Submission from the Australian Medical Association (NSW) Limited

FD/DE:17961

A. EXECUTIVE SUMMARY

- The Australian Medical Association (NSW) Limited (***AMA(NSW)***) is an independent association representing the State's medical profession. The strength of AMA (NSW) lies in its representative reach across the State's geographical zones and the profession's specialty groups. By playing a pivotal role in the formation of public health and hospital policy, AMA (NSW) is in a strong position to represent the medical profession in New South Wales.

- The mission of AMA (NSW) is to advance the interests of the medical profession and their patients through effective advocacy; to uphold the integrity and honour of the profession; to provide support and services to its members in an efficient and responsive manner; and to encourage the advancement of the health of the community.

- AMA(NSW) members include Visiting Medical Officers (***VMOs***), Staff Specialists, Career Medical Officers, General Practitioners, Locums, Doctors-in-Training (***DiTs***), and medical students, all of whom have an important role to play in the provision of medical services in the New South Wales Public Hospital System, community health and private medical practice and hospitals.

- AMA(NSW) has questioned the need for an Inquiry and the costs associated with same in circumstances where AMA(NSW) sees the need for direct investment in health service provision. That having been said, AMA(NSW) is a significant stakeholder in the health industry in New South Wales and as such wishes to assist the Special Commission of Inquiry into Healthcare Funding (***the Commission***). It welcomes the opportunity to provide this preliminary submission. AMA(NSW)'s membership base and long-standing role as an advocacy and industrial organisation, places AMA(NSW) in a unique position to understand the strengths of the current health system in New South Wales, and the challenges before it.

- AMA(NSW) is the registered industrial body for VMOs in the Public Hospital System, and as such, this submission sets out for the assistance of the Commission, the legal framework under which VMOs provide services in New South Wales. The arrangements are long-standing and well-established.

- In addition to its role as the industrial body for VMOs, AMA(NSW) provides workplace advice and support to all its members in the Public and Private Hospital Systems. AMA(NSW) understands the various arrangements in place across the health system and how they complement one another. One of the great strengths of the New South Wales Public Hospital system is the flexibility that a mix of VMO, Staff Specialist and other

arrangements as needed, provide.[1] AMA(NSW) is not the registered union for employed medical staff. AMA(NSW) does provide individual workplace support and advice to employed medical staff and is very familiar with the industrial instruments that apply.

- This submission provides a high-level overview of the matters AMA(NSW) would like the Commission to consider as it conducts its Inquiry. In very many ways the Public Heath System in New South Wales is a good system, but there are opportunities for improvement. It is critