honorary system and escalating costs of on-call rosters and call backs.

Anomalies and inequities in sessional remuneration resulted from the 1985 Determination. Many of the components on which sessional remuneration is based cannot be supported by principle or proper analysis in the Determination - particularly the compensation granted to VMOs for the so-called Medicare Effect and background practice coats. The variation in on-call and call back payments between sessional VMOs and other doctors working in the public hospital system is anomalous.

The present system of payment for sessional VMOs is' ~doctor driven"′ as doctors claim payment retrospectively for hours worked, rather than hospitals determining in advance the number of hours or services robe provided by VMOs. Lack of management control is also evident in the disputes engendered by reviews of on-call fostering and termination and variation of VMO appointments. Accountability for payments to VMOs is not possible as hospital administrators generally can neither predict the total outlay on VMOs nor verify individual claims for payment.

The lack of timely, specific and comprehensive advice to hospitals from the Department of Health on matters of management and accountability has considerably exacerbated the situation. The Department does not collect information routinely on the number of VMOs, types of appointments and payments to VMOs. The Department's management information system is inadequate for measuring doctor productivity, value for money and future service requirements.

The Committee recommends that internal control guidelines be developed for all hospitals, and enhanced reporting requirements be enforced for hospitals outside Area Health Services.

The principal recommendation of the Committee is that the present system of sessional remuneration be abandoned as it has little to commend it in terms of an efficient, equitable or accountable method of paying VMOs.

The Committee recommends that modified fee-for-service remuneration be retained subject to improvements, including hospital controls to avoid potential over-servicing.

It is recommended that part-salaried remuneration and fixed sum contracts for VMOs be further investigated by the NSW Department of Health.

LIST OF RECOMMENDATIONS

A full list of the Committee's recommendations follows. The recommendations are listed consecutively and should be considered in light of the discussion in the relevant chapters. No recommendations are contained in Chapter 1.

CHAPTER 2

Recommendation 1

It is recommended that the NSW Department of Health provide pro-active assistance to hospitals in recruiting the desired category of medical practitioner.

CHAPTER 3

Recommendation 2

It is recommended that a management information system be developed by the NSW Department of Health which can be used to measure productivity and assist in on-going review of forms of doctor remuneration in public hospitals. This system is to be reviewed after two years.

Recommendation 3

It is recommended that the NSW Department of Health's management information system measure the input and output of all doctors, including honoraries, working in public hospitals with a view to:

i) assessing the true cost of providing medical services to public patients;

ii) assessing the productivity of doctors; and

iii) evaluating the impact of changes in the form of doctor remuneration on costs and service provision.

CHAPTER 4
Recommendation 4

It is recommended that all future VMO contracts include a provision that hospitals not be compelled to pay a VMO claim which has been submitted more than two months after the end of the month in which the services were provided.

CHAPTER 5
Recommendation 5

It is recommended that the NSW Department of Health seek an urgent review of all components of the sessional hourly base rate as to principle and quantum, and the calculations of the hourly base rate if the sessional system of payments is to be retained.

Recommendation 6

It is recommended that a *"Medicare Effect"* payment be excluded from sessional VMO remuneration.

Recommendation 7
*It is recommended that the inclusion and method of including compensation for split shift work, unpaid leave and superannuation in the hourly base rate be reviewed to exclude *"double counting".*

Recommendation 8

It is recommended that any future determination of VMO rates of payment specifically provide for the correct and equitable application of flat rate weekly increases in the basic wage to the hourly base rates for VMOs.

Recommendation 9

It is recommended that the present system of on-call payments during the hours of 8.00 a.m. - 6.00 p.m. Monday to Friday be abandoned.

Public Accounts Committee

Recommendation 10

It is recommended that all hospitals critically review on-call rosters to determine whether the coverage is Justified in terms of service needs and cost effectiveness. It is recommended that on-call rosters during the day be strictly limited.

Recommendation 11

It is recommended that the practice of networking be expanded with a view to developing more cost effective and efficient on-call services.

Recommendation 12

It is recommended that the payment of an on-call allowance during call back hours be re-examined.

Recommendation 13

It is recommended that the principle and quantum of background practice costs for sessional remuneration be reviewed.

If the allowance is to be retained, it is recommended that:

i) independent research concerning background practice costs of all specialty VMOs be sought; and

ii) the amount to be compensated be the marginal cost associated with call backs.

Recommendation 14

It is recommended that the method and quantum of payment for on-.call and call back services be reviewed with a view to equalising payment for the same on-call and call back services across the four types of doctors providing services to public patients in public hospitals.

Recommendation 15

It is recommended that the NSW and Commonwealth Departments of Health review the practice of VMOs manipulating patients' public/private insurance status in order to boost their total income. It is recommended that the Commonwealth's Medicare rebate and the State's VMO payment for the same service be neutral in terms of the incentive for switching insurance status.

CHAPTER 6
Recommendation 16

It is recommended that future contracts of appointment for VMOs clearly provide that on the expiry of the contract there be no legal obligation for automatic renewal and non-variation of all the terms and conditions of the contract.

Recommendation **17**

It is recommended that if sessional remuneration is retained all VMO claims for payments include at least the following particulars of each service:

i) date
ii) start and finish time
iii) name of patient
iv) nature of service

Recommendation 18

It is recommended that the NSW Department of Health develop more effective procedures to ensure that the advice in Departmental circulars is timely, specific, comprehensive and properly implemented. Follow up to be undertaken by regular hospital visits and appropriate scrutiny by Department of Health senior management.

Recommendation 19

It is recommended that the. NSW Department of Health continue to collect and analyse information of the nature of that collected for the survey into 1987/88 VMO payments. Where further information is required to assist the monitoring of VMO payments, this to become a part of the routine collection of information.

Recommendation 20

It is recommended that Hospital Boards outside the established Area Health Services be subject to provisions similar to those of the Annual Reports (Statutory Bodies) Act, to the extent that this is practicable and appropriate.

Recommendation 21
It is recommended that the internal control and audit requirements and the accounting arrangements for Hospital Boards outside Area Health Services be reviewed and, where practicable, brought into line with the requirements of the Public Finance and Audit Act.

Recommendation 22
It is recommended that hospital internal control guidelines be developed to ensure accountability for the use of public funds in relation to VMO payments.

CHAPTER 7
Recommendation 23
It is recommended that a component of submissions for future change to VMO remuneration be whether value for money will be obtained from the change.

CHAPTER 8
Recommendation 24
It is recommended that the current system of sessional remuneration be abolished by phasing out the system as existing contracts expire.'

Recommendation 25
It is recommended that the current modified fee-for-service system for remunerating VMOs be retained subject to:

i) regular review and' monitoring of practice patterns be enforced with a view to achieving optimal utilisation of services and cost effectiveness;

ii) hospital managements pre-determining the level and range of services to be provided by the hospital;

iii) hospital management pre-determining, in consultation with each VMO, the level of service to be provided by the VMO, with consideration given to a global payment cap;

the enforcement of performance standards (quality and cost); and

the continuation of an appropriate base fee schedule.

Recommendation 26

It is recommended that the NSW Department of Health investigate the part-salary system of payment for VMOs, giving particular consideration to the system as it operates in New Zealand.

Recommendation 27

It is recommended that the NSW Department of Health give consideration to the applicability of prospective fixed sum payment for VMOs in NSW.

This following alternatives for setting the lump sum may be considered:

expected patient population and case-mix; or

total expected units of service.

Recommendation 28

It is recommended that individual VMOs not have the right to choose their preferred method of remuneration.

It is further recommended that the current situation by which VMOs at metropolitan district and country base hospitals can choose by specialty be abandoned.

Recommendation 29

It is recommended that any remuneration system implemented by the NSW Department of Health be accompanied by:

an evaluation of the new system 12 months after implementation;

ii) regular monitoring and review of practice pa tterns and their effect on quality and cos; and

iii) an appropriate base rate of payment.

1. INTRODUCTION

REFERENCE FROM MINISTER

1.1 On 24th October, 1988, the Public Accounts Committee (PAC) received a reference from the Minister for Health, The Hon. P. E. J. Collins, M.P., to inquire into payments to Visiting Medical Officers (VMOs) in New South Wales public hospitals (Appendix 1).

TERMS OF REFERENCE

1.2 The Terms of Reference are as follows:

(1) to inquire into reasons for the marked increase in public hospital payments to V.M.O.'s over the last five years;

(2) to review the vest benefit of the payments rode to V.M.O.'s engaged in the States public hospitals over the last five years;

(3) to identify and analyse any anomalies and inequities in Sessional V.M.O. remuneration;

(4) to inquire into the degree of accountability and financial control which exists in respect of payments made for services provided by V.M.O.'s engaged in N.S.W. public hospitals;

(5) to inquire into the existing arrangements and methods of renumeration for on-call services required of V.M.O.'s;

(6) to provide advice on the alternatives available to renumerate V.M.O.'s engaged in N.S.W. public hospitals;, and

(7) to consult with appropriate professional and other groups with an interest in the question of payments to V.M.O.'s engaged in the State's public hospitals in relation to Terms of Reference (1) to (6) above.

BACKGROUND TO PAC INQUIRY

1.3 Prior to receiving a reference from the Minister for Health, the PAC had commenced its own informal inquiries into the cost of a number of health care services.

1.4 The PAC visited country hospitals in all health regions and consulted with professionals in the health care sector during the period June to September 1988.

1.5 In the course of informal inquiries, the PAC also observed difficulties in recruiting doctors in country areas and the growing shortages of Resident Medical Officers (RMOs) in many country hospitals - issues which the Government has recently addressed.

1.6 Other matters of concern, such as cleaning costs and bad debts, were also noted and these may .be followed up in subsequent PAC inquiries.

1.7 The PAC's interest in VMOs arose from a number of sources

· including the Auditor-General, newspaper comment on a

"leaked" NSW Department of Health report and previous PAC reports on medical care costs. These are outlined below.

COMMENTS IN THE AUDITOR-GENERAL'S REPORTS

1.8 The NSW Auditor-General commented in recent Annual Reports that:

"... additional health costs resulting from settlement of the doctor's disputes ... the costs were around $9M in 1984-85

> *in the vicinity of $29M. The Commonwealth is expected to meet a substantial proportion of these costs*

under the Medicare Agreement". (1984-85 Auditor-General's Report, Part I, Page 61)

"In i985-86 the cost of Visiting Medical Officers warn $140o 8M compared with a budget of S$5.2M (actual cost for 1984-85 was $52M) Further the Commonwealthhas agreed to make a special payment of up to $25M in 1986-87 in relation to the increased hourly rates of payment to Visiting Medical Officers." (1985-86 Auditor-General's ***Report, Part I, Page 53)***

> *"In 1986-87 the cost of Visiting Medical Officers warn $160.8M compared with a budget of $158M (actual cost for 1985-86 was $140.8M) ... offset by $25M received from the Commonwealth." (1986-87 Auditor-General's Report, Part I, Page 116)*

"... a special payment of $26.4M was made in 1987-88 to New South Wales (by the Commonwealth in relation to the increased hourly rates of payment to Visiting Medical Officers in public hospitals". (1987-88 Auditor-General's ***Report Volume 2, Page 133)***

COMMENTS IN THE MEDIA

1.9 The Sydney Morning Herald, 28th January, 198 8, reported as follows:

[R:\PARLIM~1\450002.TIF]

Report on Payments to Visiting Medical Officers

'.. The Secretary of the department ... confirmed last night that the Government was investigating the increases ...

'He said Justice Macken had increased the rates for VMOs after the doctors' dispute was taken to arbitration in 1986

However, the report says that half of the increase in ordinary sessional payments is attributable to the disproportionate increase in hours claimed - these doubled between 1982-83 and 1986-87- and the rest is due to the new Macken rates.

"It appears that most of this increase in hours claimed is not due to the acceptance of sessional payment by honorary VMPs (visaing medical practitioners) or an acceptance of sessional payment increase in sessional VMOs' numbers overall, "the report says.

"Rather, hourly sessional allocations to existing VMOs have increased markedly ...

"Although the increase is partly due to an increase in

to be attributable to an increase in hours claimed. Without further investigation, on a regional basis, it is impossible to determine the extent to which this increase in hours paid is justified':

PREVIOUS PAC INQUIRIES

1.10 The PAC ' s 1982 inquiries into hospital expenditure overruns and public hospital accountability reviewed the methods of remunerating doctors for public work (Report Nos. 2 & 3). While the recommendations of those 1982 reports have been superseded following major changes to Government policy (such as the introduction of Medicare, the use of arbitration and the ensuing 1985 Macken Determination), many of the concerns expressed by PAC members about ensuring accountability and control over VMO payments remain.

METHOD OF INQUIRY

1.11 In addition to informal inquiries, formal hearings were held between November 1988 and February 1989. T he method of inquiry included:

inspections of hospitals and regional health administrative centres in NSW;

discussions with interstate Departments of Health, hospitals and other organisations (Appendix 2);

review of submissions and correspondence received in response to the advertisement of the Inquiry (Appendix 3) and notification by letter of all Members of Parliament (Appendix 4);

public hearings (Appendix 5); and

wide informal and formal consultation as required by the Terms of Reference.

THE KEY ISSUES

1.12 The key issues appear to be *the reasons for the marked increase since 1983 of payments to VMOs rand whether value for money has been received by the taxpayer.*

2. REMUNERATION OF MEDICAL PRACTITIONERS IN PUBLIC HOSPITALS

2.1 There is a long and complicated history behind the current system of remunerating doctors in public hospitals (see Appendix 6). The arrangements are complex and it is beyond the scope of this Report to probe into the various systems of paying all doctors who work in public hospitals. However, it is impossible to inquire into the payment of VMOs without an understanding of the context in which VMOs work.

THE MIX OF MEDICAL STAFF AND VMOS

2.2 Medical services to non-private patients .(referred to as public patients throughout this Report) in public hospitals may be provided by one or more of the following types of practitioners:

. salaried staff (specialists and resident medical officers)
· clinical academics
honorary visiting medical practitioners (honoraries)
visiting medical officers - sessional
- fee-for-service
- lump sum contracts

Public Accounts Committee

TABLE 2.1

Approximate Number **of Doctors Servicing Public Hospitals in New South Wales**

TYPE OF PRACTITIONER

Salaried Staff - Specialists	800
- Resident Medical Officers	2,500
Clinical Academics	160
Honorary Visiting Medical Practitioners	800
Visiting Medical Officers - Sessional	3,000
- Fee-for-Service	2,000
- Lump sum contract	20

1. The numbers of practitioners are estimates as at March 1989.

2. Only Salaried Staff numbers are equivalent full-time positions.

3. Some doctors are included in more than one of the categories as they may have different types of appointments at different hospitals.

4. There are about 13,500 practising medical practitioners registered in NSW.

2.3 Some of the factors governing the mix at a particular hospital are:

the level and range of services provided by the hospital;

the Medical Staff Council's view of what the appropriate mix should be;

- the geographic location of the hospital; and

- the availability of the appropriate type of practitioner (which is governed in part by the willingness of doctors to accept appointments under the various ava ilable modes of remuneration).

2.4 The availability of the different types of practitioners has been a major factor in determining the mix in recent times. Examples are a reduction in available honoraries with the resultant increase in VMOs, and a reduction in salaried specialists resulting in an increase in VMO specialists.

2.5 Specific examples are the specialties of anaesthetics, radiology and pathology. These are often more cost effectively and efficiently staffed by full-tim e specialists. The limited availability of qualified specialists wishing to work as salaried 'staff often frustrates the best staffing policy.

2.6 The PAC recognises, however, that given the level and volume of service needed in some instances, it may be more appropriate and cost effective to employ a VMO.

2.7 The PAC noted that the mix of medical practitioners in hospitals is not determined solely by the NSW Department of Health or the hospital specifying the type of practitioner which they feel is most appropriate.

2.8 Depending on the relative rates of remuneration, the private practice opportunities, the supply of doctors in the specialty, the range and type of services to be provided and the geographic location, it may prove impossible to fill a staff position. The hospital may be

forced to provide the required services by the appointment of one or more VMOs.

2.9 The decision to appoint a staff specialist or a VMO can be forced upon the hospital by other means. For example, in one country hospital the PAC was told that the Chief Executive Officer (CEO) had intended to employ an additional doctor as a staff specialist, but that the existing VMOs made it clear that they would withdraw their services completely if this were done. The CEO considered he was in a powerless position because he required the services of these VMOs in addition to another docto r. Given the difficulties encountered in attracting doctors to that country town, the CEO eventually succumbed to the pressure and decided the new appointment would be a VMO, not a salaried staff specialist.

Recommendation 1

It is recommended that the NSW Department of Health provide pro-active assistance to hospitals in recruiting the desired category of medical practitioner.

TYPE OF PRACTITIONER

SALARIED STAFF - SPECIALISTS

2.10 Staff Specialists receive a salary for services provided to public patients. For services provided to private patients attending at public hospitals, staff specialists have available four different arrangements which allow them to earn extra income. These arrangements are known

as Schemes A, B, C and D, and brief details of each Scheme are provided in Appendix 7.

SALARIED STAFF - RESIDENT MEDICAL OFFICERS

2.11 There are currently about 2,500 Trainee (interns, resident medical officers and registrars) and Career Medical Officers in full-time employment within the NSW public hospital system.

CLINICAL ACADEMICS

2.12 Clinical Academics are employees of universities with medical faculties. They are required to provide, as part of their university appointment, research and teaching services and participate in clinical duties in teaching hospitals. While their numbers are relatively small, they are an important part of the public hospital specialist workforce and many hold the position of Head of Department in the hospital. Most clinical academics also perform additional clinical services to public hospital patients for which they receive a fixed annual amount from the hospital according to the level and amount of additional services provided.

HONORARIES

2.13 The exact number of Honoraries, that is, visiting medical practitioners who do not wish to be paid for treating public patients, is not known. Since there is no payment to Honoraries, records of the services they provide are not collected by the NSW Department of Health. However, the Department estimates that there are approximately 800 Honoraries currently within the State's public hospital system. This figure includes practitioners who receive no payment from the public hospital and others, such as VMOs

and staff specialists, who provide unpaid additional services at a hospital or hospitals other than their employing hospital.

2.14 During the course of this Inquiry, arrangements were concluded to enable orthopaedic surgeons to be contracted by hospitals/Area Health Services as Honorary Medical Officers (HMOs).

2.15 HMOs are a type of honorary and will have the right to treat private patients in public hospitals, with billing for these patients by and at the discretion of the HMO.

2.16 HMOs wall provide their services to public patients of the hospital, and participate in the on-call roster on an honorary basis.

VISITING MEDICAL OFFICERS

2.17 VMOs are medical practitioners contracted to provide services to a public hospital, other than as an employee. The number of VMOs is shown in Table 2.1. The number has grown since 1983 and remains the most common form of appointment. VMOs may be paid on a sessional, modified fee-for-service or lump sum contract basis.

2.18 It is noted t hat for most VMOs, the main source of income is their private practice.

VMO REMUNERATION

2.19 Standard rates of remuneration and the terms and conditions of work for VMOs on fee-for-service or sessional contracts are determined either by arbitration under Part Vc of the Public Hospitals Act, 1929, or by

agreement between representatives of the contracting parties.

SESSIONAL CONTRACT

2.20 A medical practitione r is required to provide medical services during periods or sessions specified in the contract to all classes of patients of the public hospital to which they are appointed. There are two options in determining the number of sessional hours to be paid. The first option is a pre-agreed (prospective) number of hours and the second option is the number of hours of work actually performed. The choice of option is made by the VMO and can be changed every six months. Most sessional VMOs select t he second option.

FEE-FOR-SERVICE CONTRACT

2.21 A medical practitioner is required to provide medical services as specified in the contract to all classes of patients of the public hospital to which they are appointed. Under modified fee-for-service remuneration, the *"modification"* is that the payment is a percentage of the Medical Benefits Schedule fee. Fee-for-service VMOs are reimbursed on the basis of the scale of fees in the Medical Benefits Schedule, the maximum being 85% of the listed fee (equivalent to the *"bulk billing"* rebate set by the Commonwealth Government for private medical services Outside hospitals).

LUMP SUM CONTRACTS

A small number of VMOs under lump sum contracts provide medical services on the terms arranged directly by the hospital/Area Health Service and the VMO(s). These contracts are generally utilised where it is impractical

to use sessional or fee-for-service contracts or where the provision of the required services cannot be arranged under sessional or fee-for-service contracts.

SYSTEM OF REMUNERATION FOR VMOS

2.23 After the settlement of the 1984-85 doctors' dispute, the system of remuneration covering the majority of VMOs was as follows:

Teaching hospitals - sessional payments only.

. Metropolitan District and Country - Base Hospitals -

VMOs can, as a discipline group, choose sessional payments or fee-for-servi ce payments at the commencement of their contract period. The six disciplines into which each VMO for each hospital must be placed are:

- Surgery
- Medicine
- Obstetrics and Gynaecology (O & G)
- Anaesthetics
- Orthopaedics
- Paediatrics

Once the choice of a particular discipline is made, each VMO within that discipline is bound to

be remunerated on that basis for the remainder of

the term of the contract. Until recently,

contracts were for three years. The terms and conditions of proposed new contracts are currently being negotiated.

- Country Hospitals - modified fee-for-service only. Fee-for-service payments in country public hospitals are restricted to a maximum of 85% of the scheduled fee. Superimposed upon this option is the 1988 country doctors' *"settlement package"* (see Appendix 8) .

2.24 The above options are not required by legislation, by formal arbitrated Determinations o r by a term of the Medicare Agreement. They have been implemented by the NSW Department of Health following discussions between the Commonwealth Government, the State Government and the medical profession (including the NSW Branch of the AMA). As the options have often been compromise arrangements, they do not necessarily represent the views of any of the parties as to their preferred remuneration option.

2.25 The PAC has been informed that many individual doctors and the AMA have never been happy with the options available, and have continually sought alteration . to enable individual VMOs to choose their preferred method of remuneration, and to change between the options over the course of the year, as they wish.

2.26 A submission from a Urologist, for example, stated the view of many other VMOs as follows:

> *"I see no reason why individual VMOs should not have the option of being paid either on a Fee-for-Service or Sessional basis. The compulsion to accept a form of payment decided by others in a rather disparate group comes from administrative laziness ".*

Public Accounts Committee

2.27 The NSW Department of Health stated in a submission that it has:

"since the 1985 Macken Determination, become increasingly unhappy with this part of the agreement because of the resulting cost blow-out caused greater numbers of VMOs choosing sessional payments ".

THE SYSTEM OF ARBITRATION

2.28 Arbitration on the remuneration rates, terms and conditions of work for VMOs on fee-for-service and sessional contracts is conducted under the Public Hospitals Act, 1929 (NSW). While the power exists for there to be an arbitration on fee-for-service rates and conditions, no such arbitration has ever been sought by the AMA or the Minister for Health.

2.29 The hourly rate and many of the. terms and conditions of work for VMOs under sessional contracts have been determined by an arbitrator on seven occasions since 1976, as follows:

8/9/76	-	Mr A. J. Rogers, QC	-	Private Arbitration
8/12/78	-	Justice Macken	-	Determination under Public Hospitals Act
29/2/80	-	Justice Macken	-	' ....
18/9/81	-	Justice Macken	-	" " "
15/12/82	-	Justice Macken	-	" " "
14/12/83	-	Justice Macken	-	" ....
19/12/85	-	Justice Macken	-	" " "

2.30 Remuneration rates and certain other conditions have also been revised by agreement between the parties - for example, the Interim Medicare Effect and State Wage Case decisions - or by decisions made by the NSW Department of Health. The Department can make such decisions provided they do not conflict with matters specifically determined by the arbitrator.

2.31 The current arbitration decision under which sessional VMOs are paid is referred to as the "1985 Macken *Determination ".*

2.32 Part Vc of the Public Hospitals Act specifies that the Attorney General shall appoint a member of the Industrial Commission of NSW as arbitrator upon receipt of an application from either the NSW Branch of the Australian Medical Association (AMA) or the Minister for Health.

'2.33 Under the Act, the only medical profession representative body which has the right to request an arbitration and to have unlimited right to appear before the arbitrator, is the NSW Branch of the AMA.

2.34 The PAC wrote to the NSW Attorney General seeking information on the selection of an arbitrator. In his reply he stated:

"The practice over many years has been that the Attorney General on receipt of an application under Section 29L of the Public Hospitals Act writes to the 'President, Industrial Commission of NSW, seeking the nomination of a Member of the Commission. Records of my

General of the day has always' accepted the President's nomination."

"It would appear that Mr Justice Macken's previous experience in the area was the main criterion for his nomination and appointment in

2.35 The arbitrator makes the determination and according to Section 29M(2) of the Public Hospitals Act:

"shall endeavour to bring the persons appearing before him to agreement regarding the matters in respect of which he is required to make a determination ..."

2.36 The Act states that the arbitrator shall determine:

"the terms and conditions of work, the amounts or rates of remuneration and the bases on which those remounts or rates are applicable, in respect of medical services provided by visiting medical officers under sessional contracts "

and,

"the rates on a fee-for-service basis of remuneration in respect of medical services provided by visiting medical

contracts".

2.37 The Act specifies that the arbitrator:

"is not bound by the rules of evidence. and may inform himself on any matter as' he sees fit "

and,

"shall act judicially and be governed by equity and good conscience without regard to technicalities and legal forms".

Report on Payments to Visiting Medical Officers

2.38 In response to disquiet from several sources following the 1985 Macken Determination, the Public Hospitals Act was amended in 1986 to include Section 29N(2). This section provides guidance to the arbitrator concerning the matters that should be considered in formulating a Determination :

"The Arbitrator in making a determination shall have regard to--

- the economic consequences of the proposed determination;

- the most recent determination of the Industrial Commission of New South Wales under Section 57 of the Industrial Arbitration Act 1940 of-

i) the amount; or

ii) the method by which an amount may be determined,

by which rates of wages in awards made under that Act shall be varied; and

- the principles of wage fixation for the time being adopted as a general ruling or declaration of principle, by that Commission, in connection with awards made under that Act. ~

2.39 The PAC also sought information from the Attorney General regarding the research and professional assistance provided to an arbitrator. The Attorney General replied:

"There 'is no record of any request by an Arbitrator for research or professional assistance. A Member of the Industrial Commission would have access to the research facilities of the Commission library but, in common with other Arbitrators, probably relies on material prepared and presented by the parties ".

2.40 Thus, arbitrators are not required to have a quantitative or economics background and are not automatically provided with such assistance. Further, arbitrators are not generally predisposed to call expert witnesses to provide submissions on the economic consequences of remuneration determinations.

2.41 The PAC has heard considerable evidence from several sources to suggest that the 1985 Macken Determination may have been based on calculations and figures which were in error; and that the arbitrator did not foresee or have argued before him submissions on the full impact of increased sessional VMO rates on the NSW health budget. There is apparently no check of the arbitrator's calculations before the Determination is cast. This will be discussed further in Chapter 5.

2.42 The task of ma king a Determination is complex. The PAC believes that it is difficult for a single Judge to give adequate consideration to the diverse issues and factors involved in making a determination regarding VMO rates of remuneration and conditions of service, and to consider the ramifications for the public health care system. When these issues are not fully argued before the Judge in submissions from the parties, these difficulties are magnified.

2.43 In addition to the concern expressed about t he' mix of skills required to reach an appropriate Determination, there is concern about the lack of a routine mechanism by which the Determination, its interpretation or its implementation is assessed. When asked about assessment the Attorney General replied:

"The administration of the Public Hospitals Act, 1929 is vested in the Minister for Health° The only role of the Attorney General is to appoint arbitrators and I am not aware of any assessment by my predecessor of the appropriateness of any particular determination. The success or otherwise of a determination is more likely to be apparent to the Minister for Health whose administration is more directly involved".

2.44 The Minister for Health may assess the arbitration and may take steps to alter the Act under which arbitration takes place (as happened in 1986). Under the present system, the Minister cannot be expected to evaluate whether the 'arbitrator has had adequate resources and skills for undertaking the task of making a Determination.

2.45 It should also be noted that at the time of the 1985 Macken Determination, the Public Hospitals Act prohibited appeals against the Determination, even for technical errors. A 1986 amendment to the Public Hospitals Act, Section 29QA, provides for an appeal in respect of future determinations ·

2.46 There is no recourse to the original arbitrator or the Industrial Commission of NSW when interpr eting *"what wins* really intended' in the 1985 Macken Determination. The Determination has been the subject matter of cases before the Supreme Court of NSW and the results of these' cases would suggest that over time certain aspects of the Determination have been interpreted in 'a very different

manner to that originally intended. This also adds significantly to the costs of interpretation in that additional and lengthier court cases are required. The

outcome of recent cases based on interpretations of the 1985 Macken Determination are discussed further in Chapter 5.

SPECIFIC COMMENTS ON THE 1985 MACKEN DETERMINATION

ECONOMIC CONSEQUENCES

2.47 As stated earlier, after the 1985 Macken Determination the Public Hospitals Act was amended to include Section 29N(2) which requires that the arbitrator " *shal1 have regard to ... the economic consequences of the proposed determination"*

2.48 The PAC considers that the economic consequences of a determination should automatically have been considered by the arbitrator. As a minimum, the following economic consequences should be considered:

the costs of the Determination (financial payout);

- the benefits of the Determination (any increases in efficiency or quality); and

the impact on the efficiency of health care delivery to the general public.

INFORMATION

2.49 The Act also specifies that the arbitrator *"... may inform himself on tony matter ms he sees fit".*

2.50 The PAC noted that as with economic considerations, the arbitrator in 1985 did not see it as his role to inform himself as fully as he might. The arbitrator was surprised that the NSW Department of Health did not argue the *background practice cost component* of the hourly rate more vigourously, yet it seems he did not ask the Department for a more t horough analysis.

2.51 It appears that it is the arbitrator's view that only the material put before him should be considered. The PAC considers that this approach to VMO arbitrations is inappropriate and that the arbitrator(s) should adopt a more pro-active role.

2.52 The PAC's view concerning the appropriate means of dispute settlement and determination of rates of payment for VMOs is discussed in detail in the " *Determination of Rates and Dispute Settlement"* section of Chapter 8.

3. PAYMENTS TO VISITING MEDICAL OFFICERS

3.1 Since 1983/84, payments to VMOs for the provision of medical services to public patients in public hospitals have increased at a rate which is not sustainable by the usual reasons related to increases in the *cost* of providing a public service, such as inflation and increased use of the services. In summary the increases are:

an expected increase in total payments of 345% between 1983/84 and 1988/89;

- an expected increase of 402% in payments to VMOs on sessional contracts; and

an expected increase of 228% in payments to VMOs on fee-for-service contracts over the same period.

3.2 This growth in payments to VMOs in NSW is indicated by Table 3.1 which details payments, by the NSW Department of Health, to public hospitals in respect of VMOs.' The data in the Table has been adjusted so that payments are shown in the year in which the services were provided. For example, although payments in 1988/89 are expected to total $235.5M, $2.1M relates to 1985/86, $9.2M to 1986/87 and $20.2M to 1987/88, leaving $204.0M relating solely to services expected to be provided in 1988/89.

Report on Payments to Visiting Medical Officers

TABLE 3.1

Payments to Public Hospitals for VMOs

	1983/84	1984/85	1985/86	1986/87	1987/88	1988/89 Estimate
	$M	$M	$M	$M	$M	$M
Sessional	31.3	49.3	88.1	125.3	137.9	157.0
Fee-for-service	12.8	16.0	34.8	35.1	39.5	42.0
Lump sum contracts	1.7	2.9	3.7	4.0	4.5	5.0
TOTAL	**45.8**	**68.2**	**126.6**	**164.4**	**181.9**	**204.0**
Increase in Total Payments		49%	86%	30%	11%	12%

NSW 'Department of Health

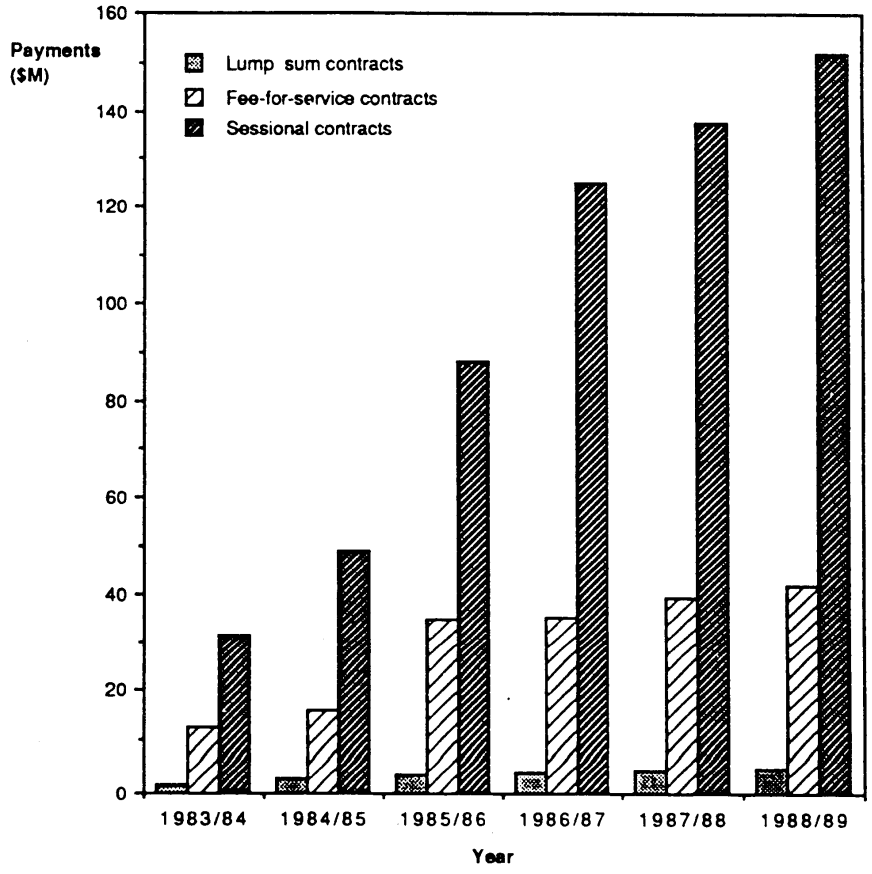
NOTE:

1. Includes costs of the July 1986 State Wage Case Decision (+ 2.3%) and the Court of Appeal of the Supreme Court of NSW's decision concerning the application (+ 9.49% and + 5.2% respectively) of the March 1987 and February 1988 State 'Wage Case Decisions (refer to section on *"Application of State Wage Case Decisions"* in Chapter 5 for further details).

3.3 A graphical representation of the information presented in Table 3.1 follows as Figure 3.1.

FIGURE 3.1

Payments to VMOs, 1983/84 to 1988/89



Source: Table 3.1

THE NUMBER OF VMOS AND THE NUMBER OF HOSPITAL APPOINTMENTS OF VMOS

3.4 The NSW Department of Health was able to provide details of a recent study into VMO numbers covering the period August 1985 to July 1987. The survey results are shown below in Table 3.2.

TABLE 3.2

Number of VMOs by Type[1]

TYPE OF VMO	AUG. 1985	AUG. 1986	JULY 1987
Sessional	2,094	2,342	2,571
Fee-for-Service	1,465	1,661	1,704
Honorary	849	685	691
Other (eg lump sum contract)	240	101	81
TOTAL	4,648	4,789	5,047

Source: NSW Department of Health

NOTE: 1. The above data represents approximately 83% of the VMO activity and is, therefore, mainly useful for trend analysis.

3.5 The survey results demonstrate that:

'' the number of both sessional and fee-for-service VMOs has increased; and

the number of both honorary and *"other"* VMOs has decreased.

3.6 The NSW Department of Health survey into 1987/88 sessional and fee-for-service payments by public hospitals identified the following VMO appointment numbers and VMO numbers who received payments during 1987/88:

TABLE 33

	NUMBER OF HOSPITAL APPOINTMENTS BY SPECIALTIES	NUMBER OF VMOS WHO RECEIVED PAYMENTS
Sessional	2,838	(See
Fee-for-Service	1,813	Note)

3.7 Column 2 represents the number of individual VMOs who received either a sessional or a 'fee-for-service payment during 1987/88. As some VMOs received both sessional and fee-for-service payments the total number of 4176 VMOs cannot be divided into the two categories.

3.8 The total in column 2 is also lower than the total in column i because VMOs may hold multiple hospital sessional (or fee-for-service) appointments.

TRENDS IN SESSIONAL AND FEE-FOR-SERVICE PAYMENTS

3.9 The following Tables 3.4 and 3.5 indicate the trends in the two major categories of VMO payments. Lump sum contract payments to VMOs are relatively minor and are therefore not included.

TABLE 3.4

Trends in Sessional and Fee-for-Service VMO Payments

INCREASE ON PREVIOUS YEAR		
YEAR	SESSIONAL PAYMENTS %	FEE-FOR-SERVICE PAYMENTS %
1983/84	....	
1984/85	+ 58	+ 25
1985/86	+ 79	+ 118
1986/87	+ 42	+ 1
1987/88	+ 10	+ 13
1988/89	+ 14[1]	+ 6[1]
Source: Table 3.1		
NOTE: 1. Estimates		

3.10 The 118% increase in 1985/86 for fee-for-service payments was mainly the result of two aspects of the settlement of the 1984/85 Doctors Dispute, namely:

an increase in the fee-for-service paid to country hospital VMOs (from 75% to 85% of the Medical Benefits Schedule fee); and

the introduction of choice of remuneration for VMOs at metropolitan district and country base hospitals (see Appendix 9) which resulted in a significant number of sessional VMOs changing to fee-for-service remuneration.

3.11 The small increase of 1% 'in fee-for-service .payments 1986/87 is a reflection in part of the number of fee-for-service VMOs who changed back to sessional remuneration after the 1985 Macken Determination substantially increased the sessional rates of remuneration.

TABLE 3.5

Trends in Sessional and Fee-For-Service VMO Payments

PROPORTION TO TOTAL VMO PAYMENTS		
YEAR	SESSIONAL PAYMENTS %	FEE-FOR-SERVICE PAYMENTS %
1983/84	68	28
1984/85	72	23
1985/86	70	27
1986/87	76	21
1987/88	76	22
1988/89	77[1]	21[1]

Source: Table 3.1

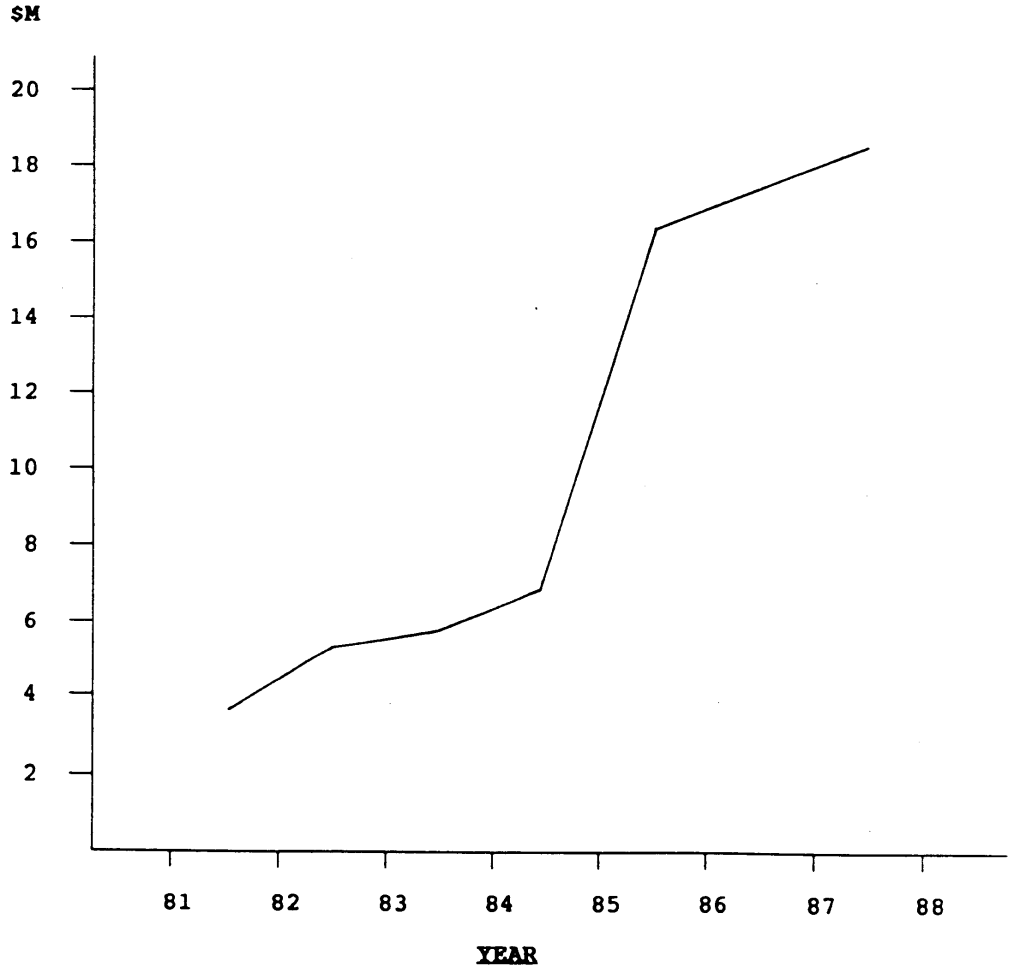
NOTE: 1. Estimates

TRENDS OVER TIME IN SELECTED HOSPITALS AND REGIONS

3.12 The PAC visited the six Health Regions and nine of the ten Area Health Services in NSW. With few exceptions, the VMO payment records of individual Hospitals/Regions/Area Health Services showed rapid growth in VMO payments over tame. For example, Figure 3.2 shows the growth for a typical country health area, the North Coast Region. Figure 3.3 shows the growth for a typical non-teaching metropolitan hospital, the Blacktow n Hospital.

FIGURE 3.2

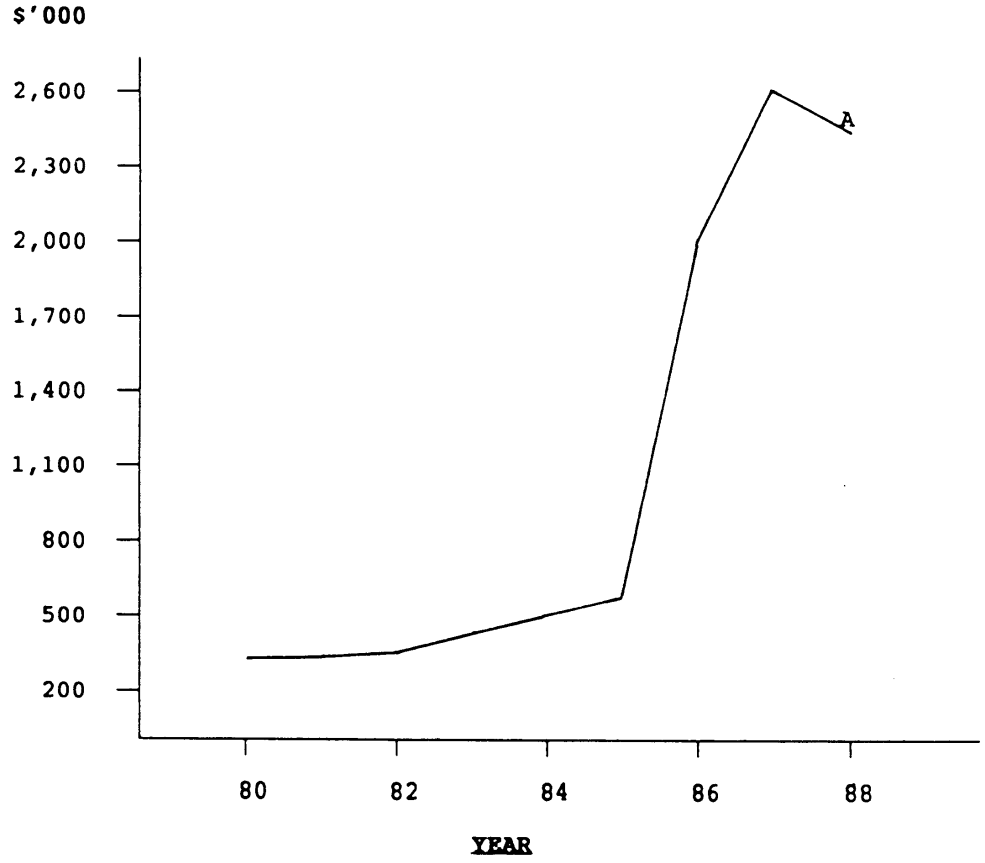
VMO Payments: North Coast Region, 1981/82 to 1987/88



Source: NSW Department of Health, North Coast Regional Office

FIGURE 3.3

VMO Payments: Blacktown Hospital, 1980 to 1988



Source: Blacktown Hospital

NOTE: A - Payments fell as a result of the rationalisation of doctors on-call and a sustained effort in checking and verifying VMO claims.

PAYMENTS BY GROUPS OF SPECIALTIES

3.13 Sessional and fee-for-service payments by public hospitals to VMOs for services to public patients during 1987/88 are shown in Table 3.6. The Table indicates groups of specialties and number of VM0s in these groups arranged in earning bands. Separate tables isolating the sessional payments and fee-for-service payments are detailed in Appendices 10 and 11.

TABLE **3.61**

PAYMENTS TO VMOS $	NUMBERS OF VMOS BY GROUPS OF SPECIALTIES							TOTAL NO. OF VMOs PAID
	MED	SURG	ANAE	0 & G	PATH	RAD	GP	
Between 0-10,000	272	195	77	46	35	52	638	1317
10-20,000	148	82	33	46	12	19	220	560
20- 30,000	108	91	30	43	2	16	154	444
30-40,000	78	72	34	35	3	15	78	315
40- 50,000	103	71	27	34	3	7	62	307
50-60,000	82	82	31	25	0	7	38	266
60-70,000	77	66	33	27	1	6	33	244
70-80,000	48	51	22	17	2	8	16	164
80-90,000	48	40	36	5	0	5	11	145
90-100,000	26	44	27	12	0	4	6	119
100-110,000	13	29	24	4	1	5	5	82
110-120,000	14	26	21	3	1	3	4	71
120-130,000	4	11	17	3	0	2	2	39
130-140,000	5	11	14	2	0	I	0	33
140-150,000	3	5	4	0	1	2	1	16
150-160,000	4	5	6	0	0	0	2	17
160-170,000	0	3	3	0	0	0	0	6
170-180,000	0	2	2	1	0	2	1	8
180-190,000	1	2	2	0	0	1	I	7
190-200,000	0	0	0	0	1	0	0	1
200-210,000	1	0	0	0	0	3	0	4
210-220,000	0	0	0	0	0	3	0	3
230-240,000	0	0	0	0	0	1	0	
240-250,000	0	1	0	0	0	1	0	2
260-270,000	0	1	0	0	0	0	0	1
280-290,000	0	0	0	0	0	1	0	1
310-320,000	0	0	0	0	0	1	0	1
390-400,000	0	0	0	0	0	1	0	1
720-730,000	0	0	0	0	0	1	0	1
	1035	890	443	303	62	171	1272	4176

Source: NSW Department of Health, Survey into VMO Payments in 1987/88 by Public Hospitals.

NOTE: 1. Notes to Table 3.7 apply to the above data.

TOTAL SESSIONAL PAYMENTS, 1987/88

3.14 The major components of sessional VMO payments are:

Ordinary - Sessional: payments for the services provided by VMOs during periods or sessions specified in their respective sessional contract, that is, the normal hourly remuneration.

On-Call: payments for participation in the roster to be available to attend hospital public patients regardless of whether the VMO is actually called to return to the hospital.

- Call Back: payments for a call to attend a hospital public patient at a time when the VMO would not otherwise have attended the hospital.

3.15 The NSW Department of Health's survey into payments to VMOs by public hospitals during 1987/88 indicates that $115.6M was paid to sessional VMOs for services to public patients. This is shown in Table 3.7.

Report on Payments to Visiting Medical Officers

TABLE 3.7

Total Sessional Payments, 1987/88

		M	%
Sessional Payments	:	$ 80.5	70
0n-call Payments	:	$ 23.8	20
Call Back Payments	:	$ 11.3	10
TOTAL		$115.61,2,3	100

NOTES: 1. Does not include cost of the 1986 and following State Wage Case Decisions.

2. Does not include cost of on-call and private practice cost loadings applying to call backs (these result from a Court Decision on 18 May 1988).

3. May include payments for more than 12 months for individual doctors due to late submission of 1986/87 claims.

CURRENT SESSIONAL REMUNERATION

3.16 The current rates of remuneration, including ordinary sessional, on-call and back hours are shown in Table 3.8.

TABLE 3.8

Current Remuneration Rates - Sessional VMOs[1]
Effective From 5th February, 1988

CLASSIFICATION OF VMO	ORDINARY SESSIONAL **HOURS**	**ON-CALL**	8.00 AM TO 6.00 PM **MONDAY TO FRIDAY**	CALL BACKS **OTHER**
	$ PER HOUR	$ PER HOUR	$ PER HOUR	$ PER HOUR
GP with less than 5 years post-graduate experience	83.00	6.30	89.30	98.75
GP with 5 years but less than 10 years post-graduate experience	91.00	7.10	98.10	108.75
GP with 10 years or more post-graduate experience or Fellow of RACGP	108.50	8.85	117.35	130.63
Specialist	127.50	10.25	137.75	153.13
Senior Specialist	135.50	11.05	146.55	163.13

NOTE: 1. Rates shown include the July 1986 State Wage Case Decision - 1985 Macken Determination rates increased by 2.3% - and the March 1987 and February 1988 State Wage Case decisions as interpreted by the Court of Appeal of the Supreme Court of NSW - rates further increased by 9.49% and 5.2%.

TOTAL FEE-FOR-SERVICE PAYMENTS, 1987/88

3.17 The NSW Department of Health's survey into payments to VMOs by public hospitals during 1987/88 indicates that $38.3M was paid to fee-for-service VMOs for services to public patients. This figure is not adjusted for retrospective payments as the figures are in Table 3.1.

CURRENT FEE-FOR-SERVICE REMUNERATION

3.18 The current rates of remuneration for modified fee-for-service VMOs are based on various percentages of the Commonwealth Medical Benefits Schedule fee for the service performed. Table 3.9 provides information on .the applicable rate s of payment for a standard consultation for a country GP, a non-country GP and a specialist. These are only three typical examples as different fees apply to different services across all specialties.

TABLE 3.9

Modified Fee-For-Service Payments to Fee-For-Service VMOs

	STANDARD CONSULTATION MON- FRI **7 AM** - 6 PM SAT 7 AM TO MIDDAY	ON-CALL ALLOWANCE PER DAY	AFTER HOURS CONSULTATION MON - FRI 6 - 10 PM, NOT WARD ROUND	AFTER CONSULTATION SAT, SUN, PUBLIC HOLIDAYS, 6 - 10 PM, NOT WARD ROUND	LATE NIGHT CONSULTATION 10 PM TO MIDNIGHT ALL DAYS	ANTI-SOCIAL HOURS CONSULTATION MIDNIGHT TO ALL DAYS	7	HOURS AM
	S	**S**	**$**	**$**	**$**	**$**		
Country GPs[4]	15.96	63.83	36.731	36.732	63.833	79.793		
Other GPs[5]	15.85	*Not Applicable*	15.85	15.85	15.85	15.85		
Specialist (Physician)[5][6]	44 *20*	*Not Applicable*	44.20	44.20	44.20	44.20		

NOTES:

1. For first patient only, thereafter $26.60
2. For first 3 patients only, thereafter $26.60
3. For first patient, thereafter $36.73
4. Based on Country Doctors Dispute Settlement Package
5. Based on 85% of the Medical Benefits Schedule Fee
6. Initial consultation only

COMMENT ON DEPARTMENT OF HEALTH INFORMATION SYSTEMS

3.19 The PAC sought information concerning VMO cost increases over time, including information about costs in individual hospitals, particular specialties, division of cost into fee-for-service and sessional categories, division of sessional payments into base, on-call and call back components, rostered hours and productivity and output of other medical practitioners in the public hospitals.

Little of this information could be produced immediately by the NSW Department of Health. It took some months before data used in this Report became available to the PAC. Some vital information remains outstanding.

3.21 The NSW Department of Health does not collect detailed information regarding the cost of VMOs across the State on a routine basis.

The routine data collection system of quarterly and annual returns from public hospitals reveals only the total number of VMO appointments and payments. It fails to record the number of hours worked or services delivered (and hours worked varies considerably), nor does it disaggregate the components of the payments into, for example, on-call or call back allowances.

3.23 It is interesting to note that during this Inquiry, the Department conducted a survey of VMO payments in 1987/88 resulting in a great deal o f new computer output information about VMOs and their payments.

3.24 While the survey may be of use to the Department and the AMA in any future negotiations, the PAC found the survey inadequate to the task of addressing the important question of cost benefit.

3.25 The PAC heard evidence to suggest that the Department's management information system failed to produce the data required for an assessment of output, productivity or cost effectiveness of medical practitioners.

3.26 As an example of the problem, information on the number of honoraries and their work was essential to address the Terms of Reference of this Inquiry. Given that Medicare was planned some time in advance, it was also predictable that the role of honoraries would change. The NSW Department of Health should have been assessing how much work they performed, and hence what impact their loss would have (as in the case of Orthopaedic surgeons), and how much it would cost to pay honoraries for their services.

3.27 Apparently little of this research and planning was conducted at the State Department of Health level and the PAC has seen little evidence to suggest that the situation has changed in this regard since 1985.

3.28 The PAC considers it is essential that the NSW Department of Health develop a management information system which can:

assess the "true" cost of providing medical services to public patients;

assess productivity; that is, output per doctor and other hospital staff, and productivity changes over time, for example, as the result of improved technology;

to estimate the other costs (for example, other health .workers) associated with doctors in public hospitals; and

to effectively plan for future service provision.

3.29 It is noted that the NSW Department of Health' s information system has also been the target of criticism on a number of occasions in the past, including the 1985 Urwick Report (unpublished) and 1986 O'Donnell Report [1]. These reports found that a great deal of information was collected and processed by the Department and that the information contained inaccuracies and was put to little use.

3.30 The PAC agrees with the O'Donnell Report (page 11) comment that:

"Generally speaking. the line item. cash limit method of controlling hospitals has contributed to the endless between hospitals and Department - and wastes a lot of administrative effort in the process - but has not really helped hospitals to identify and control costs. The (unpublished) "Urwick Report

'Information to Boards is on a line item basis. But if. say. payments to VMOs is over. they can't see which Division

1 Review of NSW Teaching Hospitals' Financial Performance. Report of the Committee of Review, June 1986 (Chairman: Mr J. O' Donnell).

"We would commend to the Department and the hospitals the direction taken by the State's Treasurer who is moving the State's accounting from a line item to a program or function basis".

3.31 Further, the PAC agrees with the O'Donnel Report ' s recommendations on management information systems (page 13):

"Freeze the present wasteful development of different management information systems (M.I.S.) - stop producing the masses of unused rand often inaccurate) returns and divert the saved resources elsewhere.

"Settle on one primary M.I.S. to be used by all hospitals, which will at least meet the common needs of Department and hospitals and will accommodate extension for hospitals ' individual

to area or network management is the right time to introduce one common system to tie in with the the area management concept."

3.32 The PAC understands that the main findings of the Urwick and O'Donnell Reports have not been made public and have not been acted upon. The neglect.of such reports is, in itself, an indictment of the Department and regrettably shows a failure on the Department's part to be accountable.

3.33 The Department informed the PAC that it had taken steps to implement a new management information system.

Recommendation 2

It is recommended that a management information system be developed by the NSW Department of Health which can be used to measure productivity and assist in on-going review of forms of doctor remuneration in public hospitals. This system is to be reviewed after two years.

Recommendation 3

It is recommended that the NSW Department of Health's management information system measure the input and output of all doctors, including honoraries, working in public hospitals with a view to:

i) assessing the true cost of providing medical services to public patients;

ii) assessing the productivity of doctors; and

ii) evaluating the impact of changes in the form of doctor remuneration on costs and service provision.

4. REASONS FOR THE INCREASE IN VISITING MEDICAL OFFICER PAYMENTS

4.1 The PAC heard evidence in formal hearings and received a number of submissions concerning reasons for the increase in VMO payments between 1983 and 1988.

4.2 The main reasons [2] suggested to the PAC are as follows:

1. The 1985 Macken Determination--
   a) Increase in the sessional base hourly rate of pay.
   b) Increase in the background practice cost allowance.

c) Increase in the on-call rate of pay.

d) Increase in the call back rate of pay.

2. Conversion of unpaid honoraries to paid VMO appointments.

3. Conversion of fee-for-service VMOs to sessional contracts.

4. Conversion of staff (specialists and junior medical officers) and clinical academics to sessional VM0 appointments.

5. More public patients following the introduction of Medicare in 1984.

6. Increase in medical service intensity.

7. Cost of living/economic/other adjustments to VMO rates of remuneration.

8. Increase in the number of claims for payment for on-call hours.

9. Changes in the attitude of doctors following the introduction of Medicare and the 1984/85 doctors' dispute.

10. Retrospective application of the 1985 Macken Determination and late lodgement of payment claims.

2 Some of these include reasons why total payments to all hospital doctors, not Just VMOs, may have increased.

4.3 Each of the reasons suggested to the PAC has been considered. The outcome of these investigations is reported in this Chapter.

REVIEW OF CAUSES OF ESCALATING VMO COSTS

4.4 There is no doubt that the chief single cause of the abnormal escalation of VMO costs is the 1985 Macken Determination relating to sessional remuneration. The Determination:

increased the on-call rate to 10% of the hourly rate.

increased the background practice cost component from a maximum of $2.65 per hour to a maximum Of $25.00 per hour;

- increased and changed the method of applying the Medicare Effect payment. The payment increased from a maximum $12.50 per hour to a maximum of S30.30 per hour. (See Column 2, Table 5.1.)

This resulted in increases in the rate for ordinary sessional hours by up to 90% and tripled the on-call rates.

4.5 Other important factors are:

the increase in the number of VMOs paid on a sessional basis; and

- indexing of sessional and fee-for-service rates for cost of living increases.

1985 MACKEN DETERMINATION

4.6 In December 1985, the Macken Determination dramatically altered the cost relativities between sessional and fee-for-service remuneration. Increases in sessional remuneration *were* based, in part, on the "Medicare *Effect",* that is, loss of income resulting from the shift from private to public pat ient status. In addition, restructured on-call and call back arrangements led to a further substantial increase in total sessional expenditures.

4.7 The effect of the higher sessional rates was compounded by the increase in the number of VMOs engaged under sessional contracts. The conversion of VMO status in order to take advantage of sessional payments is discussed in paragraphs 4.43 - 4.69.

4.8 Four specific aspects of the Macken Determination which contributed to increased VMO payments are discussed in this Chapter:

. sessional base hourly rate of pay;
background practice cost allowance;
on-call rate of pay; and
call back rate of pay.

(a) INCREASE IN SESSIONAL BASE HOURLY RATE

4.9 As noted in Chapter 2, sessional VMOs are paid for ordinary sessions, on-call and call back services.

4.10 The sessional base hourly rate, as determined by Mr Justice Macken in 1985, was ar rived at by the following calculation, using a sessional senior specialist as an example:

Ordinary Remuneration Rate (1)	Medicare Effect Loading (2)	Normal Hourly Rate (1)+(2) (3)	Other Loadings {49.3% of (3)}	Base Hourly Rate (rounded to nearest $1)
$33.00	$30.00	$63.00	$31.06	$94.00

4.11 The *"other loadings"* are paid to compensate for superannuation, split shifts and unpaid leave. Payment for all hours worked (ordinary sessional hours, call back and on-call) is based on the base hou rly rate.

4.12 In addition to the above hourly rate the 1985 Macken Determination granted a background practice costs loading of $20 per hour for general practitioners and $25 per hour for specialists. This increased the senior specialists hourly rate to $119 per hour.

4.13 A survey conducted by the NSW Department of Health found that ordinary sessional hour payments increased by 302% between 1982/83 and 1987/88 as shown in Table 4.1. During the same period payments for on-call and call back increased by 644%.

4.14 The 1985 Macken Determination has been one of the most important causes of this increase. The Determination increased the hourly rates as shown in Table 4.2.

TABLE 4.1
Changes in Sessional VMO Payments

	YTD JUNE 83		YTD JUNE 88 [1]		% CHANGE
Payments	$M	% of TOTAL	$M	% of TOTAL	YTD JUNE 83 YTD JUNE 88
Ordinary	21.39	83%	86.02	72%	+ 302%
On-call/ call back	4.45	17%	33.11	28%	+ 644%
TOTAL	25.84	100%	119.13	100%	+ 361%

Source: NSW Department of Health submission to PAC Inquiry
NOTE: 1. Includes retrospective payments

TABLE 4.2

'Rolled Up'[1] Hourly Rates Exclusive of Private Practice Loading Before and After the 1985 Macken Determination

SESSIONAL HOURLY **RATES**		
CLASSIFICATION OF VMO	**BEFORE DETERMINATION** S	**AFTER DETERMINATION** $
G.P. with less than 5 years experience	38.70	54.00
G.P. with 5 to 10 years experience	42.30	60.00
G.P. with 10 or more years experience or fellowship	49.10	75.00
Specialists	55.20	87.00
Senior Specialists	59.30	94.00

Source: NSW Department of Health, Summary Briefing Paper
NOTE: 1. The "rolled up" hourly rate is derived by applying to the hourly rate, the loadings paid in lieu of superannuation (7.5%), leave (36.8%) and the working of split sessions (5%) - a total of 49.3%.

4.15 The magnitude of the increase in the sessional base hourly rate granted by Mr Justice Macken was certainly a surprise to both the NSW Department of Health and many individual doctors with whom the PAC met. Many considered that the new rates were "over-generous" by a large margin. The AMA considers the 1985 Determination to have been "equitable" rather than *"over-generous".*

4.16 The adversarial nature of the debate continued long after the arbitration process was completed. While the sessional VMOs and their representative body, the AMA, claim that the 1985 Macken Determination was fair and Just, the PAC was overwhelmed with evidence from other interested parties pointing out anomalies in, and created by, the Determination.

4.17 Following the 1985 Macken Determination, disagreement arose in respect of whether the on-call allowance should be paid when a VMO provides call back services. The Court of Appeal of the NSW Supreme Court held that payment for call back hours should <u>also</u> include the payment of the on-call allowance.

4.18 The PAC considers that the effect of this is a double payment. The anomalies created by this interpretation of the 1985 Macken Determination are discussed in detail in Chapter 5.

4.19 The anomalies and inequities of the sessional hourly base rate are discussed further in Chapter 5. The specific aspects of the sessional base hourly rate reviewed in Chapter 5 are:

- inclusion of the Medicare Effect in the rolled up rate;

inclusion of the superannuation, unpaid leave and split shift allowances in the rolled up rate; and

application of State Wage Case decisions to the sessional base hourly rate.

4.20 As the total number of "ordinary" sessional hours claimed increased by only 29% between 1982/83 and 1987/88 (NSW Department of Health records), it is the increase in the hourly rate of pay as determined by Mr Justice Macken in 1985, rather than the increase in the hours claimed, which is more important in explainin g increased payments to

(b) INCREASE IN BACKGROUND PRACTICE COSTS LOADING (PRIVATE PRACTICE LOADING)

4.21 Background practice costs are the overhead costs VMOs necessarily incur in operating their private practice. These costs include:

- rental or ownership costs of an office or surgery;
- salaries for a receptionist and nursing assistant;
- stationery, postage, telephone; and
- insurance.

4.22 A background practice cost loading has been applied to VMO sessional remuneration on the basis that cha rges for time spent with public patients in public hospitals should include a proportion of the overheads incurred in running a private practice. The AMA has argued that the loading is necessary to ensure that the VMOs return from the

private practice as a whole is not adversely affected by time spent with public patients in public hospitals.

4.23 Despite the NSW Department of Health arguing that there should be no recompense for background practice costs, a loading for this component has been included in all determinations on sessional rates since 1979.

4.24 By November 1985, the private practice loading of $1.90 per hour for GPs and $2.50 per hour for Specialists (as set by the 1981 Macken Determination) had risen to $2.65 and $3.49 respectively by the application of State Wage Case decisions.

4.25 In his 1985 Determination, Mr Justice Macken substantially increased the loading to $20.00 per hour for GPs and $25.00 for specialists. The private practice loading is paid in addition to the normal hourly rate. The $94.00 per hour sessional rate quoted in Table 4.2 is, therefore, increased by $25.00 giving a total sessional hourly rate of $119.00 for a Senior Specialist.

'4.26 The 1985 Determination stated that this loading:

"... shall be paid ... per hour during which the (VMO) provides services under his sessional contract"

4.27 .Tested in the Courts [3], it was decided that the-.background practice cost loading applies not only to ordinary sessional hours, but also to call backs and travelling time associated with call backs.

3 Supreme Court of New South Wales, No. CA 275 of 1987 and No. ED 3935 of 1986

4.28 Table 4.3 indicates the effect of the increase in the background practice cost loading after the 1985 Macken Determination. To put the increase into proper perspective, the background practice loading now represents:

about 15% of all payments made to sessional VMOs

about 11% of all VMO payments during 1987/88

and has been estimated at approximately $23M for 1988/89.

TABLE 4.3

Effect of Increase in the Background Practice Costs Loading - 1985 Macken Determination

Classification of VMO Increase	Rolled Hourly Rate[1] if Loading not Amended by Justice Macken	1985 Determination Rolled Hourly Rate	up Macken Up
	$	**$**	
	%		
GP (less than 5 years) 30	57	74	
GP (5 to 10 years)	63	80	27
GP (more than 10 years)	78	95	22
Specialist	90	112	24
Senior Specialist	98	119	21

NOTE: 1. Assumes the 1985 Macken Determination is applied except for the increase in the Background Practice Costs Loading, which for the purpose of this exercise is included at the 1981 rates appropriately escalated for State Wage Case judgements.

4.29 The PAC considers that in the 1985 arbitration, Mr Justice Macken may have had evidence submitted on background practice costs by the AMA which was highly selective and that the NSW Department of Health argued an ill-prepared case on this issue. Further, the PAC considers that the · dollar value of the private practice component was an ad hoc figure, unsupported by principle or proper analysis.

4.30 The anomalies and inequities of this aspect of sessional remuneration are discussed furt her in Chapter 5.

(c) INCREASE IN ON-CALL RATE OF PAYMENT

4.31 On-call payments are made to sessional VMOs for holding themselves available during a specified period of rostered time to attend hospital public patients. It should be noted that the payment is made on the basis of the number of hours rostered on-call, and is. not related to whether the VMO is actually called back to the hospital.

4.32 The current on-call payment for sessional VMOs is 10% of the hourly base rate.

4.33 On-call and call back payments to VMOs increased by 644% over the 1982/83 - 1987/88 period, as shown previously in Table 4.1. Not only is this 644% increase remarkable in itself - it also brings the on-call and call back component of payments to almost one third of the total VMO bill.[4]

4 Background practice costs loading does not apply to the on-call rates of pay. The information supplied by the NSW Department of Health does not permit separation of on-call and call back payments to VMOs for 1982/83 - 1987/88.

4.34 **In** 1987/88, on-call payments represented 20% of all payments to sessional VMOs and about 15% of all VMO payments in NSW [5]. These figures are extraordinary; that is, almost $24M was paid in 1987/88 to sessional VMOs for holding themselves available for *be called in to the hospital".*

4.35 The PAC received evidence at one large country hospital it visited that:

"on-call payments now amount to 40% of the hospital's budget for VMOs".

4.36 The existing arrangements for on-call payment for sessional VMOs are unsatisfactory. The cost of having on-call cover in a specialty at a hospital with only VMOs and no staff specialists in that specialty is approximately $88,000 per year. That is, in a hospital where there is only one senior specialist VMO in a particular specialty, that VMO could earn $88,000(6) for being on-call alone. If the specialty were one which rarely required call backs, the value of this service is questionable.

4.37 The anomalies and inequities of on-call payments for sessional remuneration are discussed further in Chapter 5.

(d) INCREASE IN THE CALL BACK RATE OF PAY

4.38 Call back payments are made for services provided to a public patient when a VMO is called back to the hospital when they would not otherwise have attended the hospital (that is, outside the normal sessional hours).

5 These figures relate to a different survey that referred to in Note 3.

6 Assumes Senior Specialist base hourly rate of $96.00 plus 9.49% plus 5.2% (see Chapter 5) and 15 hours sessional per week.

4.39 The current call back allowance for sessional VMOs is 10% of the hourly base rate for the hours 8.00 a.m. to 6.00 p.m., Monday to Friday and 25% of the hourly base rate for all other hours (except public holidays which attract a 50% loading). The 1985 Macken Determination provided for a minimum call back payment of one hour plus travelling, time to a maximum of 20 minutes each way.

4.40 By a decision of the Court of Appeal of the Supreme Court of NSW, the background practice cost loading is also applied to call back payment.

4.41 As noted in paragraph 4.13, payments to VMOs for being on-call and called back increased by 644% over the 1982/83 - 1987/88 period. Call back payments represented approximately 10% of all payments to sessional VMOs in 1987/88.

4.42 The anomalies and inequities of call back payments for VMOs are discussed further in Chapter 5.

CONVERSION OF UNPAID HONORARIES TO PAID VMOS

4.43 Evidence was submitted to the PAC that the increase in VMO payments was attributable in part to the conversion of unpaid' honoraries to paid VMO status.

4.44 As an indication of the volume of VMOs who changed their status, .the NSW Department of Health has advised that in the two months following the release of the details of the 1985 Macken Determi nation, 126 honoraries converted to paid VMOs at a per annum cost of some $3.1M to the Department.

Public Accounts Committee

4.45 The Department of Health has estimated that honorary Visiting Medical Practitioners numbers decreased by some 20% between 1984/85 and 1986/87. Little information is available as to how much the honoraries contributed to the provision of services to hospital patients and, therefore, the effect of this reduction in the number of ho noraries cannot be related quantitatively to the rise in VMO costs.

4.46 The reason for the change, according to one doctor, was as follows:

"The change from Honorary to paid visiting status of many senior doctors, such as myself . . . was made when it became apparent that the Government was determined to socialise the Public Hospital System."

Another **doctor said:**

"The incomes of VMOs have come to depend ' more and more upon their remuneration for the management of "hosPital" patients as the proportion of their patients with private health insurance has decreased. Thus more and more doctors have relinquished their honorary status and have sought .payment for their services in public hospitals"

4.47 The AMA expressed its official view as follows:

"Following the introduction of Medicrare some visiting medical officers suffered drastic reductions in their remuneration. This was because up until the introduction of Medicare the so called Robin Hood principle operated within the public hospital system. That is to say, visiting medical officers were able to and did provide services free of charge, to the needy, as they were adequately compensated by being able to charge appropriately those persons who had private health insurance or persons who chose to be treated

privately. With the advent of Medicare there came a massive transfer of patients from the private to the public sector thereby depriving visiting medical officers of their main source of income".

the AMA stated:

fallen off substantially as they can't make ends meet.

"... the drop in the number of insured patients made it less possible for a doctor to continue to provide his services to the uninsured patient for no remuneration; he just couldn't make ends meet with his fairly substantial overheads.

"So that is one of the reasons why the costs have increased, in that there are more people (doctors) *actually billing for their services than there were five years ago ".*

4.49 Informal comments made to the PAC also suggested that:

some doctors felt the Government had interfered so much .with their profession that they wanted to retaliate by getting their "found of flesh" and to *"extract every lastpenny";* and

some doctors felt the rates were so generous that they wanted to extract as much as they could *"before the loopholes were closed".*

4.50 The PAC found it difficult to assess from the data available what portion of the increased payments to VMOs was due to the conversion of previously unpaid honoraries to paid VMO status and whether some of the increase was due to the lower propensity to bill by some VMOs.

4.51 The NSW Department of Health could not provide the PAC with an accurate number of unpaid honoraries in 1983 and 1988, information on the public work they actually performed in terms of patient numbers, hours worked, or other relevant data. The Department cannot quantify what nursing, administrative and equipment costs are associated with the work of honoraries. The Department did not know how many honoraries changed to fee-for-service, sessional or other contracts.

4.52 It is extraordinary that the Department could only guess at the number of honoraries in the public system both before and after Medicare.

4.53 The PAC received a number of submissions concerning the merits and demerits of the old honorary system. Its abolition has certainly caused an adverse reaction from sections of the medical profession.

4.54 Whatever its merits, it appears that the *"old"* honorary system no longer exists and is most unlikely to be reinstated - at least in its extensive pre-Medibank form. This cause of the cost increase in VMO payments could not be avoided by the NSW Government. It was partly a result of Federal Government policy and was predictable.

CONVERSION FROM FEE-FOR-SERVICE TO SESSIONAL REMUNERATION CONTRACTS

4.55 As noted in Chapter 2, only those VMOs working in country base and metropolitan district hospitals were free to elect to change their method of remuneration following the 1985 Macken Determination, and then they were only able to do so if the majority of their specialty group chose to change at the particular hospital.

4.56 As a result of the continuing increase in both sessional and fee-for-service VMO numbers, and the varying times spent by VMOs performing their duties, it was difficult to determine whether there has been a sustained shift from fee-for-service to sessional status.

4.57 The NSW Department of Health, however, did advise that in the two months following the issue of the Departmental Circular advising details 'of the 1985 Macken Determination, 162 VMOs had changed from fee-for-service status to sessional status at an additional cost of $4.2M per annum.

4.58 The 1985 Macken Determination almost doubled the sessional rates of pay. This inordinate increase raised sessional VMOs' incomes to above fee-for-service payments for an equivalent provision of medical services.

4.59 No formal evidence was given, and the NSW Department of Health could not provide a quantitative estimate of the impact of fee-for-service versus sessional p ayment on net income of VMOs.

4.60 It is clear that Mr Justice Macken did not merely bring sessional rates of pay into line with rates of pay for other practitioners - he did not achieve what he set out to do. Mr Justice Macken apparently did not consider in detail the medical benefit rebate system by which fee-for-service doctors are remunerated in hospitals. This appears to have caused a major anomaly in that the sessional rates are now much higher than equivalent fee-for-service rates.

4.61 The PAC is convinced that for many VMOs the 1985 Macken Determination lifted sessional rates of remuneration considerably above fee-for-service remuneration for performing the same services. Consequently, the change from fee-for-service to sessional status is due in part to the higher remuneration which could be obtained under the latter arrangement.

CONVERSION OF STAFF SPECIALISTS AND CLINICAL ACADEMICS TO VMO APPOINTMENTS

4.62 The PAC noted that following the Medicare doctors' dispute and the 1985 Macken Determination, many doctors switched from a salaried status to VMO status. It has been submitted that "there is a queue to become a VMO" because of .the income and conditions attached to VMO appointments.

4.63 The PAC was hampered in its attempt to quantify this conversion because historical statistics concerning the numbers of Staff Specialists, Junior Medical Officers and Clinical Academics employed were not in the pos session of the NSW Department of Health.

4.64 The weight of verbal evidence, however, would suggest that there has been a pronounced shift away from the provision of medical services by salaried medical staff to the use of VMOs.

4.65 The PAC heard evidence at public hearings from an eminent VMO who had previously been a staff specialist, to suggest that there were a number of other factors apart from rates of pay which may have influenced the observed switch of status. This is illustrated in the following evidence given at a public hearing (25th January, 1989):

PAC: "But why did you become a VMO?

The reasons for that are complex ... I was never very good at filling out requisition forms .. o and it was important for me as a person to get out to work in other hospitals, to meet different people, to see how people were doing things differently.

The other side of that coin was my desire to become an academic neurosurgeon and I did some research in Oxford and wrote a thesis and got a post-graduate degree and was interested in academic medicine, but my perception, having looked at academic medicine in Australia, was that there was very little future in it, certainly academic surgery in the early 1980s and I don't think things have changed very much."

4.66 It could also be argued that the trend towards VMO appointment was due to the type of positions which were created. If the NSW Department of Health,hospitals "created" more VMO positions in lieu of staff positions, then this could explain the trend.

4.67. It should be noted that the conversion of staff specialists and clinical academics to VMO appointments cannot' be controlled by simply specifying the number of each category of appointment a hospital *"should~* have (however determined). Many forces determine the ease of recruiting doctors to VMO rather than other types of

appointments, including the influence of the AMA, Specialist Colleges restrictions and geography.

4.68 The 1985 Macken Determination increased the sessional VMO rates of payment to a level above that of staff specialists and fee-for-service VMOs. The PAC considers that the propensity of doctors to seek VMO appointments rather than staff appointments reflects this difference in rates of remuneration.

4.69 In summary, the increase in payments to VMOs is due, in part, to some staff speci alists (and to a lesser extent clinical academics) switching to VMO appointments. The effect is not as great as the effect of honoraries choosing to take up paid VMO appointments. Unfortunately, the quantitative effect cannot be assessed using information provided by the NSW Department of Health.

MORE PUBLIC PATIENTS

4.70 Following the 1984 introduction of Medicare, many Australians relinquished their private health insurance and elected to be treated as Public patients by doctors assigned to them by the hospital which they attended. Apparently, those who relinquished their private insurance felt that the compulsory "premium", the Medicare levy of 1% on taxable income (and later increased to 1.25%), would provide sufficient medical cover while in hospital.

4.71 The number of public patients was further increased by some privately insured patients electing to be treated as public patients when admitted tO a public hospital.

TABLE 4.4

Change in Total Numbers of Public and Private Inpatient Bed Days in NSW Public Hospitals

	1982/83 ('000's)	1987/88 ('000's)	CHANGE 1982/83 - 1987/88 %
Public patient Bed-days ('000'S)	3,244	3,917	+21
Private Doctor patient Bed-days ('000's)	3,294	2,094	-36
Total Bed-days ('000's)	6,538	6,010	-8

Source: NSW Department of Health

TABLE 4.5

Change in Proportions of Public and Private Inpatient Bed-days in NSW Public Hospitals

	1982/83	1984/85	1987/88
Percentage of Public patient Bed-days	49.6	66.1	65.2
Percentage of Private Doctor patient Bed-days	50.4	33.9	.34.8

Source: NSW Department of Health

4.72 The change in insurance status and privately insured patients opting to be treated as public patients have been major factors resulting in an increase in the number and proportion of public bed-days as shown in Tables 4.4 and 4.5.

4.73 The Commonwealth/State financial arrangements of the Medicare Agreement specified that patients were not to be charged for medical services in public hospitals if they chose to be treated as public patients.

4.74 Thus, it is not surprising that public inpatient bed days should have increased and that this increase would contribute to increased VMO costs.

4.75 However, the change in public/private insurance was not symmetrical in its effect on bed-days. Public inpatient bed-days increased b y 21% while private doctor bed-days in public hospitals declined by 36%. This difference may be due' to a shift of private work to private hospitals, or the fact that those who remained with private insurance generated less hospital bed-day occupancy.

4.76 The 21% increase in the number of public patient bed-days in public hospitals explains at least some of the increase in VMO costs. The PAC could not precisely determine the proportion 'of the increase in VMO payments **which could** be' attributed to this increase in public work. Such an exercise would require knowledge **of:**

- the age, sex and case-mix of those who changed from private health insurance status;

- the intensity and type of medical treatment . provided to these patients;

how much treatment was provided by VMOs rather than other medical personnel; and

what the actual cost of the VMO services were.

4.77 This information is not readily available from the NSW Department of Health. This, again, is a reflection of the inadequacy of the Department's management information systems.

4.78 Another matter of relevance is the impact of Medicare on the State's budget. The introduction of Medicare increased the burden of health care on the States for the following reasons:

loss of accommodation charges from formerly privately insured patients; and

the extra cost 'of providing medical care (which was formerly covered by private health insurance funds and the Commonwealth Government).

4.79 While the Commonwealth collects the 1.25% levy on income, the State has to negotiate for its share from the "Medicare Agreement", which is negotiated every five years. The State thus receives compensation funding from the Commonwealth for treating public patients. There is some question as to whether this funding is sufficient to cover the extra costs imposed on the State by the Commonwealth's introduction of Medicare.

4.80 While this is an important point in terms of Commonwealth/State financial negotiations and in terms of the State's ability to pay extra VMO payments out of its budget, it is not essential to the question of why

payments to VMOs have increased. Payments, either through the State or the Commonwealth, are ultimately borne by the

4.81 Since 1975 (but excluding a period from 1981/83) the Medicare Agreement has required the State to provide outpatient services free of charge to any person presenting as a public outpatient at a public hospital. The result of this situation is that substantial non-urgent outpatient activity has developed at public hospitals, particularly in country areas where after hours medical services are not available. The PAC could not determine the effect of this practice on VMO payments. It is noted that the NSW Department of Health is collecting information on this issue.

4.82 The PAC found that the introduction of Medicare led to a large increase in public patients, which in turn led to an increase in payments to VMOs. This extra cost is borne by the State Government, not the private health insurance funds and the Commonwealth Government, as was the case prior to Medicare.

4.83 The Committee recognises that apart from the effect of Medicare, other factors may generally affect the number of public patients. For example, the increase in the pensioner population (especially aged and unemployed persons, many of whom have Medicare-only insurance) may contribute to VMO payments. These demographic trends are considered to have only a minor effect.

INCREASE IN MEDICAL SERVICE INTENSITY

4.84 In a submission from the NSW Department of Health it was noted that even though available beds decreased by 11.4% in the period 1982/83 to 1987/88:

hospital separations (the total of public and private patients discharged) had increased by 1.3%;

average length of stay of all public hospital

patients had decreased from 7.2 to 6.5 days; and

bed occupancy had increased by 2.8% on average,

the lowest occupancy being in some country hospitals (between 65% - 75%).

4.85 The Department argued that:

"What this indicates is that even though there are less beds and bed-days in the system, the throughput of patients is significantly higher.

"Higher throughput leads to an increase in the intensity of service provision. Although better patient management and new technology have led to shorter lengths of stay, the number of services provided over time (intensity) has increased. It is well known that most services, including medical services, are provided to patients in their first 2 to 3 days stay as hospital inpa tients "

4.86 This higher throughput could contribute to an increase in medical services payments. However, the PA C could not isolate the change in intensity of service for public patients. The PAC found that the inadequacy of the Department's management information data base regarding

VMOs hindered the PAC's ability to assess quantitatively the relationship between service intensity and the rise in VMO payments.

COST OF LIVING ADJUSTMENTS

4.87 Similar to the process of wages indexation, VMO remuneration rates are also periodically adjusted t o reflect Wage Case Decisions and other economic factors.

4.88 Fee-for-service rates are indexed from time to time by way of adjustments by the Commonwealth to the Medical Benefits Schedule fee levels. When indexing does occur, the same escalation factor is not applied to all the items of service in the schedule. The fee-for-service remuneration rates received by VMOs have increased by some 40% since 1982/83 through this process.

4.89 All of the Determinations regarding sessional rates of pay since 1979 have included a provision for the variation of the rates to the extent necessary to give effect to the change in the basic wage. Since 1982/83, increases of approximately 45% have been applied to the sessional hourly rate of pay, 6% relating to a work value case and

the remainder for flow-ons of Wage Case Decisions (including the' controversial 9.49%. and 5.2% for the February 1987 and March 1988 decisions, referred to in paragraphs 5.40 to 5.53).

4.90 Clearly, the above increases would increase VMO payments accordingly and in part explain some of the increases in costs since 1982/83.

INCREASE IN CLAIMS FOR PAYMENT FOR ON-CALL HOURS

4.91 Over the 1983 to 1988 period there has been an increase in the number of paid on-call hours. This increase has occurred for two reasons:

change in attitude - on-call was previously reimbursed at such a low rate that many VMOs did not bother to claim for payment. Attitudes changed with the introduction of a significant payment specifically for on-call. Doctors who had previously considered on-call to be a part of their duty started claiming payment.

an increase in rostered specialties - hospitals now include an increasing' number of major specialties in on-call rosters. Hospitals are mindful that they may be open to criticism from VMOs and the community if they do not have each specialty providing on-call cover.

4.92 The PAC understands that Mr Justice Macken did not intend the extensive on-call rosters and consequent payments which are made at present. That is, he meant the on-call rate to be applied to a "reasonable" number of hours of on-call, presumably "after hours" on-call when the inconvenience is more significant.

4.93 The anomalies and inequities of this aspect of sessional remuneration are discussed further in Chapter 5.

4.94 The issue of on-call fostering is also a management issue and is discussed further in Chapter 6.

CHANGED ATTITUDES

CLAIMS FOR PAYMENT

4.95 The PAC heard comments which suggested that the attitude of doctors towards claiming for services provided in the public sector had changed and that this greater willingness to claim had resulted in increased VMO costs.

4.96 For example, a VMO informed the PAC that one cause of the increasing payments **was:**

"The alienation of VMOs by the bureaucratic hierarchy. In the private hospital system the administrators and the visiting doctors usually have a harmonious relationship. Unfortunately, this is the exception in the public hospital system: too often bureaucrats determine policy without reference to the doctors primarily responsible for the care of patients. At present VMOs face an impenetrable buffer zone of bureaucrats between themselves and the decision makers. This has created an atmosphere of distrust within public hospitals and a tendency for doctors to grab what they can before more bed closures and practice restrictions are imposed".

4.97 While this change in attitude is important for several reasons, by itself, it does not account for a large proportion of the increase in VMO payments.

4.98 The PAC considers that the introd uction of Medicare resulted in doctors, who previously received income from private patients only, moving to a system in which they claimed payment from private patients and from the Government for public patients.

ABUSE OF THE SYSTEM

4.99 A number of submissions to the PAC outlined actual and potential misuses and abuses of the system of VMO remuneration, including:

paid sessions being used for other than public patient services. This includes--

- seeing private patients at the same hospital

- not being at the hospital

instructing private patients to come to the public hospital for out of hours services, thereby attracting a call back for a "public" patient who would otherwise have gone to a private surgery; and

being paid on-call at two or more hospitals for identical on-call periods.

4.100 The PAC **could not** find evidence that such abuse was widespread, although some individual cases were verified. There is no evidence to suggest that exploitation of the system accounted for a significant proportion of the increased cost of VMOs.

4.101 Nevertheless, given the present legal requirements under the 1985 Macken Determination, verification of sessional claims is not usually possible and this needs to be remedied. This issue is discussed further in Chapter 6.

RETROSPECTIVITY

4.102 The PAC heard evidence that payments to VMOs had increased significantly because:

the Macken Determination was applied from a date prior to the actual Determination; and

doctors who initially did not claim payment, tendered claims for services provided up to two years prior to submitting their claims.

RETROSPECTIVITY OF THE DETERMINATION

4.103 The Public Hospitals Act, Section 29M, specifies that the arbitrator shall set a date *"not being a date or dates earlier than the date of the determination"* from which the Determination applies.

4.104 The arbitrator is expressly forbidden to award retrospectively and it is understood that retrospectivity was not raised as an issue before the arbitrator.

4.105 In the Determination brought down by Mr Justice Macken on 19th December, 1985, it was stated that *"this Determination shall have effect and operate from Wednesday 1st January, 1986".*

4.106 To assist in ending the 1984/85 doctors' dispute, the interim resolution package backdated the $12.50 Medicare Effect increase in sessional hourly rates to 1st July, 1984. Subsequently, the increased Medicare Effect as determined by the 1985 Macken Determination was backdated to 1st July, 1984.

4.107 Thus, in the first financial year following the introduction of the 1985 Determination, there was a significant increase in payments. (The data in Table 3.1 on payment to Public Hospitals for VMOs has been adjusted for retrospective payments.)

4.108 The decision to award payments retrospectively has occurred in other industrial disputes (for example, the steel industry, the waterfront and other industries) and was difficult to avoid given the protracted nature of the doctors' dispute.

4.109 It highlights the problem for public sector managers of risk management; that is, the avoidance of a strike versus acquiescence to unions.

LATE LODGEMENT OF CLAIMS

4.110 Evidence submitted to the PAC included correspondence between a major teaching hospital, one VMO and the NSW Department of Health which revealed that the VMO was claiming for services provided up to two years earlier. The effect of this practice was devastating for management because such payments could not be.planned or budgeted for in advance.

4.111 In the *Raisons for Determination* pages 32-33, Mr Justice Macken stated:

"The AMA sought to have the new Determination provide a right to payment
within 14 days of submission of an
account and, in default, payment of
interest at the rate of 20% per annum.

provision but agreed to instruct hospitals to pay accounts, where practicable, within one month of receiving them. In view of this undertaking I do not propose to change

the provision to reflect the AMA claim but I expect that the AMA will monitor the position and if the instruction to the Health Corporation leads to hardship for VMOs no doubt an application will be made to have the position reconsidered at the time of the next Determination."

4.112 Sessional VMOs are required by Clause 14 of the 1985 Macken Determination to submit claims by no later than the 15th day of the next calendar month from the date of service.

4;113 It is not known how many VMOs lodge claims later than one month after the service is provided. The PAC formed the impression from its hospital inspections that the practice was widespread.

4.114 However, there are no sanctions to ensure claims are submitted on time. The Department of Health has attempted to ensure that this "loophole" is closed and that all claims are lodged within the current accounting period.

Recommendation 4

It is recommended that all future VMO contracts include a provision that hospitals not be compelled to pay a VMO claim which has been submitted more than two months after the end of the month in which the services were provided.

5. ANOMALIES AND INEQUITIES

INTRODUCTION

5.1 Term of Reference 3 of this Inquiry requires the PAC:

"To identify and analyse any anomalies and infinities in

5.2 The following anomalies were brought to the PAC's attention during its inquiries:

- the determination of the hourly base rate, particularly the inclusion of the Medicare Effect loading;

- the inappropriate inclusion of superannuation, unpaid leave and split shift loadings in the normal bas e hourly rate;

- the inappropriate application of recent State Wage Case decisions (flat weekly increases) to the sessional base hourly rate;

- the system of on-call payments and on-call rosters;

- the system of call back payments, particularly the simultaneous payment for call back hours and on-call hours;

- the inclusion of a significant background practice costs loading in the sessional base hourly rate;

the incentive to change the status of public hospital patients;

comparison with payments for VMOs interstate, particularly compensation for the Medicare Effect;

the variation in on-call and call back pay arrangements between staff specialists, clinical academics and sessional and fee-for-service VMOs; and

the lack of accountability built into the claim form requirements which effectively means that claims for payment cannot be routinely verified or audited in the usual manner (discussed in Chapter 6).

5.3 These anomalies have caused increased payments to VMOs and provided opportunity for dissension amongst those providing medical services to public patients in public hospitals.

5.4 During the course of this Inquiry, the PAC became aware of the following anomalies underlying the basis of sessional VMO remuneration:

VMOs place great emphasis on being 'indepndent contractors" in relation to their public hospital appointments and yet they seek all the benefits of employee status (particularly financial security) through an industrial determination;

- the 1985 industrial determination cannot be remitted to the Industrial Commission of NSW for interpretation and it has been interpreted in accordance with strict principles of contract law, rather than an industrial determination, in the Supreme Court of NSW; and

- the present system of payment for sessional VMOs is "*doctor-driven*" in the sense that hospitals do not determine in advance the number of hours or services to be provided by VMOs based on patient numbers, case-mix or availability of star f specialists - rather, payments are based on hours claimed retrospectively by VMOs.

SESSIONAL BASE HOURLY RATE

5.5 The PAC considers that the increase in the sessional base. hourly rate and the method of its calculation, as determined by Mr Justice Macken in 1985, have caused anomalies and inequities in sessional remuneration.

5.6 The following aspects of the sessional base hourly rate are discussed:

inclusion of Medicare Effect compensation; unpaid leave and split shift loadings; superannuation loading; and application of State Wage Case Decisions.

5.7 The magnitude of the increase in the hourly base rate resulted in increases in the rates for ordinary sessional hours by up to 90%. The AMA was questioned about the equity of the increases as follows:

"The 1985 Macken Determination, do you think that was over-generous?

WITNESS: No ·. · not at all. That was a decision which was presided over by one of the most experienced judges in the arbitration court, and I think it was an equitable decision. By no means do Z think it was over-generous at all . ·.

You were disappointed because you thought you should have got $180, and you only received $119?

WITNESS:: We accepted the arbitrator's decision, and we expected the government to do so too. It was an arbitrator's decision, argued rationally and reasonably at some length with a wealth of information, we accept his version as being reasonable and just·

PAC.. If it was reasonable and just, the $180 was excessive P .

WITNESS: We can see that we couldn't necessarily get what we thought was reasonable, but you must remember that this was at a time of enormous industrial upset,, and we felt that rather than have any demur about that finding, we should accept it for the sake of the maintenance and running of the hospitals in New South Wales.

We have heard evidence presented to the Committee that some of the medical profession thought it was a wee bit over-generous.. What percentage of the medical profession does the AMA represent ?

WITNESS: The people concerned in this determination, and we are talking mainly about ...[doctors] in proceduralist functions. I can't give you a precise figure, but overall in the State it probably represents about 50%, [of all VMOs] *but that takes in general practitioners. I think the figure would be much higher than that when it comes to proceduralists. And under the statute, I understand we represent all* ***VMOs.***

PAC: I understand that you were the only people with legal standing before the arbitrator, is that correct ?

The Commonwealth Government was also in attendance, they were recognised as parties to the dispute.

No, I mean from the medical profession?
We were the only medical representation at that inquiry, in this instance, you are quite right.

How do you reconcile the fact then that we have had evidence from VMOs who thought it was a bit of a windfall, that it was a little unexpected?

I would find it hard to get into their minds."

5.8 The PAC did not proceed with further inquiry in regard to this matter given that the AMA would not concede that their claim for $180 per hour was less than equitable. The NSW Department of Health and many individual doctors maintain that the rate actually granted, $119 per hour for Senior Specialists, was over-generous.

5.9 The PAC considers anomalies were also created in that there were aspects of the sessional base hourly rate which were incorrectly app1ied, particularly the inclusion of various loadings. These are discussed below.

Recommendation 5

It is recommended that the NSW Department of Health seek an urgent review of all components of the sessional hourly base rate as to principle and quantum, and the calculations of the hourly base. rate if the sessional system of payments is to be retained.

(a) INCLUSION OF MEDICARE EFFECT COMPENSATION

QUANTUM OF COMPENSATION

5.10 The introduction of Medicare was said to 'reduce the private patient income which doctors could earn in public hospitals. This is known as the Medicare Effect and was recognised by Mr Justice Macken as an important reason to increase the sessional rates of pay.

5.11 The PAC was concerned to find that Mr Justice Macken said

. . in relation to the quantum to be awarded for the Medicare Effect:

"The real difficulty lies in the fact that the fixation of such an amount calls for the application of intuitive faculties rather than a mathematical mind". (Reasons for Determination, page 18.)

5.12 Mr Justice Macken, on page 9 of his *Reasons for Determination* (of the 1985 Determination) states:

voluminous and as it was largely unchallenged [ephasis added] I need *only refer to examples to indicate its effect on VMO practices. One VMO said that where previously he had charged a rebated fee to only 7% of his patients this had now risen to 40% Another said that in his Western Suburbs teaching. hospital the proportion of private to public procedures had fallen from 50% to 13%. Another claimed that his 73% private patients had fallen to 53%. Other evidence proved equivalent reductions in every specialty."*

5.13 What Mr Justice Macken did not mention in his *Reasons for Determination* was that the VMO whose proportion of private patients fell from 73% to 53%, increased his income from fees by 27% over the same period.

5.14 The *"voluminous"* evidence referred to actually consisted .of 94 exhibits, some 21 of which were selected financial statements from individual doctors' practices. These doctors were witnesses called by the AMA to appear before Mr Justice Macken.

5.15 In applying *"intuitive faculties"* to the determination of an amount, Mr Justice Macken did not appear to notice that the doctors' financial records generally did not separate income from private patients from that derived from public patients. It would also appear that Mr Justice Macken did not attempt to average the decline in incomes presented as evidence in reaching a figure for Medicare Effect compensation. There was apparently no attempt to draw systematic or general conclusions from this material.

5.16 Further, Mr Justice Macken did not consider, and evidence was not presented, that any decline in income could possibly be attributed to factors other than the Medicare Effect.

5.17 The NSW Department of Health also failed to present evidence which could demonstrate that some VMOs may have increased their income after the advent of Medicare due to the extra income received from treating the increased number of public patients in hospitals.

5.18 PAC analysis of sixteen of the twenty-one VMOs (Specialists) pre and post Medicare fee income details (1982/83 and 1984/85) submitted to Mr Justice Macken reveals:

- one VMO's income did not change;
  nine VMOs' incom e declined by an average of 8%; and
  six VMOs' income actually increased by an average of 17%.

5.19 Against this background, the 1985 Macken Determination increased a Senior Specialist sessional VMO's rate of pay by 90% (see columns 1 and 3, Table 5.1) to compensate for, as Mr JustiCe Macken stated, *"the so-called Medicare*

5.20 There is every reason to believe that the evidence submitted by the AMA was atypical and inconclusive as to the reduction in the number of private patients and consequent effect on income across all VMO specialties. Further, the PAC is concerned that the NSW Department of Health did not challenge this evidence and present its case as fu11y as it might have.

5.21 The PAC considers that no general conclusion or reliable remuneration adjustment on the basis of the Medicare Effect' could be based upon such self-selected financial

5.22 As part of the settlement of the 1984/85 doctors" dispute, all sessional VMO hourly rates were increased by a flat $12.50 effective from 1st July 1984, subject to final arbitration. This interim amount had risen to $13.32 by November 1985 as a result of the application of the two 1985 State Wage Case Decisions.

Report on Payments to Visiting Medical Officers

TABLE 5.1

Rolled Up Base Hourly Rate Based on 1985 Macken Determination

As at 1 January, 1986

Classification of VMO	Ordinary Remuneration Rate (a)	Medicare Effect Loading	Normal Hourly Rate (Cols 1 & 2) (b)	Loading for Super., Split Shifts, Leave (49.3% of Col. 3) (c)	Rolled Up Base Hourly Rate (Cols 3 + 4) (b)
	S	$	S	$	S
GP (less than 5 years)	18.59	17.00	36.00	17.75	54.00
GP (5 to 10 years)	20.85	19.07	40.00	19.72	60.00
GP (more than 10 years)	26.15	23.92	50.00	24.65	75.00
Specialist	30.17	27.59	58.00	28.59	87.00
Senior Specialist	33.14	30.30	63.00	31.'06	94.00

NOTES:
(a) Includes the November 1985 State Wage Case judgement (3.8%)
(b) Rounded to nearest $1
(c) Superannuation 7.5%, Split Shifts 5%, Unpaid Leave 36.8%, Total 49.3%. The unpaid leave loading is paid because VMOs are not paid for the following periods of leave which they can, if they wish, avail themselves of each year:

3 weeks Study and Conference Leave
3 weeks Sick Leave
2.2 weeks Public Holidays
5 weeks Annual Leave
0.8 weeks Long Service

36.8% = 14 weeks leave etc x 100
38 weeks of work I

5.23 In his 1985 arbitr ation of the interim Medicare Effect loading, Mr Justice Macken varied the $13.32 flat amount as follows:

increased the $13.32 to $17.00 and applied this amount to the base hourly rate for GPs with less than five years experience;

increased the new Medicare Effect loading of $17.00 for the other four higher classifications of VMOs by re-introducing the relativities which existed between the classifications prior to the application of the interim Medicare Effect loading of $12.50 [this raised the $17.00 loading to $19.00, $24.00, $28.00 and $30.00 respectively (rounded to nearest dollar)]; and

applied the Medicare Effect loading to the unrolled base hourly rate, that is, prior to the application of the 49.3% loading for split shifts,

> unpaid leave and superannuation, thereby 'increasing the Medicare Effect loadings by a further 49.3%. (See Table 5.2.)

5.24 Thus, by applying the Medicare Effect loading to the unrolled hourly base rate, Mr Justice Macken further increased the hourly base rate. This is anomalous', as the disabilities for which the 49.3% loading are compensation (superannuation, split shifts and unpaid leave) are not affected in any way by the change in the proportion of public to private patients.

Report on Payments to Visiting Medical Officers

5.25 The comparative amounts included in various hourly rates are shown in Table 5.2.

TABLE **5.2**

Comparison of Various Medicare Effect Loadings

CLASSIFICATION OF VMO	INTERIM LOADING INDEXED TO NOV 1985	RESULT IF LOADING IS APPLIED AFTER ROLLING UP THE HOURLY RATE	ACTUAL RESULT WHEN LOADING APPLIED BEFORE ROLLING UP THE HOURLY RATE (Col 2 + 49.3%)
	$ PER HOUR	$ PER HOUR	$ PER HOUR
GP (less than 5 years)	13.32	17.00	25.38
GP (5 to 10 years)	13.32	19.00	28.37
GP (more than 10 years	13.32	24.00	35.83
Specialist	13.32	28.00	41.80
Senior Specialist	13.32	30.00	44.79

NOTES: 1. Column 1 is the interim. Medicare Effect loading of $12.50 indexed for the May and November 1985 Wage Case Decisions.

2. Column 2 is the interim loading determined by Mr Justice Macken (see second point in paragraph 5.23).

3. Column 3 represents the actual amount of the Medicare Effect loading included in the 1985 Macken Determination hourly rates.

5.26 The PAC considers that conceptual errors have crept into the apparently logical calculations of the hourly base rate. This is of particular concern because payment for all hours worked - ordinary sessional, on-call and call back - are based on the sessional hourly base rate.

PRINCIPLE OF COMPENSATION

5.27 In addition to the anomalies regarding the quantum and method of including the Medicare Effect payment, the PAC considers that there is a question as to the equity of compensating VMOs for the Medicare Effect at all. The PAC · is unable to .accept the principle underlying the payment - · that is, that the State Government is obliged to financially compensate VMOs when their income is reduced.

5.28 In making this statement, the PAC is mindful of the following factors:

· it has not been established with any reliability that the majority of VMOs' income decreased following the introduction of Medicare;

all VMOs have substantial sources of private income other than payment for their work as VMOs in public hospitals;

NSW is the only State in Australia which compensates VMOs for the loss of income from private patients following the introduction of Medicare;

the Commonwealth Department of Health maintained in its submissions to the 1985 Macken Determination that the claim for compensation by NSW VMOs was *"spurious"* and not supported by principle; and

restructuring occurs in many industries without government compensation for subsequent changes in income, yet VMOs have sought and received substantial payment over several years from public funds for such restructuring.

Recommendation 6

It is recommended that a "Medicare effect" *payment be* excluded from sessional VMO remuneration.

(b) **SPLIT SHIFT** AND UNPAID LEAVE LOADINGS

5.29 The NSW Department of Health submitted to the PAC that the inclusion, in the rolled up rate, of compensation for split shift work and unpaid leave is illogical and that it results in payment to VMOs for leave not actually taken, sometimes two or more times over. The Department's case is outlined in Appendix 12.

SPLIT SHIFT LOADING

5.30 The split shift loading of 5% is intended to compensate VMOs for working shifts of less than 3.5 hours duration. As this loading is included in the rolled up hourly rate of pay (see Table 5.1), the loading is paid during on-call and call backs.

5.31 This is anomalous in that:

on-call payments are not for actual services performed, but for holding oneself in readiness to work and therefore the loading should not apply; and

VMOs are already compensated for working short periods during call backs in that call backs attract a loading of between 10% to 25% and a minimum payment of one hour plus actual travelling time to a maximum of 20 minutes each way.

5.32 The PAC is of the opinion that the split shift loading of 5% should not apply to on-call and call back payments. The cost of this loading on these payments for the current financial year is estimated at $l.8M.

UNPAID LEAVE LOADING.

5.33 The unpaid leave loading of 36.8% [see Note (c) to Table 5.1], is intended to compensate VMOs for not being paid while on leave. There are, however, some fundamental anomalies in Mr Justice Macken's calculation of the loading.

5.34 The unpaid leave compensation consists of the following:

Study and Conference Leave	3 weeks
Sick Leave	3 weeks
Public Holidays	2.2 weeks
Annual Leave	5 weeks
Long Service Leave	0.8 weeks
	14 weeks per annum

5.35 Anomalies in the application and calculation of the unpaid leave loading include:

study, conference and sick leave are entitlements which lapse if not taken within the prescribed time. The average amount of study, conference and sick leave actually utilised by VMOs would approximate two weeks per year. However, Mr Justice Macken calculated the unpaid leave loading on the basis of all VMOs using maximum entitlements, that is, six weeks per year. The PAC considers that the amount which should have been included in the formula was the average leave actually taken and not the maximum six weeks; and

inclusion of every public holiday in the loading assumes that all VMOs report to work on all public holidays for their normal sessional hours. The PAC has been advised that this is not the case and that a one week loading would be representative of the facts.

5.36 The PAC considers that a more accurate assessment of the number of weeks of unpaid leave for which VMOs should be compensated is nine weeks per annum. On this basis, the unpaid leave loading would be 20.9% and not 36.8%. This suggests that sessional VMOs will be over-paid some $20M during 1988/89 as a result of the excessive compensation for unpaid leave.

(c) SUPERANNUATION LOADING

5.37 The NSW Department of Health submitted that:

'The rolled up rate also has a degree of double counting in respect of the 7.5% loading for the non-provision of superannuation. In the proceedings before Justice Macken leading up to his 1985 Determination, the AMA argued strongly that the private practice loading should be massively increased to compensate for background practice costs. A not insignificant portion of the cost said to be incurred in the maintenance of the VMOs ' private practices was the cost of superannuation. Given that Justice Macken accepted the evidence and arguments put by the AMA in relation to private practice cost and increased the loading to (between) $20 and $25 per hour, it is considered that VMOs are being compensated twice for the superannuation factor and that the 7.5% loading on the ordinary remuneration rate to take account of superannuation should be deleted."

5.38 The PAC notes, however, that th e doctors' financial evidence provided to Justice Macken by the AMA .does isolate superannuation expenses.

5.39 The calculations used in the 1985 Determination of the base sessional hourly rate as they relate to superannuation are complex. The PAC has been persuaded by arguments which query the basis of these calculations.

Recommendation 7

It is recommended that the inclusion and method of including compensation for split shift work, unpaid leave and superannuation in the hourly base rate be reviewed to exclude *"double counting".*

(d) APPLICATION OF STATE WAGE CASE DECISIONS TO SESSIONAL BASE HOURLY RATE

5.40 As with previous determinations, the 1985 Macken Determination (Clause 9) provided for VMO rates to be varied "*to the extent necessary to give effect to the change in the Basic Wage".*

5.41 The PAC does not question the principle of adjusting sessional rates of pay by the application of the normal percentage increases in pay rates awarded in State Wage Case Decisions.

5.42 However, the March 1987 and February 1988 State Wage Cases resulted in flat rate increases in the Basic Wage of $10.00 per week and $6.00 per week respectively. The majority of wage earners thus received an additional $16.00 gross weekly income from these two decisions..

5.43 The AMA instituted proceedings in the Equity Division of the Supreme Court of NSW (ED 3905 of 1987) relating to the amount by which sessional VMO rates should rise following these two Wage Cases.

5.44 The AMA argued that the hourly VMO rates should be increased by the percentage by which the basic wage had increased, that is, by 9.49% and 5.2% respectively.

5.45 The NSW Department of Health argued that the increase in hourly VMO rates should be the weekly increases awarded ($10 and $6 respectively) divided by the nominal standard hours per week (40), t hereby arriving at increases of 25 cents and 15 cents per hour respectively.

5.46 The Court, in agreeing with the AMA argument, would appear to have considered only the legalistic interpretation of the wording of the Determination without taking into account the "spirit" of the escalation clause in the Macken Determination.

5.47 A subsequent appeal by the NSW Health Department to the Court of Appeal of the Supreme Court of NSW (CA 217 of 1988) was dismissed in a decision handed down on 23r d March, 1989.

5.48 The result is that the increases of $10.00 and $6.00 (a total.of $16.00 per week) for the average worker:

have been translated into increases of $9.00 and $5.50 in the sessional hourly rate of pay for Senior Specialists; and

an increase in a Senior Specialist VMO weekly remuneration of $551.00 for 38 hours of sessional work.

5.49 The PAC considers that the AMA used a loophole (that flat weekly increases could not be translated into an hourly increase by referring to the nominal hours of work in a week) to gain increases in the hourly rate of pay far in

excess of those Justified by the March 1987 and February 1988 State Wage Case decisions.

5.50 The PAC further considers that Mr Justice Macken did not intend that increases of $10.00 and $6.00 per week would increase sessional VMO rates of pay by $9.00 and $5.50 per hour (total of $14.50). This is over 30 times greater than $16.00 per week for workers covered by a weekly award rate.

5.51 The additional cost of this inordinate increase in the sessional rate of pay has been estimated at about $14M per annum.

5.52 The PAC notes that Queensland Senior Visiting Specialists' rate of pay increased by 18 cents per hour and Victorian Sessional Medical Officers' rates per session (of 3.5 hours) increased by 75 cents as a result of the $6.00 per week March 1988 wage rise.

5.53 It is the view of t he PAC that the NSW increases are anomalous and inequitable. The VMO sessional hourly rate increases should have related to 25 cents and 15 cents per hour in accordance with the NSW Department of Health case, and the Court's contrary finding is primarily the result of defective drafting of the Determination.

Recommendation 8

It is recommended that any future determination of VMO rates of payment specifically provide for the correct and equitable application of flat rate weekly increases in the basic wage to the hourly base rates for VMOs.

ON-CALL PAYMENTS AND ROSTERS

5.54 A review of the history of on-call payments to VMOs reveals that the various Macken Determinations have used different bases for calculation of the payment (that is, flat dollar sum per hour or a percentage of the hourly base rate). Indeed, it was not until the 1985 Determination that a definition of *"on-call"* was inserted in the agreement.

5;55 The 1985 Macken Determination altered the method of on-call payment from a single allowance for each hour of on-call, to 10% of the hourly base rate (exclusive of the private practice loading). The submission from the **NSW** Department of Health concerning the problems with the on-call rate of payment granted by Mr Justice Macken, are discussed in Appendix 14.

5.56 The on-call rate of 10% of the hourly rate was intended to reflect the "true *cost*" or "*inconvenience cost"* in keeping oneself available in the event the hospital required the VMO to be called back to the hospital to attend public patients outside the normal sessional hours.

5.57 Table 5.3 details on-call payments to VMOs by specialty during 1987/88. Table 5.4 details call back payments to VMOs by specialty during 1987/88.

TABLE 5.3

oN-CALL PAYMENTS DURING 1987/88 TO SESSIONAL VMOS[1,2]

NUMBER OF VMOS BY PAYMENT BANDS

SPECIALTY	S0-$1000	$1000 S5000	$5000 $10000	$10000 $20000	$20000 $30000	$30000 $40000	$40000 $S0000	$50000 $60000	$60000 $80000	TOTAL **NO. OF** VMOs
General Medicine	9	38	38	72	32	11	I	-	-	201
Cardiology	1	I	13	17	2					34
Endocrinology	2	2	1	4	2	1	-	1	-	13
Gastroenterology	-	3	2	14	1					20
Neurology	-	3	6	16	1					26
Paediatrics	-	5	9	28	25	19	3	i	1	91
Renal Medicine	I	-	-	4	i	-	I	-	-	7
Rheumatology	-	2	2	4	1					9
Thoracic Medicine	-	-	1	7	3	3	-	-	-	14
General Surgery	5	11	31	88	31	6	1	1	-	174
Cardiothoracic Sur	-	I	3	4	3	I	i	-	-	13
Neurosurgery	I	I	-	2	3	5	4	-	-	16
Orthopaedics	2	4	4	33	15	6	-	i	1	66
Paediatric Surgery	-	-	-	3	2	1	-	I	-	7
Plastic Surgery	-	1	2	7	10	5	5	-	2	32
Urology	-	5	2	11	10	8	7	4	2	49
Vascular Surgery	1	-	-	3	2	I	1	-	-	8
Anaesthetics	16	81	133	89	23	**3**	-	-	-	345
Ear, Nose, Throat	-	3	5	17	18	10	6	-	-	59
Obstet & Gynae	7	19	64	67	36	11	1	-	1	206
Opthalmology	2	12	10	13	7	5	3	-	-	52
Psychiatry	-	9	15	15	7	1	1	-	2	50
Radiology	3	-	6	1	1					11
General Practice	27	109	31	24	8	1	1	-	-	201
Palliative Care	-	3	4	2						9
TOTAL	77	313	382	545	244	98	36	9	9	1713

Source: NSW Department of Health

NOTES: 1. Notes to Table 3.7 apply to this table.

2. Specialties with less than 8000 hours on-call not included.

TABLE 5.4

Call Back Payments During 1987/88 to Sessional VMOs1,2

NUMBER OF V'MOS BY PAYMENT BANDS

SPECIALTY	$0-$1000	$1000-$5000	$5000-$10000	$10000-$20000	$20000-$30000	$30000-$40000	$40000-$50000	$50000-$60000	$60000-$70000	NO. OF	TOTAL VMOS
General Medicine	50	61	29	26	9	1	1	-	-		177
Cardiology	14	9	4	2							29
Endocrinology	8	3									11
Gastroenterology	11	9	-	-	1						21
Neurology	18	4	1								26
Paediatrics	13	37	17	12	5	1	3	3	-		91
Renal Medicine	3	2	1		1						7
.Rheumatology	4	2									6
Thoracic Medicine	9	6	2								17
General Surgery	23	60	53	32	14	4	3	-	-		189
Cardiothoracic Sur	4	9									13
Neurosurgery	4	7	3	1	1						16
Orthopaedice	14	32	4	9	3	1	-	-	-		63
Paediatric Surgery	1	3	1	1							6
Plastic Surgery	6	15	6	3	1						31
Urology	14	15	6	6							41
Vascular Surgery	-	5	3	2							10
Anaesthetics	30	102	92	94	15	4	2	2	1		342
Ear, Nose, Throat	19	31	6	2'	-						58
Obstet & Gynae	38	56	58	32	14	2	4	-	-		204
Opthalmology	30	19	2								51
Psychiatry	20	16	5	-4,	-	-	1	-	-		46
Radiology	5	8									13
General Practice	87	115	45	20	4	6	5	1	-		283
Palliative Care	5	-	1								6
TOTAL	430	626	339	247	67	19	19	6	1		1754

Source: NSW Department of Health

NOTES: 1. Notes to Table 3.7 .apply to this table.

2. Specialties with on-call payments for less than 8,000 hours not included.

SPECIALTY	NUMBER OF VMOS BY PAYMENT BANDS								
	$0-$1000	$1000-$5000	$5000-$10000	$10000-$20000	$20000-$30000	$30000-$40000	$40000-$50000	$50000-$60000	$60000-$70000

TOTAL	430	626	339	247	67	19	19	6	1

5.58 The arrangements for on-call payments under the current 1985 Macken Determination are inequitable for the following reasons:

inclusion of the loadings for superannuation, unpaid leave and split shift in the sessional base hourly rate and therefore the on-call rate of pay;

regardless of the inconvenience of being on-call (particularly related to the time of day) the same on-call rate applies;

the intention of Mr Justice Macken to place VMOs and a medical staff specialist on similar on-call arrangements, in terms of monetary compensation, was not realised;

the decision to pay VMOS 10% of the hourly base rate was not supported by the material submitted to Mr Justice Macken; and

the cost of having each specialty provide on-call cover to a hospital is $88,000 per year, which for many specialties cannot be justified on the basis of call back patterns and value for money.

LOADINGS

5.59 An anomalous situation exists in relation to the on-call rate of remuneration because almost one-third of the hourly rate upon which the on-call rate is based consists of the loading for superannuation, unpaid leave and split shifts.

5.60 As no physical services are being provided during on-call, it is the view of the PAC that VMOs should not be compensated for these factors whilst on-call. The per annum cost of the loadings wit hin on-call payments is estimated at $10M.

INCONVENIENCE

5.61 The PAC was told in formal Hearings that being on-call was onerous. However, inquiries revealed that this was not the only factor to be considered in reviewing the system of on-call payments. Even in specialties where call backs were frequent, the onerous nature of being on-call and available to attend the hospital is.mitigated by:

the fact that many VMOs are on-call 24 hours a day, seven days a week for their private patients;

the ability to conduct private work/consultations during time on-call and hence the opportunity to earn a " *double"* income; and

the ability to travel and dine out (with beepers) and enjoy most forms of relaxation during the hours that would normally be leisure time.

5.62 There appears to be few restrictions imposed by being on-call, given rapid transport and modern communication systems, apart from the *"feeling that one might be called".*

5.63 The PAC recognises that being on-call, however, not only includes the possibility of call backs, but also the possibility of telephone consultations with RMOs or Registrars.

5.64 One Specialist VMO estimated that he would average two telephone consultations per night and that his record was 18 calls between midnight and 8.00 a.m.

5.65 There is no accurate and complete record of such telephone calls and there are varying reports of the frequency with which VMOs are actually called.

5.66 The PAC recognises that the nature of on-call requirements for country VMOs where there is little resident medical officer or registrar cover has been a major factor in the formulation of the increased fees payable to country VMOs as a result of the settlement of the 1987/88 country doctors dispute.

5.67 Other doctors receive considerable on-call payments for very little service or personal inconvenience and this gives rise to enormous inequity between VMOs in different specialities and especially between country and city hospitals. No attempt has been 'made to measure the personal or other costs and recompense accordingly.

5.68 The PAC considers that it was misled by VMOs in regard to the degree to which being on-call was burdensome. In response to questions at Hearings, every opportunity' was taken to point out examples of onerous on-call call backs. However, the numerous occasions when on-call had little impact on their private life and the fact that they were sometimes paid twice for the same hours, (by private patients for consultations and by the hospital for on-call), were not mentioned.

5.69 The PAC considers that while the call-back payment should reflect the costs involved, the on-call rate appears to be over-generous and does not reflect the relatively low inconvenience of merely being available - especially

during normal working hours - to return to the hospital if called.

5.70 The PAC does not believe this was the intention of the on-call allowance. The PAC considers the present payment for on-call during normal working hours should be abandoned.

Recommendation 9

It is recommended that the present system of on-call payments during the hours of 8.00 a.m. - 6.00 p.m. Monday to Friday be abandoned.

5.71 The PAC considers that if on-call payments are retained during normal working hours, determination of future on-call rates take int o account income earned from private patients during on-call hours, the degree of inconvenience experienced and the hours of the day involved.

PARITY WITH STAFF SPECIALISTS

5.72 In 1985, Mr Justice Macken changed the method of paying the on-call allowance from $20.86 for the first 12-hour on-call period and $1.75 for each hour thereafter, to 10% of the base hourly rate.

5.73 In deciding that payment for on-call shoul d be a percentage of the hourly rate, Mr Justice Macken stated:

> *"Dr Morgan, in explaining the recent agreement applicable to staff specialists, said that a 10% call back and a 10% on-call allowance was now paid to all staff specialists ... I propose to return to the percentage approach and, thus, keep the V.M.O. in line with the staff specialist in this regard".*

5.74 However, the 1985 Macken Determination did not achieve the intended result of placing a VMO and a medical staff specialist who were on similar on-call arrangements in the same position in terms of monetary compensation.

5.75 Using comparable wage bases as at 1st January, 1986, a medical staff specialist on the highest rate of pay received $6,450 per annum ($64,496 x 10%) for being on-call at all times. A VMO on a senior specialist rate of pay would have received $75,012 per annum for being on-call for exactly the same times (10% x $94 per hour x 24 hours x 365 days less 15 hours sessional per week).

5.76 Clearly, the VMO is in a more advantageous remuneration position for the same inconvenience. If equity were to be achieved between staff specialists and VMOs for on-call payments, VMOs should receive a lower percentage of the base hourly rate for being on-call or receive an annual amount for being on-call up to a maximum of the equivalent salaried rate.

ON-CALL**ROSTERS**

5.77 The decision regarding inclusion of a specialty within an on-call roster is complex. The Committee has been advised by the NSW Department of Health that even if call backs are rare:

"To not have each specialty providing an on-call cover at a hospital requires a very difficult decision of Judgement by the Board of the hospital or Area Health Service and lays the Board open to community and VMO criticism that the hospital is not providing essential services as it is required to do."

5.78 A medical administrator, in a submission to the PAC, commented on the legal problems for a manager of on-call rosters as follows:

. . *"One of the major constraints on the reorganisation of on-call arrangements is the medico-legal requirement for cover for residents and registrars treating patients after hours in the wards and in casualty. We have had the experience of the dispute [the* 1984/85 doctors dispute] *when these arrangements totally fell apart in many hospitals. We still have experience of non-cover in some hospitals for Orthopaedics - I am not offering a solution, just suggesting that the assumption of the need for a responsible VMO/Staff Specialist for every admitted patient may be a false one ".*

5.79 The Committee understands that Mr Justice Macken envisaged that VMOs might be on-call for a night once every two or three weeks.

5.80 Table 5.3 indicates .that most doctors are not earning large amounts from the on-call payment system although the opportunity clearly exists for some doctors to do so. However, if the on-call payments are viewed in relation to the number of actual call backs it is clear that the on-call payment system requires extensive review.

5.81 There should not, for example, be extreme differences between the hours rostered on-call and the level of service actually provided based on call backs. Table 5.5 details the payments made to VMOs for on-call and call back and the average number of hours paid on-call per instance of call back.

5.82 The data in Table 5.5 shows that significant on-call payments are made in specialties which have substantially varying incidences of call backs. Two specialties which demonstrate this are Ear, Nose, Throat and General Practitioner specialties, which have a similar number of on-call rostered hours but considerable differences in the incidence of call backs.

5.83 Clearly, the Justification for making on-call payments to the Ear, Nose and Throat specialists under the above circumstances warrants review.

5.84 The PAC considers that the total on-call payments bill for the State is so high that the on-call rosters and the rates of payment need to be re-examined.

5.85 Further, Mr Justice Macken was probably not aware of the fact that on-call may be manipulated or result in intimidation of medical administrators and CEOs by VMOs.

Public Accounts Committee

TABLE 5.5

On-Call and Call Back - Sessional VMOs by Specialty[1,3]

SPECIALTY	HOURS	PAYMENTS	HOURS	HOURS/CALL BACK	PAYMENTS
		$ ' 000	$ ' 000		
General Medicine	294 898	2,679	9,908	(41)[2]	1,056
Cardiology	43 264	401	707	(70)	82
Endocrinology	22 422	207	64	(415)	8
Gastroenterology	32 753	254	486	(101)	55
Neurology	31 916	294	177	(236)	19
Paediatrics	230 527	2,074	7,587	(43)	852
Renal Medicine	14 304	131	213	(122)	23
Rheumatology	11 019	100	55	(306)	6
Thoracic Medicine	30 891	287	297.	(115)	35
General Surgery	270343	2,488	13,942	(32)	1,614
Cardiothoracic Surgery	27 825	254	229	(302)	26
Neurosurgery	50.312	465	678	(163)	80
Orthopaedics	132 317	1,215	3,225	(68)	370
Paediatric Surgery	20,228	186	239	(169)	29
Plastic Surgery	100,552	911	1,340	(180)	159
Urology	148,937	1,353	1,422	(153)	160
Vascular. Surgery	16,733	170	547	(58)	61
Anaesthetics	355,684	3,096	28,259	(24)	3,081
Ear, Nose, Throat	151,111	1,387	1,348	(170)	147
Obstetrics & Gynaecology	313,971	2,899	15,998	(34)	1,589
Opthalmology	87,218	769	602	(230)	70
Psychiatry	77,789	716	1,429	(82)	173
Radiology	10,010	88	216	(83)	24
General Practitioner	154,442	1,079	21,357	(13)	1,500
Palliative Care	9,494	71	73	(327)	8

Source:NSW Department of Health, Survey into 1987/88 VMO Payments

NOTES:
1. Notes to Table 3.7 apply to this table.
2. The bracketed figure ( ) represents the average number of hours of paid on-call per instance of paid call backs.
3. Specialties with less than 8,000 hours on-call are not included.

5.86 In a submissi on to the Inquiry, one medical administrator commented as follows:

"Anaesthhetic sessions - artall.sis of theatre registers and sessional claims
may show great disparity. Anaesthetists argue that they are involved in care of pa,'eats in recovery or busy helping another Anaesthetist even though other staff report they are in the tea-zoom,
or in one case I have personally encountered - giving an anaesthetic to a
private patient. We are totall unable to specify what is a reasonable amount of work to do in a given time. Some doctors stretch the work out to fill the time. especially in Outpatients.

I reduced the Anaesthetic sessions at this hospital from five to four hours -
suddenly all the Anaesthetists were starting work at 7.15 a.m.. etc. The
Administration is frequently unable to give Anaesthetists 28 days notice as surgeons take leave at shorter notice. Constant reminders help only minimally.
are made to feel like penny-pinching idiots for daring to question them on this".

5.87 On-call payments could be reduced through the concept of networking. Networking involves VMOs being on-call simultaneously at more than one hospital, while only receiving payment from one hospital.

5.88 Rationalising the cost of providing adequate and appropriate on-call coverage has been impeded by the general refusal of the AMA to agree to the extension of networking of on-call medical services. An objection of the AMA has been that networking might be detrimental to the delivery of medical services; for example, a surgeon may be required to operate in an unfamiliar theatre.

Public Accounts Committee

5.89 The PAC is aware that several hospitals have successfully introduced networking. It is not convinced that the objections to networking are insurmountable, especially given that many VMOs already have multiple appointments and operate in a variety of hospital s.

5.90 The Medical Superintendents Association has suggested another option to address the problem of on-call rosters as follows :

> *"... a rearrangement of the current 'sessions' with limited on-call by day '. and with sessional payments for work on admitting days. If the hospital does pay a (lower) on-call payment during the day, the public hospital must have absolute priority on that day from that practitioner's activities. Sessional rates also would vary in accordance with the experience of the house staff".*

5.91 A prominent medical witness told the PAC that if VMOs were rostered on-call but not paid an on-call allowance they would refuse to be called back. These issues are discussed further in Chapter 6.

Recommendation 10

It is recommended **that all** hospitals critically review on-call rosters to determine whether the coverage is Justified in terms of service needs and cost effectiveness. It is recommended that on-call rosters during the day be strictly 1inited.

Recommendation 11

It is recommended that the practice of networking be expanded with a view to developing more cost effective and efficient on-call services.

SIMULTANEOUS PAYMENT FOR CALL BACK HOURS AND ON-CALL HOURS

5.92 Following the implementation of the 1985 Macken Determination, disagreement between the AMA and the NSW Department of Health arose concerning whether the on-call allowance should be paid to VMOs during:

- call back hours; or
- normal sessional hours.

5.93 The matter could not be resolved and the Court of Appeal of the NSW Supreme Court [7] decided that the current Macken Determination should be interpreted so as to provide that the on-call allowance should not be paid during normal sessional hours, but should be paid for call backs occurring during periods of rostered on-call hours, including the paid travelling time associated with such call backs.

5.94 It was argued by the NSW Department of Health that this was not what was intended by Mr Justice Macken. While the 1985 Determination reintroduced the pre-1981 concept of on-call payment being one tenth of the hourly rate, it did

7 Supreme Court of New South Wales - No. CA 275 of 1987

not reintroduce the pre-1981 provision which made it clear that the on-call payment was not to be paid during periods for which the VMO was being paid for a call back. The PAC considers that this was an over-sight by Mr Justice Macken.

5.95 The PAC has reservations about the logic and equity of this decision. The original purpose of each type of payment was as follows:

ordinary sessions were defined as scheduled blocks of times paid at a particular rate;

call backs were defined as hospital initiated calls to attend public patients; and

- on-call was time rostered to be available to come back to the hospital. Both on-call and call back payments clearly included compensation for the inconvenience and opportunity cost respectively.

5.96 Whereas the call back rate covers the opportunity costs of changing whatever other activity was being performed, travelling time and other costs, the on-call rate covers the inconvenience of being available just in case.

5.97 It should be noted that if called back, a sessional VMO is paid at the higher inconvenience rate (10% - 25% loading on hourly rates) for a minimum period of one hour, plus actual travelling time to a maximum of 20 minutes each way. If the VMO is asked to perform another service while still at the hospital on a call back, it is reasonable to continue the higher call back fee for as long as the VMO is called back.

5.98 However, to pay an on-call allowance simultaneously with a call back payment appears to be an error of logic since while a VMO is on a call back, they are automatically available for the hospital public patients as needed.

5.99 When Mr Justice Macken arbitrated the current arrangements in 1985, it appears that he set the on-call rate of pay to reflect the inconvenience to a VMO of being available and did not consider or intend on-call to be paid during a session or a call back.

5.100 If the logic of the previously mentioned judgement is extended, then VMOs should also be paid an on-call payment during their ordinary sessional hours since they may be redirected or called back by the hospital at any time to attend to a more seriously ill patient. The Court, however, specifically referred to this interpretation and rejected the argument that on-call payments should be made during ordinary sessional hours occurring during a period of rostered on-call.

5.101 The PAC considers that the AMA's case and the Supreme Court's decision are based on a strict legal interpretation of the 1985 Determination. The original concept of the on-call allowance has been lost in favour of a legalistic definition which has resulted in double payment and inecquitable and anomalous remuneration for sessional VMOs.

5.102 The PAC does not accept that VMOs are inconvenienced by having to hold themselves available to be called in to the hospital if they are already at a **hospital on** a call back providing a service for which they are being paid.

Public Accounts Committee

Recommendation 12

It is recommended that the payment of an on-call allowance during call back hours be re-examined.

BACKGROUND PRACTICE COSTS

5.103 The background practice costs allowance was first included in sessional remuneration in 1979 by Mr Justice Macken. However, in granting a nominal allowance for these costs, Mr Justice Macken stated:

"This claim both in concept and in quantum has caused me the greatest difficulty in this arbitration and has been the claim most strenuously opposed by the Health Commission ".

and,

"I remain unconvinced that it is an appropriate principle to adopt that a base hourly rate for a Visiting Medical Officer should be loaded so that during the performance of his sessional work at a hospital his rate of pay, while so engage. should include a loading such as would bear the proportion of background practice costs which are incurred by a visitor".

5.104 The issues raised in 1979 as to principle and quantum of the allowance have not been addressed in subsequent Determinations. In the 1985 Determination, Mr Justice Macken:

provided no reason for accepting the principle of a background practice cost;

without a comprehensive knowledge of the actual costs involved and a statement that *"any such allowance is impossible to mathematically calculate ",* largely accepted the AMA's evidence of background practice cost increases; and

granted a significant increase in background practice costs allowance from $2.65 and $3.49 per hour to $20.00 and $25.00 per hour for GPs and specialists respectively.

5.105 While the PAC recognises that private practice costs may have increased as the AMA submitted to Mr Justice Macken, the AMA's submission consisted mainly of the results of surveys conducted in 1976 and 1978 and updated to 1985 values. These results were supported by the income and expenses details of approximately twenty specialist VMOs'. The PAC does not consider the AMA submission Justifies the increase in background practice costs loading which Mr Justice Macken awarded in 1985.

5.106 In the 1985 *Reasons for Determination,* (pages 22 -24), Mr Justice Macken stated:

"It is not possible to detail every component of background practice costs, let alone weigh them all appropriately to quantify a fair level of reimbursement to a V.M.O. In any event as between the specialties background practice costs differ, and sometimes markedly... As such .a loading cannot be quantified with great precision and because in any event, it involves a high degree of averaging between specialties..."

5.107 The NSW Department of Health has never accepted this component of the arbitration. The Department's case against the loading was impeded by the lack of private income data to challenge the AMA's claims. The AMA's claims in 1985 were double what was eventually awarded.

5.108 The PAC considers that the background practice cost evidence put before the arbitrator in 1985 by the AMA may not have adequately allowed for:

the proportion of that cost used to maintain the private practice simultaneously;

the sharing of costs with other medical practitioners in the same rooms;

the fact that some specialists, for example anaesthetists, may have no background practice costs;

the benefit to be gained from working in public hospitals as against private hospitals; that is, no facility charges for treating private patients; and

- the *"intangible"* benefits to be gained from working in public hospitals (intellectual challenge, exchange of ideas, the use of public hospitals for generating private patient income at no cost to the doctor, interesting emergency work, research environment).

5.109 Submissions to the PAC also suggested that the two rates of background practice costs allowance, one for GPs and one for specialists, were too generalised. In particular, it has been argued that anaesthetists may have minimal

background practice costs because demand for their services is derived from surgeons, and is not patient initiated. Anaesthetists in the main do not require a secretary/receptionist or rooms which most other doctors require.

5.110 The PAC has difficulty in accepting why secretarial and office space costs should be so much higher for specialists than for GPs, especially given that some GPs may employ more highly paid nurse/secretaries to assist in community health work.

5.111 The PAC considers that the background practice cost loading should not equal. the average or maximum costs of a private practice. It is considered that the background practice costs associated with public patient work should be the additional or extra cost over and above the cost required to run the private practice without VMO work in public hospitals.

5.112 It is the PAC's view that if a VMO withdrew from working in the public sector, it is doubtful that practice costs would decline substantially due to the large component of

> fixed costs. in running a private practice. The substantial background practice cost loading for sessional remuneration is anomalous in that it currently levies these largely fixed costs against work performed during sessional hours.

5.113 The PAC is further concerned that background practice costs are not only paid during ordinary sessional hours but, following a recent Supreme Court decision [8], also paid during call back hours.

8 Supreme Court of New South Wales, Court of Appeal - No. CA 275 of 1987

5.114 The NSW Department of Health has argued that this is an incorrect interpretation of the intention of the 1985 Macken Determination · Their argument is outlined in Appendix 13.

5.115 The PAC also notes that it was the view of the President of the Court of Appeal that interpretations of Determinations of this type should be referred back to the arbitrator. This was not possible under the Public Hospitals Act 1929, as the case involved the 19 8 5 Determination. In his Judgement, Mr Justice Kirby said:

"It would have been a more sensible resolution of the present dispute if the issues in contention between the parties could have been taken back to the arbitrator (Macken J) *to make clear, as arbitrator, what the parties considered to be unclear in his award".*

5.116 The decision to apply the background practice cost loading to call backs will mean that payment for each call back will increase by at least $33.25 for a senior specialist. The PAC considers this a further anomaly and inequity of the current sessional remuneration system.

Recommendation 13

It is recommended that the principle and quantum of background practice costs for sessional remuneration be reviewed.

If the allowance is to be retained, it is recommended that:

independent research concerning background practice costs of all specialty VMOs be sought; and

ii) the amount to be compensated be the marginal cost associated with call backs.

VARIATION IN ON-CALL AND CALL BACK PAY ARRANGEMENTS

5.117 The four main categories of doctors servicing public patients in hospitals - staff, clinical academics, sessional VMOs and fee-for-service VMOs - are each covered by different on-call and call back remuneration.

5.118 The different arrangements have resulted in inequalities in the amount of remuneration received for similar duties. These anomalies have been a source of dissension between some of the doctors involved.

5.119 Staff specialists play a key role in the provision of medical services in public hospitals. In particular, they provide continuity of patient care, they perform teaching and research functions and they contribute to the management and development of medical services in public hospitals. Despite the fact that they perform the same

duties as VMOs, their rate of remuneration is considerably lower than the sessional rate for VMOs.

5.120 The NSW Department of Health and the Public Medical Officers Association (PMOA) are currently undertaking a Joint workforce study of staff specialists. The purpose of the study is to examine the extent of shortages of staff specialists in various disciplines, reasons for the shortages, including remuneration levels and relativities with other groups, and options for addressing the problem.

5.121 Disparities also occur between VMOs and staff specialists who are participating in the same on-call ros ter. VMOs receive 10% of the hourly rate for each hour they are on-call as well as receiving between 110% and 125% of their normal hourly rate if they are called back.

5.122 Salaried staff specialists, however, receive an annual call back/special allowance of 20% of their base salary as compensation for being called back and for certain unique aspects of the work of staff specialists - which includes regularly being on call, irrespective of the actual time spent rostered on-call or the number of call backs involved. The maximum allowance payable is currently $14,101 which is considerably less than the on-call payments received by many VMOs.

5.123 Resident Medical Officers receive an on-call allowance of $8.72 per day. If called back, they are paid a minimum of two and a half hours at time and a half for the first two hours and double time thereafter.

Recommendation 14

It is recommended that the method and quantum of payment for on-call and call back services be reviewed with a view to equalising payment for the same on-call and call back services across the four types of doctors providing services to public patients in public hospitals.

INTERSTATE DIFFERENCES

5.124 The PAC inspected a number of hospitals and Health Departments interstate. From discussions with managers, staff specialists and VMOs, it was clear that sessional VMOs in NSW are infinitely better paid than their equivalent interstate colleagues, especially in Queensland and Victoria.

5.125 Using Victoria as an example, a comparison of rates showed that the hourly rate for a NSW Senior Specialist VMO was approximately 80% higher than for an equivalent Sessional Medical Officer in Victoria.

5.126 The main reasons for this interstate inequity seem to be:

.. the manner in which the Medicare Effect was interpreted in NSW and translated into an increase in the sessional rate; and

the large increase' in the background practice

costs loading granted in the 1985 Macken Determination.

5.127 No other State increased rates for VMOs specifically for the Medicare Effect.

INCENTIVE TO CHANGE THE STATUS OF HOSPITAL PATIENTS

5.128 The PAC heard evidence from a number of sources that VMOs can be financially advantaged when patients change their *"status"* in a public hospital.

EXAMPLE 1

5.129 A VMO Obstetrician admits a patient to a public hospital for confinement. The patient elects to be treated as a private patient and the VMO delivers the baby, thereby entitling the VMO to a fee from the patient which normally includes all post-natal care. However, the day after the delivery, the patient elects to change to non-chargeable (public patient) status. The VMO may then charge all post-natal care visits sessionally, thereby being paid twice for the post-natal visits.

EXAMPLE 2

5.130 A fee-for-service Specialist VMO, for example a physician, sees a patient in their private room and charges the patient an Item 110 which is an initial consultation fee (significantly higher than the fee for subsequent visits). They then admit the patient to a public hospital and the patient elects to be treated as a public patient. The VMO charges the hospital for Item 110 for the initial visit, even though they have already seen and evaluated this patient.

VARIATION TO EXAMPLE 2

5.131 A patient is admitted through casualty without having previously seen the VMO. The VMO charges the hospital an Item 110. After discharge the VMO begins seeing the patient in their private room and charges another Item 110 to the patient.

5.132 The PAC is concerned about the practice of manipulation between private and public status of patients. This has implications for Commonwealth/State funding of medical services.

Recommendation 15

It is recommended that the NSW and Commonwealth Departments of Health review the practice of VMOs manipulating patients' public/private insurance status in order to boost their total income. It is recommended that the Commonwealth's Medicare rebate and the State's VMO payment for the same service be neutral in terms of the incentive for switching insurance status.

6. ACCOUNTABILITY AND MANAGEMENT CONTROLS

6.1 Two major questions arose during the course of the PAC's inquiries into the growth in VMO payments:

- is there , adequate control by management of payments to VMOs ?

  are managers able to account for payments to VMOs?

HOSPITAL MANAGEMENT CONTROL

TERMINATION OR VARIATION OF CONTRACTS

6.2 The PAC inquired as to whether a VMO's appointment could be terminated, varied, or not renewed at the expiry of their contract·

6.3 It was submitted to the PAC that many hospital managers were concerned that there are no effective sanctions against VMOs for submitting erroneous claims for payment, or being neglectful of their duties.

6.4 The PAC notes that although contracts of appointment for VMOs generally contain a provision for termination of services for *"conduct that seriously threatens patient welfare or the proper administration of the hospital",* this provision must be viewed with regard to the significant practical and legal difficulties of proving such conduct.

6.5 In other submissions to the PAC, hospit al managers referred to the difficulties in negotiating with VMOs when the Period for renewal of contracts arrived and the hospital management contemplated a variation of the services or hours to be provided.

6.6 A submission to the PAC concerning a Sydney hospital exemplified this situation. In discussions with a VMO regarding renewal of his contract, it was suggested by the Medical SuPerintendent that the contracted time be reduced from 6 hours to 3 hours Per week on the basis that the maximum hours worked for the past nine months had been an average of 2.9 Per week. After pressure was brought to bear on various levels of management, the hours of the particular VMO were not reduced.

6.7 The submission concluded with a comment that was typical of the evidence submitted to the PAC on renewal or variation of VMO contracts:

"... this case raises issues which are reflected more widely in the hospital system .

the unwillingness of specialists to reduce hours if they are no longer required.

b) the willingness of some specialists to use any means to retain their-salaries ..,

the impotence of managers to rationalise salaries".

Recommendation 16

It is recommended that future contracts of appointment for VMOs clearly provide that on the expiry of the contract there be no legal obligation for automatic renewal and non-variation of all the terms and conditions of the contract.

CONTROL OF THE ON-CALL ROSTER

6.8 As discussed in C hapter 4, the increase in the number of hours of on-call payments claimed has contributed significantly to the increase in payments to VMOs.

6.9 While the hourly rate of on-call is beyond the scope of hospital management (as it is set by the 1985 Macken Determination), the on-call roster can be managed by the hospital according to:

patient demand;

ability to network with other hospitals; and ability to manage the risk of not paying VMOs on-call.

6.10 On-call rosters are normally determined by the Board of the hospital or .Area Health Service in conjunction .with the medical profession involved at the particular hospital.

6.11 Apart from recommending the maximum number of GPs which should. be on-call at the smaller country hospitals, it would appear that the NSW Department of Health has not issued sufficient criteria to hospitals to assist them in making rational and consistent roster decisions. Detailed

criteria for selecting which specialties will be on-call should not be confused with advice on fostering which is issued to hospitals/Area Health Services when requested.

6.12 This lack of direction by the Department has been a contributing factor to the increasing occurrence of intimidation of administrators by VMOs in regard to the selection of specialties to be included in on-call rosters.

6.13 The PAC is most concerned that the intimidation of administrators by VMOs opposing rationalisation of under-utilised on-call maters has meant that VMO payments have largely been avoided as an area of potential reallocation of available resources within hospitals.

6.14 An example of intimidation in the organisation of on-call rosters is the events which occurred at a Sydney hospital undertaking an extensive review of expenditure in order to keep hospital expenditure within the budget allocation. Various strategies were proposed to enable the hospital to keep beds open.

6.15 One of the strategies proposed identified savings of over $300,000 per annum through a review of on-call payments to sessional VMOs in four specialties where few instances of call backs occurred. For example, in one of the specialties, payment was made for fewer than 10 call backs during 1987/88 and yet $74,000 was paid in on-call payments in this specialty. It was considered that the volume and nature of the emergency workload at this hospital for t he four specialties did not Justify the payment of on-call.

6.16 The initiative to reduce on-call payments was taken by the Management Committee, comprising both local managers and representatives of the Medical Staff Council of the hospital concerned.

6.17 As a result of the decision to remove the four specialties from the paid on-call roster, the following events occurred:

a Medical Staff Council meeting rejected a motion for all VMOs to accept a 7% decrease in on-call allowances to fund the return of the four specialties to on-call rosters;

the VMOs concerned initially refused to be on-call for both public and private patients;

the Medical Staff Council again expressed their opposition to the proposal and almost precipitated the resignation of members on the Management Committee;

- the NSW Branch of the AMA wrote to the hospital opposing the moves;

- at a subsequent meeting at the hospital, the Medical Superintendent was placed under very significant pressure to reverse the decision at a management level; and

other hospitals retreated from similar proposals because of the perceived disruption of service provision which could develop.

6.18 Despite considerable personal pressure placed on the hospital Management Committee, it has maintained its stand to rationalise the on-call roster.

6.19 At a public hearing for this Inq uiry, the AMA advised the PAC that administrators arranged the on-call rosters and that the responsibility for the costs involved fell on those drawing up the roster. This view is in sharp contrast to the dispute over rosters referred to above, where it would seem the medical practitioners, and particularly VMOs, wish to determine the hospitals' on-call rosters.

6.20 This example clearly points to the future difficulties in

> negotiating with individual groups to achieve a rationalisation of VMO on-call payments. It also demonstrates that the belief that *"administrators"* decide who will be on-call is a profound simplification of a complex situation.

6.21 The PAC is most critical of those in the medical profession who seek to exert their will on administrators by withholding medical services to the public hospital system. If such circumstances arise in the future, the PAC considers that a confidential report should be forwarded to the NSW Department of Health for reference to the Minister of Health.

ACCOUNTABILITY FOR VMO PAYMENTS

6.22 The lank, in terms of accountability, is between the individual VMO and the hospital manager who authorises payment of the claim.

INDIVIDUAL DOCTOR ACCOUNTABILITY

6.23 Doctors usually keep a diary for their own purposes which records their activities and may contain such information as dates, times, patients' names, treatment and clinical notes. From this diary, the VMO extracts the information necessary for billing the hospital either on a fee-for-service basis or on a sessional basis.

6.24 A typical claim for payment by a fee-for-service VMO includes the following particulars:

name of patient;

date of service;
brief description of service;
item number (Medical Benefits Schedule number); and the Scheduled fee.

6.25 The details provided by fee-for-service VMOs allow validation of their claims for payment.

6.26 However, the only information required to claim payment for normal sessional hours is the commencing and finishing time for the VMO and the total number of hours spent providing services to public patients.

6.27 Clause 14 of the 1985 Macken Determination specifies'.'

"Record of Attendance

(a) to facilitate the calculation of the number of contracted hours per calendar month to be specified in a Sessional Contract in accordance with Clause 6 of this Determination a Visiting Medical Officer shall maintain a record indicating the date upon which he has been required to render service pursuant to this Determination. Such record shall indicate the commencing and finishing times during which services were rendered and the

number of hours, to the nearest quarter-hour,
such elapsed time as is attributable to services which are to be remunerated in accordance with
this Determination.

to facilitate the making and verification of

Clauses 8(a) and (b) and 15(ii) of this Determination, a Visiting Medical Officer shall
keep a record showing particulars of each service, that is to say the date, time of day, name of patient and nature of service rendered.

the records referred to in this Clause shall be submitted ... by no later than the fifteenth day of the succeeding calendar month.

6.28 As Clause 6 refers to sessional hours, sessional VMOs are not required to provide the following details of work performed during normal sessional hours:

the names or numbers of patients seen;

· the specific time spent in providing a service to

each public patient; nor

· the nature of the service provided.

6.29 Clause 8(a) and (b) refers to call backs and Clause 15(ii) to public holidays and therefore these details are required for call backs and all services provided on public holidays.

6.30 Thus, the VMO is the only person who can verify that the 'sessional hours claimed were actually spent 'providing services to public patients. There are no means available for the hospital to apply the normal validation procedures on the VMO payment claims. In addition,. the hospital cannot check whether the hours claimed 'were used to provide the type of services which the hospital wished to provide.

6.31 While the PAC met many doctors who kept immaculate records, there is an opportunity for abuse or error on the generous side by practitioners, especially those who do not maintain adequate records.

6.32 For example, one submission stated that the writer was advised:

"VMOs have attended outpatient sessions for only half an hour of a three hour clinic and then left to see private patients in the same hospital."

proportion of time at the hospital was allocated to public patients, it is easy to round up consistently in the favour of increased public payments, either deliberately, or by leaving a margin for error when only rudimentary records are maintained.

6.34 The extent of errors which are made in VMO claims is not known. However, the PAC visited one hospital where the CEO was so concerned about sessional payments that a clerical assistant was employed, in addition to the usual staff, to work virtually full-time on checking VMO claims for payment. On the basis of the extensive errors found, and the consequent reduction in VMO payments, the CEO has continued the extensive checking procedures because the cost savings far outweighed the salary of the clerical assistance.

6.35 The PAC cannot condone a system of payment of public funds in which accountability relies on self-verification.

6.36 VMOs have the incentive and the opportunity to increase their claims to the maximum possible. Further, they have no incentive or responsibility to contain costs for or on behalf of taxpayers. The PAC notes that until the current financial year, there has been a similar lack of incen tive for hospital administrations to contain costs due to the prevailing system of supplementation of budget allocations for VMO payments.

THE ACCOUNTABILITY OF CEOS AND MEDICAL ADMINISTRATORS

6.37 During several visits to hospitals, the PAC was advised that this aspect of the 1985 Macken Determination has caused many hospital administrators considerable concern. Administrators are forced to authorise payment for sessional hours claimed without an efficient means of verifying the claims by spot check comparisons with medical records, bed accommodation information or other appropriate audit trails.

6.38 The PAC considers that the ability to check this information is vital. Apparently Mr Justice Macken did **not concern** himself with the issue of limited information and the manner in which it would *affect* accountability for VMO payments.

6.39 The Medical Superintendent ' s Association made the following statement in relation to the increase in VMO payments:

"The Association warned the Department that the consequences of the Macken Determination would be very costly indeed and urged Departmental officers to provide support in asking doctors to provide more details in their sessional claims and clerical and data base help in the auditing and administration. The

Department failed to heed warnings and did not appear to understand the consequences ".

"Hospitals where doctors initially took up the modified fee-for-service option found, if they used a system which required the VMO to sign a slip at the end of each patients bed or in the medical record, that good control was possible.

"In such hospitals, many such doctors have now reverted to sessions. The consequent escalation in VMO payments cannot be put down to the on-call/call back provision. It was clear that in these hospitals at least, sessional arrangements were far more expensive and ***the closer control possible*** *in the fee-for-service verification system is needed for sessional claims as well. This system of verification (fee-for-service) seemed to ensure no servicing and provided good data for audi ting ".*

6.41 As an example of the problem, the Chief Executive Officer for the Central Coast Area Health Service informed the PAC that .'

".. · it was impossible for any Chief Executive Officer to verify in any way the claims . submitted by Sessional Contracted Visiting Medical Officers

and that,

"Whilst I am not suggesting that they are incorrect, the area of Visiting Medical Officers ' payment is the only area in our budget of $70 million plus, where I am unable to verify the claims".

6.42 Some hospital administrators informed the PAC that they *"got around"* the problems of sessional VMO accountability in their hospital. For example, the PAC was informed that the nurses and ward clerks were sometimes able to verify particular queries, and widespread accidental errors and abuse or over-generous claims would certainly be noticed.

6.43 Other hospitals sought additional information from' sessional VMOs concerning the total time spent at the hospital and comparing that with estimated time spent with private patients in the hospital, gleaned from various sources. While some VMOs agree to provide such information, administrators in other cases are forced to resort to alternative sources of information to verify and substantiate claims.

6.44 The Medical Superintendent s' submission noted that country hospitals, in particular, did not possess the administrative support staff to carry out verification of claims.

6.45 Some managers attempted to tackle the problem by issuing modified claim forms to sessional VMOs. These would have provided details of the nature of the service and the name of the patients treated during the time for which payment was claimed.

6.46 On the advice of the NSW Department of Health's' Central Administration, on e Central Coast Medical Superintendent wrote to all sessional VMOs in the Area in an attempt to explain the hospital's need to know the patient's name and nature of the service provided:

"The essential difference is that patients' names must now be provided, and this now means that sessional claims supply this information in exactly the same manner as the existing modified fee for service claim forms."

6.47 The Medical Superintendent's letter to the VMOs concluded **by stating:**

"In conclusion may I suggest our aims are threefold:

Firstly, to clarify your entitlements to ensure there can be no future misunderstanding or inadvertent claims.

- *Secondly, by virtue of the availability of the patients' name the classification can be readily and simply checked and thereby erasure our conscience is clear in regard to the disbursement of public money.*

- *Thirdly, that this system will ensure the limited funds available are equitably distributed."*

6.48 The general response of VMOs to this attempt to improve accountability is exemplified by the following reply by a **VMO:**

"This new form exceeds the requirements of Clause 14 of the Macken Determination on sessional contract (1/1/86) which clearly states the information which a medical officer is required to provide when making a claim for payment under his sessional contract. The new form seeks to obtain additional information and imposes an additional bureaucratic burden on the medical officer.

"While I understand and sympathise with [the Medical Superintendent ' s] *intentions, I believe it is illegal for the hospital to demand information to which it is not entitled under the Determination, and equally wrong for medical officers to relinquish their legal right to provide no more information than the Determination requires.*

"[The Medical Superintendent' s] *letter indicates that other hospitals have apparently successfully hoodwinked their medical officers into complying with similar demand for unauthorised additional information, and indeed have imposed further illegal obligations on them. Such actions by individual hospitals are intolerable. and it must. not be forgotten that it was threats of such unilateral variations in contractual obligations which led to the 1984/5 'Doctors ' Dismute '.* [Emphasis added **].**

"As the sole designer of our previous 'Sessional Payment Claim Form' I am aware of all the provisions of the current Macken Determination and all its predecessors. My claim form allows medical officer to fulfil all his obligations to the hospital when making a claim, nor does it require him to supply one iota 'of information more than he is legally obliged to.'

6.49 The AMA's view on sessional payment claim forms seeking details in excess of those *'allowed"by* the 1985 Macken Determination is similarly legalistic. A letter to a country hospital from the AMA's NSW Industrial Officer advised:

"... The pro forma document does not comply with instructions issued by the Department of Health (Circular No. 83/8) which deals with claims to be submitted by Visiting Medical Officers.

"Indeed Circular No. 86/105 confirms that there is no change required in records of attendance which were required prior to 1985 Macken Determination.

"Circular No. 83/8 was issued after discussion and agreement with this Association.

"It is not appropriate that a Hospital or Region of the Department unilaterally countermand a circular which was issued based on agreement with this Association.

"Justice Macken was most conscious in his judgements to not create a "bundy system" of record for each hospital patient treated by a Visiting Medical Officer, The Macken Determination makes quite clear those areas of claim which should carry details of patient's name, date and time of service (see Clause 14(h) of the said Determination)",

6.50 It is clear that many VMOs are not willing to improve accountability by supplying *"one iota of information more than they are legally obliged to"* and that CEOs and the **NSW** Department of Health are powerless to change this situation because of the provisions of the 1985 Macken Determination. It should be noted, however, that in some hospitals which the PAC visited, relations between VMOs and staff were sufficiently amicable that VMOs were willing to provide more than the legal requirement, sometimes in exchange for other concessions.

6.51 The PAC is surprised and perplexed at the concerns raised by some sessional VMOs over this matter. Most other professional groups provide detailed accounts of the services they are charging for, in addition to the total fee claimed. VMOs on fee-for-service contracts provide the patient's name, date of service, item number and then the fee is claimed. It would appear to be no more onerous

for sessional **VMOs to provide the**patient's name and the nature of the service provided.

6.52 Mr Justice Macken's 1985 Determination has prescribed the nature of the claim form and the information which will be provided by sessional VMOs and hence ensured that full accountability cannot be achieved.

Recommendation 17

It is recommended that if sessional remuneration is retained all VMO claims for payments include at least the following particulars of each service:

i) date

ii) start and finish time

iii) name of patient

iv) nature of service

DEPARTMENT OF HEALTH ACCOUNTABILITY

6.53 Many CEOs who were concerned with the lack of VMO accountability wrote to the Department of' Health requesting advice. The Central Office and Regional Office responded that the 1985 Macken Determination was binding on all hospitals and could not be altered, but that the problems would be berne in mind in future arbitrations. That is, the Department maintains it is constrained by the provisions of the Determination.

6.54 The PAC anticipated that in advising CEOs or managers concerning accountability, the NSW Department of Health would have provided information on alternative means *"tracking"* the accuracy of claims. While these methods may be cumbersome and the PAC recognises them as inadequate, nevertheless they could assist managers in accounting for their authorisation of VMO payments.

6.55 The PAC requested that the Department of Health provide evidence concerning assistance given to hospitals and area administrators with respect to the changes in remuneration which occurred after 1984.

6.56 After reviewing the Departmental evidence which included circulars of advice, the PAC considers that although the Department had inf ormed hospitals of changes which occurred in the post-1984 era, it had not provided sufficient advice and direction.

6.57 The PAC notes that the circulars are limited in content, while nevertheless appearing to provide the basic rules for implementation of changes to previous arrangements. The PAC has seen few spontaneous circulars of advice with suggestions on how to improve accountability within the bounds of the minimum requirements under the Determination. This advice may have be en provided at meetings or informally - although few hospital administrators with whom the PAC met could recall such management discussions.

6.58 Given the nature of the 1985 Macken Determination and the AMA's legalistic approach to its interpretation, the Department should have provided greater assistance to hospitals. Departmental advice appears to be reactive rather than pro-active.

6.59 The PAC recognises that the NSW Department of Health is in the process of decentralising decision making. However, the PAC is concerned that in so doing, the Department may be abdicating its responsibilities (to hospital management) in regard to certain matters that could be more appropriately dealt with by direction from Central Administration.

Recommendation 18

It is recommended that the NSW Department of Health develop more effective procedures to ensure that the advice in Departmental circulars is timely, specific, comprehensive and properly implemented. Follow up to be undertaken by regular hospital visits and appropriate scrutiny by Department of Health senior management.

ACCOUNTABILITY AND MANAGEMENT INFORMATION SYSTEMS

6.60 As noted in Chapter 3, hospital and NSW Department of Health management information systems are not helpful in auditing (in the broadest meaning of the term) payments to all VMOs.

6.61 Until the recent 1988 survey, the Department could not provide information on whether a particular VMO's claims were possible in terms of the total number of hours in a day. The Department of Health still cannot provide information on whether VMOs are being paid by two hospitals for the same hours.

Recommendation 19

It is recommended that the NSW Department of Health continue to collect and analyse information of the nature of that collected for the survey into 1987/88 VMO payments. Where further information is required to assist the monitoring of VMO payments, this to become a part of the routine collection of information.

ANNUAL REPORTING, INTERNAL CONTROL AND AUDITING IN THE ACCOUNTABILITY CHAIN

6.62 Prior to 1986, each public hospital in the State was governed by a Board. During 1986, 23 Area Health Services were created for the Sydney, Hunter and Illawarra regions. A subsequent amalgamation led to the creation of 10 Area Health Services.

6.63 The Area Health Boards, ap pointed to manage the affairs of the Area Health Services, replaced the numerous hospital boards which had responsibility. for managing the public hospitals.

6.64 Area Health Services are authorities of the State, subject to the Public Finance and Audit Act, 1983, and the Annual Reports (Statutory Bodies) Act, 1984.

ANNUAL REPORTING

6.65 Under the Annual Reports *Act,* the Area Health Services are.

required to submit an annual report (to be presented by the Minister for Health to Parliament) an d disclose certain financial and other information in their report.

Report on Payments to Visiting Medical Officers

6.66 Those hospitals outside the Area Health Services are not required to report to Parliament; nor are their disclosure requirements so clearly defined.

Recommendation 20

It is recommended that Hospital Boards outside the established Area Health Services be subject to provisions similar to those of the Annual Reports (Statutory Bodies) Act, to the extent that this is practicable and appropriate.

INTERNAL CONTROL AND AUDITING

6.67 The PAC reviewed internal audit in the context of performance review practices in government departments and authorities in its 15th Report (June 1985).

6.68 The Report emphasised the role of internal and external audit in ensuring the efficiency, effectiveness and economy of government organisations.

6.69 The Head of an Area Health Service is required by the Public Finance and Audit Act to ensure that effective internal control and audit procedures are established and maintained.

6.70 However, the PAC noted varying degrees of internal control and audit review between hospitals.

6.71 Hospitals which are not controlled by Area Health Services, and this includes most of the country hospitals, are not subject to the Act. They are subject to the requirements of the NSW .Department of Health relating to

the accounts and audit of public hospitals. These requirements have not been adequately reviewed for many years.

6.72 While the PAC recognises that differences in the standard of internal control will occur between hospitals, it is nevertheless concerned at the statewide standard of accountability.

6.73 The PAC believes that the "good stewardship" function over public funds has not been demonstrated in the overall level of control over VMO payments. Little evidence was produced to indicate that the management issues of VMO payments are being adequately addressed.

Recommendation **21**

It is recommended that the internal control and audit requirements and the accounting arrangements for Hospital Boards outside Area Health Services be reviewed and, where practicable, brought into line with the requirements of the Public Finance and Audit Act.

Recommendation **22**

It is recommended that hospital internal control guidelines be developed to ensure accountability for the use of public funds in relation to VMO payments.

THE COST OF ACCOUNTABILITY

6.74 Accountability is not without cost. There are time costs to doctors in completing claim forms and there are costs to hospitals in verifying that the claims are correct. It is essential that the cost of checking should not exceed the costs saved by checking.

6.75 The PAC considers that the adoption of risk management by not checking claims has some merit. However, given the amount of VMO claims involved (over $200M per annum) and on the basis of evidence presented to it, (such as that presented in paragraph 6.34), VMO claims need to be checked in greater detail than is presently possible. This is especially the case for sessional VMOs.

6.76 The PAC also considers that if the basic claim form for sessional payment was amended to include more information, the cost of checking by hospital administrators would be reduced.

7. VALUE FOR MONEY

INTRODUCTION

7.1 In this Chapter, Term of Reference 2 is addressed: *"To review the cost benefit of the payments made to VMOs last five years".*

7.2 The PAC views this term of reference as basic to the overall issue of appropriate remuneration of doctors who provide medical services to pu blic patients.

7.3 However, it needs to be stated at the outset that the PAC found that the evidence and research required to address this Term of Reference was either not available or inadequate to the task. Indeed, the PAC found that there was no well-defined conceptual structure available by which the cost benefit of payments to VMOs could be adequately measured.

7.4 Over the last five years, payments to VMOs have increased markedly. The broad question addressed by the PAC was whether the extra cost could be justified.

COSTS

7.5 For the purpose of this Chapter, the measure of cost will be payments to VMOs.

7.6 AS indicated in previous Chapters, over the last four years (1983/84 to 1987/88):

total payments to VMOs increased by almost 300% from $45.8M to $181.9M;

payments to fee-for-service VMOs increased by 209%

total payments to sessional VMOs increased by 340%;

payments to sessional VMOs for on-call and call back have markedly increased by over 600%; and

payments to sessional VMOs for " *background practice costs*" have increased by the 1985 Macken Determination from $2.65 per hour for GPs to $20.00 per hour (an increase of 655%) and $3.49 to $25.00 for Specialists (an increase of 616%).

BENEFITS

7.7 Assessing benefits derived from the extra payments is not an easy task.

7.8 An increase in the quantity or volume of services provided - measured for example , by the number of patients seen, number of medical services provided and the number of hours worked - *may* help to explain the increase in payments.

7.9 Benefits can also be derived from improvements in the services provided such as:

increased complexity of service provision;

improved quality of service provision;

improved *outcome* such as an increased chance of survival or quality of life; and

- an improvement in the matching o f services to demands.

7.10 On the evidence presented and available to the PAC it would *appear* that the increase in the cost of VMOs is not reflected in equivalent improvements to, and volume medical services provided to public patients.

7.11 It was submitted to the PAC that increased productivity was a benefit of the increased costs of VMOs. Productivity refers to greater output (items or services) per unit of input.

7.12 Productivity increases, if they occurred, may not all be' directly att ributable to behavioural or technical changes by VMOs. Productivity improvements are also likely to accrue as a result of the following:

improved nursing and other non-medical care;

changes in the number of Resident Medical Officers and Registrars;

improved hospital management;

- improved hospital design; and

- technological advances.

7.13 it is not the case that all increases in doctor productivity should automatically result in greater rates of pay when the reason for the productivity change originates from other workers in the health care field.

7.14 It was also submitted to the PAC that the increases in the rate of sessional remuneration under the 1985 Macken Determination were not, in any event, due to productivity increases (although *"work value"* was a major issue). It was not argued before Mr Justice Macken that a pay increase for sessional V MOs was required because productivity had increased, and no evidence was adduced to support such a claim.

7.15 Despite extensive consultation, the PAC did not receive a submission which argued that the increase in VMO payments over the last five years - total or rate of pay - was in exchange for increased productivity.

7.16 On the evidence available to the PAC, it cannot be concluded that the increase in VMO payments was attributable to the benefit of increased productivity.

7.17 In other submissions to the PAC it has been argued that benefits have accrued from the increased VMO payments through:

- compensating sessional VMOs for the loss of income caused by the introduction of Medicare;

sessional VMOs no longer being underpaid in comparison with fee-for service VMOs and salaried medical staff; and

overcoming sessional VMO recruitment problems.

COMPENSATION FOR LOSS OF PRIVATE PATIENT FEES

7.18 Doctors have argued that they required compensation, in the form of an increased rate of payment for treating public patients, for the loss of income from .private patients treated in public hospitals following the introduction of Medicare. This argument has been discussed in detail in Chapter 5.

7.19 The PAC considers that inequities in VMO remuneration were created by the level of Medicare Effect compensation granted sessional VMOs and does not accept such compensation as a b enefit of the increased VMO payments.

7.20 Further, this argument on the benefits of increased VMO payments depends on acceptance of the view that a government should always compensate the *"losers"* when a new social/economic policy is introduced. The **PAC** considers that VMOs have sought compensation for the changes in the health care system at considerable cost to the public purse.

RELATIVITIES ARGUMENT

7.21 It was submitted to the PAC that pre-1985 sessional VMOs were poorly paid comp ared with other doctors. It is difficult to judge whether other doctors providing public medical care were underpaid or overpaid.

7.22 Mr Justice Macken concluded on the evidence presented that sessional VMOs were in fact poorly remunerated compared with staff specialists and fee-for-service VMOs.

7.23 While Mr Justice Macken attempted to bring sessional VMOs into line with other doctors, his 1985 Determin ation accentuated differences between the different categories of VMOs and between VMOs and staff specialists by providing for increases in sessional hourly remuneration of up to 90%.

RECRUITMENT

7.24 It was submitted to the PAC that recruitment of sessional VMOs was difficult before the increase in payments in 1985. Recruitment no longer appears to be a problem, except in some small remote hospitals which are regarded as less attractive places of work.

7.25 It has been argued that t he increase in the rate of pay for sessional VMOs has resolved the issue of recruiting sessional VMOs, especially in teaching hospitals - yet this so-called benefit has exacerbated the problem of recruiting salaried staff, As noted earlier, there is a queue to become a sessional VMO.

7.26 Further, other factors such as the influence of the Alta and professional Specialist college restrictions should be considered in any assessment of difficulties associated with VMO recruitment.

7.27 The PAC is unconvinced that the alleged benefits in relation to sessional VMOs are of such significance as to Justify the increases in VMO costs.

7.28 Finally, the PAC was concerned that neither the NSW Department of Health or the AMA presented their submissions to the PAC in terms of cost benefit, or value for money, and it appears that neither party could produce the relevant data.

7.29 This is a strong indictment o f the NSW Department of Health. While investment appraisal and cost benefit analysis is considered essential in the public sector generally, multi-million dollar decisions are being made in the public hospital system without such appraisal.

7.30 In regard to the survey data on VMO numbers and payments in 1987/88, the PAC found that the information was not extensive enough to allow it to address the relevant issues raised by the Term of Reference on the cost benefit of increased VMO payments.

7.31 In summary:

costs (payments to VMOs) have increased by almost 300% between 1983/84 ($45.8M) and 1987/88 ($181.9M);

benefits (quantity, quality of medical care) may have increased as indicated by the 21% increase in public patient bed days and a 9% decrease in the average length of stay by patients in public hospitals; and

benefits may have accrued if it is accepted that VMOs were previously underpaid, equity for VMOs has been achieved by pay rate increases, and hospital recruitment difficulties have been ameliorated. The PAC is not convinced by these arguments given the anomalies and inequities of sessional remuneration identified in Chapter 5.

Recommendation 23

It is recommended that a component of submissions for future change to VMO remuneration be whether value for money will be obtained from the change.

8. ALTERNATIVE FORMS OF REMUNERATING VMO S

8.1 Term of Reference 6 of this Inquiry requires the PAC:

"To provide advice on the alternatives available to remunerate VMOs engaged in NSW public hospitals".

8.2 In meeting this Term of Reference, the PAC has:

consulted extensively with VMOs, hospital managers, senior staff in the NSW Department of Health and other interested parties through formal and informal meetings;

reviewed submissions and transcripts of Hearings for the Inquiry;

· examined some interstate and overseas systems of remuneration;

· reviewed the literature concerning doctor remuneration generally; and

sought and received a submission from the NSW Department of Health on options for remuneration.

8.3 As might be expected, this Term of Reference has caused the PAC much concern and deliberation.

THE CURRENT MIX OF REMUNERATION METHODS

8.4 As outlined in Chapter 2, the current arrangements for, and mix of, VMO remuneration options have developed in two main phases.

8.5 The mix of sessional and fee-for-service payments altered as a result of the 1985 doctors' dispute resolution package as follows:

teaching hospitals - sessional only;

small country hospitals - modified fee-for-service only (and the recent addition of the 1988 country doctors' settlement package); and

country base and metropolitan district hospitals - choice (by whole specialty group) of either sessional or modified fee-for-service.

8.6 The arbitration of December 1985, the Macken Determination, dramatically altered the cost relativities between sessional and fee-for-service remuneration, with increases in sessional remuneration of up to 90%. The higher sessional rates led to an increase in the number of VMOs engaged under sessional appointments as explained in Chapter 4.

8.7 The present system of remuneration has evolved primarily in response to major disputation in the hospital system rather than resulting from an appraisal of the best available system.

8.8 Prior to the 1985 doctors' dispute resolution package, country base and metropolitan district hospitals generally paid VMOs on a sessional basis. In contrast, the AMA traditionally favoured and lobbied for fee-for-service in country base and metropolitan district hospitals.

8.9 The introduction of choice to some types of hospitals after the 1984/85 doctors' dispute was an attempt to meet some of the preferences of the medical profession. It was argued that procedural specialists preferred fee-for-service payments whereas non-proceduralists generally preferred sessional payments. The medical profession and the State and Commonwealth governments anticipated that fee-for-service would be a more attractive remuneration package for most VMOs than sessional payment.

8.10 The NSW Department of Health's paper on Options for Remuneration, provided to the PAC, contains no evidence to suggest that the Department introduced the current scheme for other than "industrial" reasons. The current scheme was not adequately researched, planned or based on any particular policy.

8.11 While individual doctors wish to have the system of remuneration which best suits them personally, NSW Department of Health officers have voiced their concern at the potentially high cost of a system which can be manipulated to maximise financial rewards.

8.12 The PAC can well understand the motivation of both parties and recognises the conflicting objectives involved in the circumstances in which the arrangement was agreed. It is considered, however, that the end product - a choice by specialty group - is an ad *hoc* policy which does little to meet the requirements of all interested parties. It has not been satisfactorily demonstrated that this does

anything more than enable VMOs to maximise potential income.

8.13 The PAC is surprised that the NSW Department of Health should have failed to investigate the important issue of alternative remuneration systems. The PAC is concerned about the implications of this for the Department's capacity to manage and plan for an efficient health care delivery system.

8.14 The PAC recognises that the Department felt pressured by the AMA and the community to "do something" to meet the demands of the profession during the period of the Medicare/doctors' dispute. This industrial situation explains some of the reasons for the *ad hoc* decisions. However, the PAC considers that many of the remuneration issues could have been foreseen many years ago and hence the options should have been properly evaluated in advance.

8.15 Notwithstanding the dispute situation, the PAC considers that the remuneration options for VMOs should have been investigated to evaluate their benefits and weaknesses before being fully 'implemented. The ability of specialty groups to choose between payment modes has substantially weakened the NSW Department of Health and hospitals control over VMO costs and has undermined effective expenditure planning.

8.16 The research into the issue of remuneration for VMOs that was conducted by the Department appears to have been largely ignored by senior management.

OPTIONS FOR REMUNERATING VMOS

8.17 There are generally two basic forms of remuneration - the piece work method of paying whereby a fee for each item, service or procedure performed is paid, and payment on a time basis such as hourly for sessional or annually for salaries.

8.18 Prospective or pre-agreed fixed dollar contracts may be of either form or a combination.

8.19 There are a number of methods which could form the basis of remunerating VMOs for services to public patients in hospitals including:

- fee-for-service;
- sessional;
- part-salary; and
- prospective fixed sum contract.

8.20 Variations of the application of these basic methods of remuneration include:

- full individual VMO choice of remuneration method;
- full individual hospital choice of remuneration method;
- remuneration determined by hospital type (for example, sessional in teaching hospitals, fee-for-service in others); and
- remuneration determined by specialty or other groups (for example, fee-for-service for proceduralists, salary for others).

8.21 The PAC considers that neither the content-based nor time-based remuneration system is clearly superior for all VMOs in all circumstances. This does not mean that each VMO should be paid differently - only that no single system will be ideal. Different systems will appea l to different VMOs or administrators and different hospital types.

EVALUATION OF ALTERNATIVES

8.22 A system of remuneration must, however, meet objectives such as efficiency, cost containment, effectiveness, equity and ease of administration, rather than simply VMO approval.

8.23 In discussing the advantages and disadvantages of various alternative methods of payment, there is a need for identification of broad criteria by which the alternatives can be evaluated.

8.24 Assessment of alt ernatives should include consideration of:

· impact on resource allocation;

capacity to plan and control expenditure;

accountability for payments;

contribution to high quality care (including doctor motivation and productivity);

similar financial treatment of comparable work in different hospitals;

ease of administration; **and**

value for money.

8.25 It may be necessary to accept trade-offs between competing principles. For example, least-cost options may have an adverse effect on the quantity and quality of patient care.

8.26 Four alternative methods of remuneration are discussed below based on the evidence available to the PAC as to their costs and effectiveness. Each section is followed by recommendations.

SESSIONAL

8.27 The session was originally established as a block of time of three and a half hours..A VMO would be paid for a pre-agreed number of sessions per month, regardless of the number of hours actually worked each month.

8.28 Currently, the sessional system is based on an hourly rate of remuneration paid on the basis of claims lodged for the actual number of hours worked each period. The rate for on-call is a fixed percentage of the sessional base hourly rate. Call backs are separately remunerated at a loaded base hourly rate. The sessional hourly rate also includes a substantial private practice loading.

8.29 It was submitted to the PAC that the main advantages of sessional remuneration for VMOs are as follows:

ease of compensating VMOs for the time spent on non-patient work such as teaching or administrative tasks;

less incentive to over-service; and

relatively low costs in administration and processing claims for payment.

8.30 The PAC notes that the alleged advantage of less incentive to over-service is ameliorated by the present application of the sessional system whereb y sessions are hourly based and open-ended.

8.31 Further, the alleged advantage of low administrative costs should be balanced against the difficulties of justifying sessional VMO claims. The apparent ease of administration and processing of claims is not an "advantage" of the sessional system when the hospital administration must authorise payments for which they have inadequate verification, or staff are deployed from their regular duties to conduct verification checks.

8.32 The princi ple of a sessional system of remuneration (time-based payment) is suited to teaching hospitals where VMOs may spend considerable time on 'teaching and administrative duties. Equally, an alternative system such as fee-for-service could include an allowance or a separate fee-for-service item for such duties.

8.33 It was submitted to the PAC that the main disadvantages of the current sessional remuneration scheme for VMOs are as follows:

the lack of pre-determined agreement in respect of the amount and range of services to be provided by the particular hospital and the individual VMOs;

the lack of criteria in determining the hours required; that is, the hours requested are not based in advance on patient numbers, case-mix or availability of staff specialists but based on hours claimed retrospectively;

as payments are open-ended and hours can increase without an active management decision, this can lead to an increase in hours claimed far above that expected or budgeted for;

the inability to define what is an appropriate level of service per hour; for example, typical workload for one hour in terms of items performed, or the number of patients seen;

the high cost of on-call payments;

the high cost of call back payments;

the lack of accountability built into the claim form requirements which effectively means that claims for payment cannot be routinely verified or audited in the usual manner;

the rate of on-call and call back payments attached to the base hourly rate system, as determined by the 1985 Macken Determination;'

the inclusion of a significant background practice costs loading in the sessional base hourly rate;

the inappropriate inclusion of superannuation, unpaid leave and split shift loadings into the normal base hourly rate; and

the inappropriate application of recent State Wage Case decisions (flat weekly increases) to the sessional base hourly rate.

8.34 The anomalies and consequent disadvantages of the sessional system were discussed in detail in Chapter 5.

8.35 A particular area of concern with the present sessional system is the escalating cost of on-call rosters and call backs. As stated in Chapter 3, these outlays have increased more than six-fold between 1982/83 and 1987/88, rising from 17 to 28 per cent of total sessional payments. Contributing facto rs to this increase in expenditure, as discussed in Chapter 4, have been the on-call and call back rates as determined by Mr Justice Macken in 1985 and the increase in the number of VMOs receiving payment for participating in on-call rosters.

8.36 If a sessional system of remuneration is retained, the PAC considers that all anomalies identified in Chapter 5 should be removed. This would include at least the following changes to the system:

review of the re-introduction of a system whereby a session is a fixed block of time;

the number of sessions to be negotiated prospectively between the hospital and the VMO;

the normal sessional base rate should be totally re-negotiated;

on the grounds of equity and efficiency, the present system of payment for sessional on-call and call back arrangements should be abandoned;

· clear guidelines should be developed concerning:

- the range of different specialties which are to be placed on-call;

- the hospitals in which such on-call is appropriate;

- the number of VMOs in each specialty to be placed on-call; and

payment claim forms which contain sufficient information to allow adequate verification should be implemented.

8.37 It is the PAC's view that the sessional system as it has evolved since 1985 has little to commend it in terms of being an efficient, equitable, accountable and cost-effective method of remunerating VMOs.

Recommendation **24**

It is recommended that the current system of sessional remuneration be abolished by phasing out the system as existing contracts expire.

FEE-FOR-SERVICE REMUNERATION

8.38 The fee-for-service system remunerates doctors on the basis 'of a fee for each service or procedure provided. Private medical services, in hospitals and otherwise, are provided on this basis.

8.39 Currently, the fee-for-service system is a " *piece work"* system under which the VMO is paid a fee (a proportion of the Commonwealth Medical Benefits Schedule fee) for each item of service claimed. Apart from country GPs, no on-call payments are made, although fee-for-service VMOs participate in the on-call roster. Services provided during call backs attract payment at the usual modified fee-for-service rate; that is, no out of hours loading applies, with the exception of country GPs.

8.40 The modified fee-for-service system of paying VMOs for their services to hospital public patients is similar to bulk billing by private doctors. VMOs are paid by the State at a rate negotiated by the State - currently the rate is between 60% and 85% of the scheduled fee listed in the Commonwealth's Medical Benefits Schedule. Appendix 11 contains information on the various percentages of the scheduled fee to be paid to VMOs at metropolitan district and country base hospitals.

8.41 It was submitted to the PAC that the main advantages of fee-for-service remuneration for VMOs are as follows:

it is clear what service is being provided in exchange for the payment made as payment Can be linked to patient activity. This makes the audit, and therefore accountability, straightforward.. It means that quantity may be monitored in a routine manner;

hospitals can determine the level of service that is to be provided by the hospital and there are means by which pre-agreed levels of service provision can be negotiated with each VMO; and

it is the system used in the private medical care sector. It means that payment for similar services are remunerated in the same way, thus providing a yardstick for measuring differences between public and private services.

8.42 Further, the PAC notes that the system of piece work payment is accepted by the bulk of VMOs who practice in both the private and public sectors and is the method of remuneration most compatible with self-employment . Fee-for-service is historically the *"philosophica1ly preferred"* method of payment for many doctors.

8.43 It was submitted to the PAC that the main disadvantages of fee-for-service remuneration for VMOs are as follows:

there is a financial incentive to increase the number of procedures performed and it may encourage over-servicing or inappropriate hospitalisation;

emphasis on performing procedures may be an impediment to the proper holistic or preventative management of patients; and

payment claim processing costs may be high.

8.44 It should be noted, however, that there is no reliable evidence of any these effects in NSW public hospitals.

8.45 The PAC notes that the fee-for-service method of remunerating doctors in public hospitals has not been fully evaluated in NSW. There has, however, been some research on this method of remuneration primarily drawing on evidence from overseas health care systems and the private medical care system.

8.46 Research on the problems associated with the fee-for-service system invariably centres on the financial incentive for doctors to provide more services than are strictly necessary. It is argued that costs are increased with only marginal or no benefits to patients.

8.47 Doctors, of course, have a professional interest and responsibility to *"do whatever is possible"* for their patients (regardless, to some extent , of costs) and the argument is that the addition of a financial incentive will reinforce so-called *"over-zealous"* care or *"over-*utilisation" to an extent that value for money is not being achieved.

8.48 Further, VMOs under the present fee-for-service system (as in the sessional system) largely have control of their own work patterns in public hospitals so as to directly influence hospital budgets.

8.49 The quantitative empirical evidence concerning the importance of the financial incentive to over-service in public or private medical care is, perhaps surprisingly, inadequate. The PAC was thus not able to reach a conclusion as to the disadvantage of' the incentive to over-service in public hospitals. However, given the reservations expressed in the research on the subject, and the fact that public hospital doctors in NSW are most likely to respond to financial incentives An a similar manner to doctors in other systems, the PAC consi ders that the NSW Department of Health will need to manage the situation by administrative and clinical monitoring.

8.50 The PAC considers that if the *"incentives"* issue is addressed and the necessary and appropriate monitoring and hospital management procedures are in place, then the fee-

for-service system can potentially result in value for money.

8.51 The problem of potential over-servicing could be ameliorated through moni toring, inter-hospital comparison of practice patterns, peer review and effective management of the services to be provided by a hospital in total, and by each VMO.

8.52 The PAC notes that monitoring of practice patterns by non-medical officers has met with resistance and that even independent peer review - in whatever form - has been opposed on such grounds as clinical freedom and lack of knowledge of medical matters on the part of regulators.

8.53 It is the PAC's view that VMOs must rec ognise that the expenditure of millions of public funds requires a high level of accountability that must entail some degree of monitoring and management by medical and non-medical managers.

8.54 In addition to addressing the issue of over-servicing, the PAC considers that hospital management must prevent total payments to VMOs being "open-ended" commitments by the hospital. One means of achieving this objective is the use of global payment caps. Fee-for-service VMOs could negotiate a minimum and maximum total payment with the hospital management.

8.55 As to the alleged disadvantage of high administrative costs, it is important to note that the fee-for-service administrative costs may be "higher" because comparison is made with the current sessional system. The current sessional system is defective in that there is no accountability for claims for payments, as discussed in Chapter 6, and as such it is not an appropriate model for comparison.

8.56 The PAC considers that accountability is such a key issue that monitoring, feedback and action to curb any excessive servicing and doctor-generated demand should proceed simultaneously with further use of the fee-for-service system. While doctors may see such accountability as intrusive or as an erosion of their authority, there is a need to understand the requirement for Parliament and the public to be assured that public funds are being exp ended in the most efficient, effective and accountable way. No other industry would tolerate the expenditure of such sums without management control and accountability.

8.57 As to the issue of an appropriate base fee schedule for payment, the determination of the actual fee charged has been a matter of debate in both the private and public sectors.

8.58 In the private medical care market, rebates for patients. are 85% of the fee listed in the Medical Benefits Schedule (maintained by the Commonwealth Government's Insurance Commission in consultation with medical practitioners). As noted, fee-for-service VMOs in public hospitals are paid between 60% and 85% of the scheduled fee depending primarily on the level of Registrar or Resident Medical Officer cover at that particular hospital.

8.59 The AMA has established a separate fee schedule which is used by many private specialists and GPs. The fees are significantly above what would be paid to modified fee-for-service VMOs under the present Medical Benefits Schedule.

8.60 The PAC notes that the Commonwealth Auditor-General is in the process of reviewing the Commonwealth's Medical Benefit Schedule, which is the current base schedule on

which hospital fee-for-service doctors are remunerated. The results of this review will require monitoring by the NSW Department of Health to establish the appropriateness of the continued use of the Schedule for payment of VMOs for public hospital services.

8.61 The PAC considers that the use of the Commonwealth Schedule and the current percentages paid to VMOs ks the most appropriate basis presently available for a modified fee-for-service system. Any moves towards payment of a higher percentage of the scheduled fee should be resisted.

8.62 The base fee schedule could incorporate the principle that percentage rates may be higher, however, in circumstances where medical practitioners do not ha ve back up services, such as in country hospitals.

8.63 Another issue is the payment of on-call allowances. At present, fee-for-service VMOs (other than country GPs) are not recompensed for being rostered on-call and call backs are remunerated at the usual modified fee-for-service rate. This causes dissension between staff specialists and fee-for-service and sessional VMOs in the same hospital.

8.64 Some fee-for-service VMOs argue that they should also receive on-call payments. The PAC is not conv inced by this argument as it can find no compelling reason for recompensing on-call to sessional VMOs in the current manner and considers that the present sessional system should be abolished.

Recommendation **25**

It is recommended that the current modified fee-for-service system for remunerating VMOs be retained subject to:

regular review and monitoring of practice patterns be enforced with a view to achieving optimal utilisation of services and cost effectiveness;

ii) hospital managements pre-determining the level and range of services to be provided by the hospital;

iii) hospital management pre-determining, in consultation with each VMO, the level of service to be provided by the VMO, with consideration given to a global payment cap;

iv) the enforcement of performance standards (quality and cost); and

v) the continuation of an appropriate base fee schedule.

PART SALARY

8.65 Part-salaried VMOs are remunerated on a pro-rata rate of pay equivalent to medical staff. This alternative is not currently a form of VMO remuneration used in NSW.

8.66 It was submitted to the PAC that the main advantages of the part-salary system of VMO remuneration are as follows:

clear predictability of expenditure on VMOs for budgeting and planning purposes;

the ease of recompensing research, teaching and administrative time;

minimal incentive for over-servicing;

administrative ease in processing claims for payment;

equity between salaried staff and VMOs; and

streamlined one-off award negotiations involving less cost to both the NSW Department of Health and the doctors' representatives.

8.67 It was submitted to the PAC that the main disadvantages of part-salary - remuneration for VMOs are as follows:

there may be lack of flexibility in terms of minimum hours of service. Country and district hospitals, where a particular VMO may be required for a very short time per day, are a particular problem in this regard;

there may be an incentive to under-service or minimise work and this may lead to hospital waiting lists and inefficient or unproductive practices; and

· there may be no incentive for efficiency or quality in service.

8.68 Further, the PAC notes that part-salary remuneration may be unacceptable to some private medical practitioners. It is often stated that VMOs do not wish to be considered "employees' of hospitals, but wish to retain their autonomy and status as independent contractors.

8.69 The PAC found, however, some VMOs were not concerned with this issue during its hospital visits around the State. The history of sessional remuneration, moreover, suggests VMOs are increasingly seeking most of the benefits of employee status.

8.70 As to the alleged disadvantag e of no incentive for quality, the NSW Branch of the' AMA stated in its submission to the PAC:

"The Branch would also submit that there is significant difference between VMOs and staff specialists in their respective incentives to
VMOs have to perform services during their sessions or if paid on a fee-for-service basis have to perform services before being entitled to remuneration. Staff specialists on the other hand enjoy a salary with no particular incentive to perform their services

8.71 Represent atives of the Public Medical Officers Association have disputed the AMA's statement at public hearings. The Association of Medical Superintendents (NSW and ACT) wrote in its submission to the PAC:

"The Association refutes absolutely any contention that Visiting Medical Officers are more competent or outstanding in their field than Staff Specialists. In fact ... outlying district and country hospitals all too often have to contend with Visiting Specialists who have been unable to

secure positions at teaching hospitals
or large base or district hospitals".

8.72 There is no evidence to suggest that the quality or productivity of practitioners, on average, varied according to the remuneration method.

8.73 The PAC could find no objection in principle to VMOs being paid on a part-salary basis. The PAC is mindful that this system of remuneration operates successfully in other States and overseas.

Recommendation 26

It is recommended that the NSW Department of Health investigate the part-salary system of payment for VMOs, giving particular consideration to the system as it operates in New Zealand.

PROSPECTIVE FIXED SUM CONTRACTS

8.74 A prospective fixed sum contract can take several forms, although it necessarily includes a pre-agreed total sum to be.paid to the VMO. Contracts may be time and/or service based and they can be negotiated on an individual or group basis.

8.75 Fixed sum contracts are used minimally in NSW and require further evaluation as to their costs and effectiveness. In one NSW hospital where general practitioner VMOs are engaged under prospective fixed sum contracts, the lump sum is calculated upon an assessment of the remuneration that would have been received under a sessional contract,

with less than the usual payment for on-call taken into account in determining the lump sum.

8.76 It was submitted to the PAC that the main advantages of prospective fixed sum contracts for VMO remuneration are as follows:

the amount of payment is largely predetermined or predictable. This facilitates expenditure planning and cost control;

the lump sum covers all aspects of the contract; that is, no other payments are made;

the services to be provided in exchange for payment are clearly defined and thus negotiations for pay are based on services actually provided or at least planned; that is, they are criteria based; and

the contracts can be flexible in the sense that they can be altered to fit special or unusual circumstances - for example, where there has been a major increase or decrease in the level of services to be provided during the life of the contract.

8.77 It was submitted to the PAC that the main disadvantages of prospective fixed sum contracts for VMO remuneration are as follows:

it is time-consuming and costly from a legal and industrial viewpoint to develop individual contracts. Errors can and do arise, even with specialty-based contracts (as seen in the recent problems with Orthopaedic Surgeon contracts); and

dissension can occur if some doctors or some hospitals are able to exercise undue monopoly power and bargain more effectively than others.

8.78 The NSW Department of Health has mentioned this form of remuneration only in passing in the *"Options Paper"* provided to the PAC. In 1986, the Department did, however, encourage regional directors and hospitals to consider prospective lump sum contracts for VMOs, and issued guidelines for the negotiation of such contracts.

8.79 The PAC notes the NSW Branch of the AMA strongly objected to prospective fixed sum contracts and advised its members not to countenance any such arrangements. This may be because VMOs have come to expect an open-ended system of payments for the services they provide.

8.80 The AMA remains officially opposed to the introduction of this form of remuneration, regarding it as an attempt to circumvent the 1984/85 doctors' dispute resolution package and the entitlements of the 1985 Macken Determination.

8.81 Fixed sum contracts may also imply a decentralisation of the fee negotiating process. If this system of remuneration were introduced, measures would need to be employed to ensure that overall consistency and equity among VMOs is preserved and that small country hospitals are not disadvantaged.

Recommendation 27

It is recommended that the NSW Department of Health give consideration to the applicability of prospective fixed sum payment for VMOs in NSW.

This following alternatives for setting the lump sum may be considered:

expected patient population and case-mix; or

ii) total expected units of service.

RELATIVE COSTS OF VARIOUS SYSTEMS

8.82 Each system of remuneration has its merits and its problems in principle or practice. In the application of each method, problems may arise which override any benefits anticipated on the basis of the various advantages outlined above. To complete this review, available evidence on the relative costs of various alternatives was examined.

8.83 The NSW Department of Health submitted to the PAC a summary of three recent studies which are indicative of the relative costs of fee-for-service and sessional payments.

8.84 All three studies indicate that the sessional system of remuneration is more costly than the fee-for-service system.

8.85 It should be noted that the results of the studies are based on the actual rates of remuneration existing at the time of each study - not the merits of each system.

A MIXED REMUNERATION SYSTEM

8.86 It has been submitted to the PAC that the current mix of remuneration systems in NSW may be justified chiefly on the grounds that fee-for-service is suitable for small country hospitals and for procedural specialists, while services provided in teaching hospitals (which include teaching, research and administrative tasks) are most suitably remunerated by time-based payment. It is argued that such duties cannot be r eadily compensated as items in the Commonwealth's Medical Benefits Schedule.

8.87 The PAC considers that this is not sufficient Justification to sustain an otherwise inequitable sessional system of payment.

8.88 There is no reason why a VMO in a teaching hospital could not receive fee-for-service payments for services which are primarily treatment and a separate salary for teaching or other responsibilities. Alternatively, the modified fee-for-service payment could be loaded to take account of additional research, teaching and administrative duties.

8.89 The PAC does not accept the view that restriction of choice by specialty group within individual hospitals in the presently mixed system is the best means of containing costs.

8.90 Further, it is not equitable that some VMOs may earn more than their colleagues who perform similar services by a mere quirk of which hospital they are appointed to as a VMO.

8.91 Finally, the PAC reiterates the point (referred to in paragraph 8.7) that the present mixed system of remuneration has evolved primarily in response to major disputation in the hospital system rather than from a rational appraisal of the most efficient and effective system.

CHOICE OF REMUNERATION SYSTEMS

8.92 The system whereby individual hospitals decide which remuneration method or combination of methods to offer VMOs has much to commend it in terms of being needs-based. That is, each hospital can offer the type of contract it thinks best given the nature of its case-mix, size or recruitment difficulties.

8.93 The major problem with such a devolved system is that inconsistencies between VMO payment methods at different hospitals could cause considerable dissension; individual contracts may be subject to error; some VMOs may exercise undue monopoly power in bargaining and some smaller hospitals may find that they do not have the bargaining strength of larger h ospitals.

8.94 Further, such decisions by individual hospitals may make it very difficult for the Department of Health to budget, plan, co-ordinate and assist where disputation with VMOs occurred.

8.95 The PAC considers that these are serious problems and cannot positively recommend the scheme of individual hospital choice of remuneration system.

8.96 A system whereby individual VMOs are free to choose their own method of remuneration has been suggested by the AMA.

8.97 The objections to VMO selection of method are based on the fact that VMOs are likely to choose in such a manner that hospital payments will be maximised and not optimised in an efficient manner. Cost containment would be difficult with this increased manoeuvrability at the individual level. Evidence of this, as discussed in various sections of Chapter 4, clearly supports the view that VMOs will select the most lucrative form of r emuneration.

8.98 The NSW Department of Health and hospital managers are concerned that manipulation of the method of remuneration will escalate costs for the Government and consequently the NSW taxpayer.

8.99 The PAC is also concerned with this issue. On the one hand, it is argued that VMOs should have freedom to choose and on the other, there is the Government's responsibility to contain costs and the Parliament's responsibility to ensure accountability for the disbursement of public funds.

8.100 The PAC considers that free choice of remuneration by individual VMOs or specialty groups would probably maximise costs; hence, choice of remuneration should not be left to VMOs. The PAC considers that overall consistency and equity among VMOs should be preserved where possible.

Recommendation 28

It is recommended that individual VMOs not have the right to choose their preferred method of remuneration.

It is further recommended that the current situation by which VMOs at metropolitan district and country base hospitals can choose by specialty be abandoned.

Recommendation 29

It is recommended that any remuneration system implemented by the NSW Department of Health be accompanied by:

i) an evaluation of the new system 12 months after implementation;

ii) regular monitoring and review of practice patterns and their effect on quality and cost; and

iii) an appropriate base rate of payment.

DETERMINATION OF RATES AND DISPUTE SETTLEMENT

8.101 The issues of determination of payment rates and dispute settlement are important and complementary to the issue of alternatives for remunerating VMOs.

8.102 The PAC considers that the Minister for Health should determine the system of remuneration for VMOs. If a negotiated settlement cannot be achieved on the ~ of payment and the terms and conditions of work, these should be subject to a determination of the Industrial Commission **of NSW.**

8.103 In Chapter 2, the PAC reviewed the current legislation governing VMO remuneration (Public Hospitals Act, Part Vc), and the system of arbitration provided for in the legislation.

8.104 The limitations of the current system led the PAC to consider other options of dispute settlement, including:

arbitration by a specialist (multi-disciplinary) remuneration tribunal;

reliance on negotiated settlement without legislative recourse to arbitration; and

a determination by the full bench of the NSW Industrial Commission.

8.105 While the notion of a specialist remuneration tribunal has certain features initially appealing in terms of addressing the problems identified in Chapters 2 and 5, it is fraught with difficulties affecting all speci alist tribunals - that is, isolation, inflexibility, infrequency of operation and lack of opportunity to build up expertise.

8.106 The PAC was also mindful of the problems of legislative recourse to arbitration. The NSW Government has reason to fear the generosity of arbitrators if past experience of VMO arbitrations is to be followed. Arbitrators are not responsible for the funds required by their determinations

and do not need to reconcile their awards with the principle of parliamentary accountability for expenditure of public funds.

8.107 Accordingly, the PAC considers that negotiated settlement is the preferred option for dispute settlement. Failing such settlement, disputes as to the rates, terms and conditions of VMO remuneration should be settled by a determination of the full bench of the NSW Industrial Commission.

8.108 The PAC considers that the following features should be embodied in appropriate legislation governing VMO remuneration:

application for a determination on the rates of remuneration and terms and conditions of work to be subject to the approval of the Minister for Health;

- right of appearance to be granted to the Minister and any other person/association (and their representatives) subject to the Commission's leave;

the Commission to have the power of review and not to be bound by previous determinations on VMO remuneration;

the Commission to have regard to the economic consequences of its determinations, and in particular, the impact on the State health care budget; and

the Commission to call for expert evidence to supplement submissions from the parties where this is appropriate.

APPENDIX 1

REFERENCE FROM MINISTER

Mr. P.M. Smiles, 24 OCT 1988
Chairman,
Public Accounts Committee,
Legislative Assembly,
Parliament House,
SYDNEY. NSW. 2000

PUBLIC ACCOUNTS COMMITTEE
PAYMENTS TO VISITING MEDICAL

In the five years from 1983/84 to 1988/89 payments to Visiting ' Medical Officers will have increased by over $150 million or 330%. This is well in excess of wage increases for the general population. Concern has been expressed from many quarters as to whether this additional expenditure has resulted in any improvement in health services.

Given the extent of public funds involved, I would be grateful the Public Accounts Committee could inquire into payments to Visiting Medical Officers in New South Wales public hospital The Terms of Reference are to:

1. Inquire into reasons for the marked increase in public. hospital payments to V.M.O. 's over the last five years.;

2. Review the cost benefit of the payments made to V.M.O. engaged in the State's public hospitals over the last five years;

3. Identify and analyse any anomalies and inequities in Sessional V.M.O. renumeration;

4. Inquire into the degree of accountability and financial control which exists in respect of payments made for services provided by V.M.O's engaged in N.S.W. public hospitals; and

5. Inquire into the existing arrangements and methods of renumeration for on-call services required of V.M.O's;

6. Provide advice on r -he alternatives available to renumerate V.M.O. 's engaged in N.S.W. public hospitals; and

7. Consult with appropriate professional and other groups with an interest in the question of payments to V.M.O. 's engaged in the State's public hospitals in relation to Terms of Reference (1) to (6) above.

Yours sincerely,

PETER COLLINS, M.P.,
Minister for Health

APPENDIX 2

NSW AND INTERSTATE INSPECTIONS

The PAC either visited, inspected the VMO records of or had discussions with officers of the following organisations:

ORGANISATION

Albury Base Hospital

Albury Regional Office, NSW Department of Health

Armidale and New England Hospital

Auburn District Hospital

Auditor-General's Office (Victoria), Melbourne

Australian Audit Office

Australian Hospital Association, Melbourne

Bathurst Base Hospital

Blacktown Hospital

Bourke District Hospital

Bowral and District Hospital

'Broken Hill Base Hospital

,Central Coast Area Health Service

Chatswood District Community Hospital

Coffs Harbour and District Hospital

Commonwealth Department of Health

Cumberland Area Health Service

Goulburn Base Hospital and Health Services

Hastings District Hospital, Port Macquarie

Hunter Region, NSW Department of Health

Lismore Base Hospital

Liverpool Hospital

Manly District Hospital

Manning River District Hospital, Taree

Medical Hall Chambers, Broken Hill

Mona Vale Hospital

Mount Druitt Hospital

Narrandera District Hospital

North Coast Region, NSW Department of Health

Orange Base Hospital

Preston and Northcote Community Hospital, Preston, Victoria

Queen Elizabeth Hospital, Woodville, South Australia

Queensland Department of Health, Brisbane

Queensland Institute of Technology, Brisbane

Royal North Shore Hospital, St Leonards

Ryde Hospital, Eastwood

Shoalhaven District Memorial Hospital, Nowra

South Australian Auditor General's Office

South Australian Health Commission

South Australian Public Accounts Committee

South West Region, NSW Department of Health

St Vincent's Hospital, Darlinghurst

St Vincent's Private Hospital, Darlinghurst

Tamworth Base Hospital

Victorian Economic & Budget Review Committee, Melbourne

Wagga Wagga Base Hospital

Walgett District Hospital

Wilcannia and District Hospital

Wollongong Hospital

APPENDIX 3

SUBMISSIONS AND CORRESPONDENCE RECEIVED IN RESPONSE TO PRESS ADVERTISEMENT AND LETTER TO ALL PARLIAMENTARIANS

Date Received	Name (as on Letterhead or Below Signature)
16.1.88	NSW Branch of the Australian Medical Association
9.11.88	G R Gibson, *Visiting Urologist*
16.11.88	The Hon Elisabeth Kirkby, MLC, State *Parliamentary Leader NSW. Australian Democrats*
22.11 88	M C Kennedy, *Consultant Physician*
22.11 88	M Inglis
25.11 88	Dr J L Farlow, *Consultant Surgeon*
25.11 88	J Hatton, MP
28.11 88	Dr W L Corliss
30.11 88	Australian Hospital Association, NSW Branch
30.11 88	G Souris, MP
-	Representation from K W Mackey
-	Representation from W J H Paradice
1.12.88	Dr K M Richardson
5 · 12.88	W J Barnett, *Opthalmic Surgeon*
6.12.88	R S Arnot, *NSW State Committee, Australian Association of Surgeons*
8.12.88	The Association of Medical Superintend ents of NSW and the ACT
12.12.88	NSW Department of Health (and subsequently many submissions were received)

Public Accounts Committee

13.12.88	Combined Pensioners' Association of NSW, Inc.
21.12.88	Goulburn Base Hospital and Health Services
4.1.89	G Souris, MP - Representation from Dr P G Harris
19.1.89	Dr W H Patterson
19.1.89	M J Jensen, Visiting Surgeon
7.2.89	M R Fearnside, *Neurological Surgeon*
9.2.89	The Hon E. P. Pickering MLC *Minister for Police and Emergency Services*
13.2.89	Dr T van Lieshout
16.2.89	Public Medical Officers Association
23.2.89	Public Medical Officers Association
20.4.89	J G Allman, *Orthopaedic Surgeon*
21.4.89	P Copping

In addition to the above, two " *confidential"* submissions were received and numerous hospitals, Area Health Services and NSW Department of Health Regions forwarded detailed VMO information and/or submissions.

APPENDIX 4

CALL FOR SUBMISSIONS

[R:\PARLIM~1\450007.TIF]

(As advertised in the Financial Review Friday 28th October 1988, Sydney Morning Herald and Daily Telegraph 29/10/88)

Public Accounts Committee

LETTER TO ALL MEMBERS OF PARLIAMENT

8th November, 1988

Dear

I am writing to inform you that the Public Accounts Committee has received a reference from the Minister for Health, The Hon. P.E.J. Collins, M.P., to inquire into the Cost of Visiting Medical Officers (Terms of Reference attached).

The Committee would welcome any comments which you may wish to submit in relation to this Inquiry. Written submissions should be lodged by 15th December, 1988.

Yours faithfully,

Phillip Smiles,**LL.B., B.Ec., M.B.A., Dip. Ed., M.P.,**

Enc.

APPENDIX 5

WITNESSES AT PUBLIC HEARINGS
(TRANSCRIPT OF EVIDENCE IN SEPARATE VOLUMES)

DATE OF HEARING	**ORGANISATION/NAME OF** WITNESS
26 October 1988	Formerly with NSW Department of Health
	Mr R D McGregor
	Mr J F Markham
	Hospital Administrators
	Dr R C Rogers, Director of Services and Mr B H Mahaffey, *Chief Executive Officer* at Lismore Base Hospital
	Dr D H Campbell, *Director of Medical Services,* Hornsby Ku-ring-gai Hospital
27 October 1987	Australian Medical Association
	Dr W A Stening
	Dr W H Patterson
	Dr M J Jensen
22 November 1988	Northern Sydney Area Health Service.
	Dr S R .Spring, *Chief Executive Officer* Northern Sydney Area Health Service
	Dr R G D Boyd, *Director of Medical Services and Community Heal* Royal North Shore Hospital
	Central SYdney Area Health Service
	Dr C G Scarf, *Chief Executive Officer,* Central Sydney Area Health Service, Dr G Brown, *Executive Officer,* Western Suburbs Hospital
	Dr D G Horvath, *Acting General Superintendent,* Royal Prince Albert Hospital

Southern Sydney Area Health Service

Dr J D Campbell, *Chief Executive Officer,* Area Health Service
Dr D W King, M*edical Practitioner*

Eastern Sydney Area Health Service

Mr W G Lawrence, *Chief Executive Officer.* Area Health Service
Dr T J Smyth, *Medical Practitioner and Consultant* Area Health Service
Dr D M Robinson, *Medical Superintendent,* Sydney Hospital
Mr B R Skerman, *Chief Executive Officer.* Royal South Sydney Hospital

23 November 1988 — Repatriation Hospital. Concord
Dr 0 G Curteis, *General Superintendent,* Army Health Service
Colonel D G Rossi, *Director, Medical Services*

Resident Medical Officers Branch of the Public Service Association

Dr E A Elliott, *Secretary*

The Medical Superintendents Association of NSW and the ACT

Dr D I Lange, *President*
Dr I L Rewell, *Secretary*

Orthopaedic Surgeons Association (NSW)

Dr J S Scougall, *State Chairman*
Dr J M Harrison

24 November 1988 — Western Sydney Area Health Service

Dr B Amos, *Chief Executive Officer and President, Medical Board,* Area Health Service
Dr R C Griffin, *Director of Medical Services.* Westmead Hospital
Dr R E Jones, *Director of Medical Services.* Mount Druitt Hospital
Dr L P Guanlao, M*edical Superintendent,* Blacktown Hospital

Report on Payments to Visiting Medical Officers

24 November 1988 — NSW Department of Health - Central

Ms M C Foley, *Deputy Secretary, Corporate Services*
Mr K R Barker, *Director - Treasury and Budge t*
Mr T J Clout, Senior Industrial Officer
Dr R J J Stewart, *Assistant Secretary Health Service Planning Branch*

24 January 1989 — Dr B D Shepherd, *Orthopaedic Surgeon*
NSW Department of Heath
Mr M A Rosser, *Secretary*
Mr T J Clout, *Senior Industrial Officer*

25 January 1989 — Dr M R Fearnside, *Neurosurgeon*
14 February 1989 — Public Medical Officers' Association
Dr D L Cay, *President*
Dr G D Duggin, *Honorary Secretary*
Mr T Muldoon, *Industrial Officer*

APPENDIX 6

A BRIEF HISTORY OF THE VMO DISPUTE PRIOR TO THE 1985 MACKEN DETERMINATION

The Health Insurance Act (Commonwealth), 1973 was amended to empower the Minister to make Regulations in relation to *"the conduct of a visiting medical practitioner of a hospital (whether at a hospital or elsewhere) in relation to the performance of work which is capable of being performed at the hospital by the visiting medical practitioner. "* The wording of the statute concerned the medical profession, who maintained that the amendment was an attempt to control the private practices of visiting medical officers. By March 1984, resignations of VMOs from the public hospitals began, notwithstanding discussions then being conducted between the AMA and the Government concerning this legislation.

Stoppages of work commenced with AMA approval in early March 1984. In April 1984, the Penington Enquiry into private practice in public hospitals was announced. On 12 April 1984, the Health Insurance Act was further amended so as to provide that no more than the scheduled fee be charged to a hospital patient by a medical officer appointed to a hospital.

The amendment increased the intensity of the dispute so that by · May 1984 a number of orthopaedic surgeons had resigned from the public hospital system and other specialties began to follow suit. By mid-June, approximately 50 VMOs had' resigned. On 17 June 1984, the AMA resolved to call for an indefinite withdrawal of all but emergency services to begin on the 20 June 1984. It stopped short of calling for the mass resignation of all VMOs. Apart from emergency procedures, the end of June 1984 saw an effective ban on elective surgery in most of the large hospitals and the number of resignations by orthopaedic surgeons had further increased to approximately 70.

By September 1984, 200-300 VMOs had resigned and by January' 1985 this figure had further increased and included the majority of procedural specialists.

A measure of agreement was reached between the AMA and the Government in early 1985 and, as part of the settlement then discussed, there was recognised the need for a review of the remuneration paid under sessional contracts. It was also agreed that in certain country and non-teaching metropolitan hospitals there would be a choice of modified fee-for-service or sessional contracts for VMOs.

Report on Payments to Visiting Medical Officers

By April 1985, 1,363 VMOs had resigned. On 2 April 1985 the Commonwealth and State Governments announced a seven-point package designed to settle the dispute. The majority of AMA members accepted the package and many resignations were withdrawn.

The settlement package was contingent upon the AMA proceeding to arbitration with respect to the level of the hourly sessional rate. An interim increase in the sessional rate, in the sum of $12.50 per hour, was agreed to but *"any further increase in the level of the sessional fee can only be made through the established arbitration procedures."*

It was against this background that, on 10 September 1985, an arbitration commenced to make a new Determination.

Public Accounts Committee

APPENDIX 7

SALARIED STAFF SPECIALISTS: CONDITIONS OF EMPLOYMENT

(AS FROM 1 JANUARY 1985)

Staff specialists employed in the public hospital system may elect whichever of Schemes 'A' 'B' or 'C' they wish to work under and may re-elect at the commencement of each financial year. No separate approval by the Board of the employing hospital/Area Health Service is required.

Half time employment (Scheme *'D')* is permissible only at the discretion of the employing hospital.
Although other conditions apply, the main components of the Schemes follow:

Scheme A

- Doctor works geographically full time at the hospital
- Paid 100% of award rates plus 20% call back/special allowance
- Paid additional allowance of 16% in lieu of receiving direct remuneration from private patients.

Scheme B

- Doctor works geographically full time at the hospital
- Paid 100% of award rates plus 20% call back/special allowance
- Paid an additional up to 45% of base salary in respect of treating private patients (depending on availability of Trust funds).

Scheme C

- Doctor works geographically full time at the hospital
- Paid 75% of full time rates plus call back/special allowance (effectively permitted leave without pay for 25% of the full time commitment)
- No private practice during the 75% of time salary is payable
- Paid an additional up to 100% of base salary in respect of treating private patients (depending on the availability of Trust funds).

Scheme D

- Cannot remain at hospital on geographic full time basis. 'Must have an "outside" private practice
- Employed at hospital for 50% of the full time commitment
- Paid 50% of full time rates plus call back/special allowance
- No private practice allowed at employing hospital.

APPENDIX 8

SETTLEMENT PACKAGE

1987/88 NSW COUNTRY DOCTORS' DISPUTE

SCHEDULE OF FEES FOR GENERAL PRACTITIONER MODIFIED FEE FOR SERVICE HOSPITAL PATIENTS PAYMENTS IN NSW COUNTRY PUBLIC HOSPITALS - AS FROM 1 AUGUST 1988

The fees shown below are at 1987/88 levels and were adjusted in line with the A.C.T. indexation formula on 1 August 1988, that is by 6.385%. The 6.385% increase is not reflected below.

On-Call			2.50 per hour
- Nursing home type patients			As at previous. rates
- In hours (Monday - Friday 7.00 a.m. - 6.00 p.m; Saturday 7.00 a.m. - Midday)			
In-patients:			
Where only one in-patient is seen			22.10
Where two or more in-patients are seen on the one occasion			15.00 each
Out-patients:			
All in-hours out-patients, regardless of duration of consultation			15.00 each
- After hours (Monday - Friday 6.00 p.m. - 10.00 p.m.; Saturday 12.00 Midday - 10.00 p.m.; Sunday 7.00 a.m. - 10.00 p.m.)			
After hours ward round	Sunday only		20.00 each
	All other		15.00 each

- After hours (cont)

After hours consultations (in-patient and out-patient) not in the course of a ward round, all days except Saturdays, Sundays and public holidays

First patient	34.53
Subsequent patients	25.00 each

After hours consultations (in patient and out-patient) not in the course of a ward round, Saturdays, Sundays and public holidays

First three patients seen on the one occasion	34.53 each
Subsequent patients	25.00 each

- Late night consultation
(All days 10.00 p.m. - Midnight)

First patient	60.00
Subsequent patients	34.53 each

- Anti-social hours consultation
(All days 12.00 Midnight - 7.00 a.m.)

First patient	75.00
Subsequent patiens	34.53 each

- Emergency consultation fee (as defined) 60.00

Prolonged emergency attendance Item 160 59.50

Item 161	96.90
Item 162	'134.30
Item 163	174.25
Item 164	208.25

Ambulance escort for severely ill patients 87.00 per hour

- + reasonable return journey & out of pocket expenses

Report on Payments to Visiting Medical Officers

- Obstetrics	
Ante natal care attendance	15.00
Confinement only, including two well baby checks	100.00
Caesarian section, including two well baby checks	150.00
All post natal attendances to be paid at the standard consultaton rate (This includes attendances following an incomplete confinement (Item 201 - $55.25) and attendances on a sick neonate where a referral would be made to a paediatrician, were one available)	15.00
- Agreed procedures	
Intravenous infusion, performed by the practitioner	17.75
Intravenous infusion by open exposure	29.35
ECG Tracing only	11.75
ECG tracing and report	23.90
- Other services	85% M.B.S.
- Attendance at recognised committee meetings	Previously agreed formula

Source: NSW Department of Health

APPENDIX 9

MODIFIED FEE-FOR-SERVICE PAYMENT OPTION IN METROPOLITAN DISTRICT AND COUNTRY BASE HOSPITALS

As part of the Settlement Package of the 1984/85 Doctors' Dispute, the modified fee-for-service option of remuneration was introduced for Metropolitan District (not recognised Teaching Hospitals) and Country Base Hospitals.
The following percentage rates of the Medical Benefits Schedule fee were payable from 2 April 1985:

A. 85% of the scheduled fee where there is neither Resident Medical Officer nor Registrar at a hospital on a 24-hour, 7 day week basis available as doctor of first contact.

B. 70% of the scheduled fee where a hospital has a Resident Medical Officer on a 24 hour, 7 day week basis.

C. 60% of the scheduled fee where there are Registrars appointed in the same disciplines of anaesthesia and obstetrics.

D. 60% of the scheduled fee payable to all sub-disciplines of surgery where there are Registrars appointed within those sub-disciplines.

E. 60% of the scheduled fee payable to all sub-disciplines of medicine where there are Registrars appointed within the discipline of medicine (other than in paediatrics and psychiatry).

F. 60% of the schedule fee payable in the sub-disciplines of paediatrics and psychiatry where there are Registrars appointed within those sub-disciplines.

In respect of items C, D, E and F above, as an example in a hospital with a general surgical Registrar, all VMOs within the sub-discipline of general surgery are entitled to receive payment at the rate of 60% of the Medical Benefits Schedule fee. If there is no Registrar appointed within any other sub-disciplines of surgery, all VMOs whose work falls within those sub disciplines are entitled to receive 70% of the schedule fee. *"Discipline"* means the aggregate of all relevant sub-disciplines.

Where a Registrar becomes available or is not available for a period in excess of 28 days, there is an adjustment to the percentage level .of fee payable, upwards or downwards, in compliance with the above guidelines. Hospitals are not permitted to change established Registrar or VMO roster practices with the intention of financially disadvantaging VMOs. Where changes to rosters are necessary to provide adequate clinical cover consultation occurs with relevant staff groups.

Consistent with normal hospital practice, where Registrars and RMOs provide direct clinical services and assistance in hospital services/procedures and operations, a modified fee-for-service is not payable to a VMO in any case where a Resident Medical Officer or Registrar performs the service either as an independent act or at the request of the VMO (or Staff Specialist). The only exception to this principle is where the service is rendered by a Registrar/RMO on behalf of and under the direct supervision of the VMO, as part of that Registrar's/RMO's training/education service delivery programme.

APPENDIX

Payments to fee-for-service VM0s, by public hospitals during 1987/88, by general category and number of VMOs and arranged in earnings bands.

NUMBERS OF VMOS BY GENERAL CATEGORY

TOTAL PAYMENTS TO VMOS $	MED NO. OF VMOS	SURG	ANAE	O &G	PATH	RAD	GP	
Between 0-10,000	172	196	73	58	23	41	372	935
10-20,000	11	65	10	17	2	8	109	222
20-30,000	10	48	2	14	1	9	108	192
30-40,000	11	32	3	4	i	3	59	113
40-50,000	12	32	4	2	1	3	48	102
50-60,000	6	21	3	7	0	3	26	66
60-70,000	10	17	2	5	0	1	18	53
70-80,000	13	12	1	2	0	2	13	43
80-90,000	6	11	0	0	0	0	9	26
90-100,000	4	8	0	3	0	2	5	22
100-110,000	2	7	0	1	0	3	4	17
110-120,000	1	1	0	0	0	0	5	7
120-130,000	1	4	0	0	0	0	1	6
130-140,000	0	2	0	0	0	1	0	3
140-150,000	1	1	0	0	0	0	0	2
150-160,000	1	0	0	0	0	0	1	2
170-180,000	0	0	0	0	0	0	1	1
180-190,000	0	0	0	0	0	0	1	1
TOTAL	261	457	98	113	28	76	780	1813

NSW Department of Health

1. Notes to Table 3.7 apply to this table.

APPENDIX

Payments to sessional VMOs, by public hospitals during 1987/88, by general category and number of VMOs and arranged in earnings bands.

NUMBERS OF VMOS BY GENERAL CATEGORY

PAYMENTS TO VMOS $	MED	SURG	ANAE	O &G	PATH	RAD	GP	TOTAL NO OF VMOS
Between 0-10,000	175	88	60	28	13	27	326	717
10-20,000	140	55	27	44	10	12	112	400
20-30,000	106	70	30	29	1	13	48	297
30-40,000	75	59	33	38	2	16	16	239
40-50,000	93	55	26	32	2	4	12	224
50-60,000	80	68	27	20	0	6	12	213
60-70,000	67	48	33	22	1	9	15	195
70-80,000	38	45	24	11	2	8	3	131
80-90,000	41	30	31	7	0	4	2	115
90-100,000	19	31	28	7	0	2	1	88
100-110,000	11	18	27	1	1	4	1	63
110-120,000	9	17	17	4	1	1	0	49
120-130,000	' 4	4	17	1	0	3	0	29
130-140,000	5	5	13	2	0	1	0	26
140-150,000	1	0	5	0	1	1	1	9
150-160,000	2	4	5	0	0	1	1	13
160-170,000	.0	4	2	0	0	0	0	6
170-180,000	0	2	2	1	0	3	0	8
180-190,000	1	0	2	0	0	1	0	4
190-200,000	0	1'	0	0	1	0	0	2
200-210,000	0	0	0	0	0	1	0	1
210-220,000	0	0	0	0	0	2	0	2
230-240,000	0	0	0	0	0	1	0	1
240-250,000	0	1	0	0	0	1	0	
250-260,000	0	0	0	0	0	1	0	
260-270,000	0	0	0	0	0	1	0	1
720-730,000	0	0	0	0	0	1	0	1
TOTAL	867	605	409	247	35	124	550	2837

Source: NSW Department of Health

NOTE: 1. Notes to Table 3.7 apply to this table.

APPENDIX 12

UNPAID LEAVE AND SPLIT SHIFt WORK

The NSW Department of Health made the following submission to the **PAC:**

The use of a rolled up rate which includes compensation for unpaid leave, split shift work and non-provision of superannuation, is illogical and leads to major double payments for the following reasons:

i The rolling up of the rate assumes that all VMOs are absent on 14 weeks leave/public holidays per year. The facts are that most VMOs would be unlikely to take half of this amount of leave/public holidays.

The rolling up assumes that the payment of normal sessional hours at a higher rolled up rate will compensate the VMO to the same level that he/she would be compensated if paid the unloaded rate throughout the year, and paid when actually on leave. Given that the rolled up higher rate is also paid for call backs, and as a basis for payment of on-call payments, a VMO could be paid for the actual leave taken, two, three, four or ten' times over, depending on the amount of call back and on-call work provided and the amount of leave actually taken.

It is considered that a more logical alternative would be to unroll the rate and:

- pay the VMO during periods of actual leave the normal sessional hours or the average sessional hours; and

- pay 5% of normal sessional hours or average . sessional ho urs in compensation for working Split shifts.

This would have the added advantage of encouraging the VMOs to claim for normal sessional hours rather than call back hours in the "*questionable*" cases.

APPENDIX 13

BACKGROUND PRACTICE COSTS

The NSW Department of Health made the following submission to the PAC:

The 1985 Determination of Justice Macken was accepted to the extent that the loading was separated from the normal hourly rate and, in the Department's view, confined to normal sessional hours.

However, the acceptance of the Determination by the Department has been altered by the 18 May, 1988 Decision of the Court of Appeal of the Supreme Court of NSW, which determined that on a legal interpretation of the current Macken Determination, the $20 and $25 per hour private practice loading should be paid for hours of call back in addition to the call back rate which is already loaded by 10% or 25%, and is further increased by providing for a minimum payment of one hour plus travelling time to a maximum of twenty minutes each way. To illustrate the impact of this Decision, and the cost of a call back, the following two examples are provided:

EXAMPLE 1

Using the 1985 Macken Determination rates, a call back of a Senior Specialist in the hours 8.00 am - 6.00 pm, Monday to Friday, which takes fifteen minutes of service provision and a total travelling time of twenty minutes would be paid for as follows:

	DEPARTMENT'S VIEW	**AMA & COURT'S VIEW**
(a) Call Back payment for service Minimum 1 hour payment is ($94.00 + 10%)	$103.40	$103.40
(b) Call Back Travelling Time Payment, ie, 20 minutes is [(94.00 + 10%) x 0.33]	$ 34.12	$ 34.12
(c) Call Back Private Practice loading ie, for 1 hour and 20 minutes is ($25.00 x 1.33)	NIL	$ 33.25
(d) On-call allowance paid for the 1 hour and 20 minute period for which payment is made is [($94.00 x 10%) x 1.33]	NIL	$ 12.50
Total Payment for Call Back:	$137.52	$183.27

EXAMPLE2
Using similar facts but assuming that the call back was at 9.00 p.m.
at night, the payment to the VMO for the thirty five minute
disruption would be:

	DEPARTMENT'S VIEW	AMA & COURT'S VIEW
(a) Call Back payment for service Minimum 1 hour payment is ($94.00 + 25%) $117.50	$117.50	.
(b) Call Back Travelling Time Payment, ie 20 minutes is [(94.00 + 25%) x 0.33]	$ 38.78	$ 38.78
(c) Call Back Private Practice loading ie, for 1 hou r and 20 minutes is ($25.00 x 1.33)	NIL	$ 33.25
(d) On-call allowance paid for the 1 hour and 20 minute period for which payment is made is [($94.00 x 10%) x 1.33]	NIL	$ 12.50
Total Payment for Call Back:	$156.28	$202.03

The Department submitted that:

(a) the on-call allowance should not be paid during the period for which call back payment is made;

(b) the private practice loading should not be paid during call backs .(including paid travelling time); and

(c) the minimum payment should be one hour rather than one hour plus travelling time up to a maximum of twenty minutes each way.

The Department further submitted that:

The loadings on call backs are 10% for the hours 8.00 a.m. to 6.00 p.m., Monday to Friday, and 25% for all other hours except that on public holidays the loadings increase to 50% whatever the hour of the day. There are a number of reasons which would suggest that these loadings are, in today's circumstances, too high. Such a position could be taken on the following grounds:

Report on Payments to Visiting Medical Officers

1) The trend in private practice is for 24 hour seven days a week clinics, thus no special loading for hours outside 8.00 a.m. to 6.00 p.m., Monday to Friday, is justified in the current climate of medical service provision.

Many private surgeries, at least those of general practitioners, are open from 8.00 a.m. to 12 noon on Saturdays.

3) In most cases the call back rate is already loaded in that a minimum payment is provided of one hour plus travelling time up to twenty minutes each way - therefore the rates should not be further loaded.

The salaried Staff Specialist receives a flat amount per year which covers on-call, call back and all other incidence of employment and that allowance provides no additional loading based on the time of day a call back takes place.

It was submitted by the Department that the loading should be changed in the following manner:

a) Deletion of the 25% loading so that the loading at all times is only 10%.

b) If (a) cannot be gained then extension of the times during which the 10% loading applies to 8.00 a.m. to 12 noon on Saturdays and/or 8.00 a.m. to 8.00 p.m., Mondays to Fridays.

APPENDIX 14

THE ON-CALL RATE

The NSW Department of Health made the following submission to the PAC:

The 1985 Determination may not have achieved what Mr Justice Macken intended. He seemed to have been convinced that because Medical Staff Specialists, covered by the Medical Officers (Staff Specialist) (State) Award, had been granted a 10% allowance in compensation for having to be available at all times to provide services if required ... that it was reasonable to pay one tenth per hour on-call allowance to VMOs. That is, Mr Justice Macken intended to put a VMO and a Medical Staff Specialist, who were on similar on-call arrangements and being similarly inconvenienced, in the same position in terms of monetary compensation.

However, the Determination did not achieve this result. Using comparable wage bases (rates as at 1 January, 1986), it can be shown that a Medical Staff Specialist on the lowest rate of pay receives $4,739 p.a. ($47,394 pa x 10%) for being on-call 24 hours a day - 365 days of the year. A Medical Staff.Specialist on the highest rate of pay receives $6,450 p.a. ($64,496 x 10%) for being on-call at all times. On the other hand, a VMO being paid on the lowest rate, who is on-call for the same times, receives $47,304 p.a. (1/10 x $54 per hour x 24 hours x 365 days). A VMO on the highest rate of pay can receive $82,344 pa for being on-call for the same times (1/10 x $94 per hour x 24 hours x 365 days). Clearly the VMO is in a more advantageous remuneration position for the same inconvenience. It is considered that this was not intended by Mr Justice Macken who was aware that VMOs and Medical Staff Specialists would in fact be sharing the same on-call rosters in many cases.

The PAC acknowledges the fact that the abovementioned on-call payments to Staff Specialists do not require them to be on-call while on leave. As well the VMO on-call pay must be discounted for when the VMO is providing services during his ordinary sessional hours. However, the VMO's remuneration per hour of on-call provided still vastly exceeds the Staff Specialists remuneration. A Senior Specialist VMO would only have to be on-call for 18 hours per week (that is, less than one day per week) for 38 weeks per year to "earn" the same money - $6,450 - as the equivalent Staff Specialist who may be on-call 24 hours per day every day.

The NSW Department of Health further submitted:

It should be noted that the argument is not weakened by the fact that in the main medical disciplines the on-call roster would be shared by a number of VMOS. In fact the argument is strengthened because in a situation where one specialty is serviced by a Medical Staff Specialist and another specialty, at the same hospital, is serviced by say five VMOs, each of the VMOs will receive by way of on-call allowance more than the Medical Staff Specialist even though each VMO is only inconvenienced for one fifth of the time that the Medical Staff Specialist is inconvenienced.

If the above view of what Mr Justice Macken intended is correct, it would have been achieved by assuming that all VMOs would be available to be called to provide services at all times, or as provided for in the particular on-call roster, and to have determined that each VMO would receive an annual amount of money for being on-call. The amount of the per annum payment would be equal to one tenth of the annual salary for the appropriate specialist under the Medical Officers (Staff Specialists) (State) Award. It would of course be necessary to ensure that the total on-call allowance paid was the equivalent of the amount so derived to prevent a doctor who has VMO appointments at five hospitals getting the allowance five times. This could be achieved either by requiring the hospital at which the VMO has the greatest on-call commitment to pay the whole allowance or by apportioning the total allowance between the hospitals on the basis of the proportion of the VMOs total contract hours devoted to each hospital.

However, even with this system difficulties arise by virtue of the fact that a VMO may have appointments at three hospitals under which he is paid on a sessional basis and in addition the VMO may have appointments at two other hospitals under which he is paid on a fee-for-service basis. Under the fee-for-service option a VMO is not entitled to any payment for being part of the on-call roster and even if required to be available at all times receives no additional payment. In such circumstances VMOs can arrange their on-call periods at the three hospitals subject to on-call payment under the Macken Determination, to cover the same times as the VMO is on-call at the two hospitals where fee-for-service is payable. If the VMO is required to attend both hospitals at the same time the VMO makes the choice. Potentially, the end result is that availability for the sessional contracting hospitals during the on-call period is reduced notwithstanding a very expensive on-call payment. To cover the service a greater number of VMOs have to either be engaged or placed on-call, thus making the provision of the service even more expensive.

In the alternative, the VMOs could be put in the same position as their Medical Staff Specialist colleagues by a system by which they received an on-call allowance of one tenth of the base hourly rate but up to a maximum in any one year from all hospitals (at which he has appointments) of $6,450.

Another alternative to the current system which could, if carefully implemented, be more efficient and less costly, would be to introduce a less expensive secondary on-call allowance. Through this avenue the same number and spread of VMOs could be on-call, but those which are less likely to be called back to the hospital would be paid a lower on-call allowance.

With this method, however, the hard decisions still have to be made as to who will be on primary call; who will be on secondary call; and who will not be on-call. In addition, there is the danger that a greater number of VMOs could end up on-call and that the total cost could be increased.

Yet another, maybe better option, is to continue with the existing single on-call arrangement. To make this system (which costs for each specialty for which on-call cover is provided at each hospital about $82,000 per annum) less costly the Department would advise the hospitals and area health services that they were to critically review all on-call rosters to determine whether the level of on-call coverage can be justified on a service needs - cost benefit basis. The hospitals and area health services would be advised that in undertaking this exercise they should assume that:

the purpose of the exercise is to reduce the overall cost of on-call payments;

(2) a VMO on the on-call roster is required to hold himself available to be called back to provide services to patients if required; and

(3) a VMO, not on the roster for a specified period, while not required to hold himself available to be called back, is, if contacted, to be generally available to attend the hospital to provide services to patients, if required.

To make such a scheme acceptable to the AMA and VMOs there would need to be a financial incentive for them to accept the major reductions that would necessarily result from the scheme's implementation. This proposal is a move in principle towards more VMOs being on-call and higher payments for VMOs called back to provide services.

A package could be developed which loaded the call back rate to a greater extent than it currently is loaded, in respect of the call back of VMOs who were not on the on-call roster. In other words, you would savagely cut the number of VMOs on the on-call roster but increase the payment if a VMO was called back to provide a service.

In terms of money it is considered reasonable that a person not on the on-call roster who is called to the hospital to provide a service to a patient (other than a private patient) should be paid the appropriate call back fee plus a $50.00 disturbance fee. This principle has been developed in the context of the negotiations relating to the country doctors' dispute and seems to cause no problems for the AMA in principle. There is no justification for the fee being different for various categories as the disturbance is equal and the call back payment already reflects differential potential alternative fee loss.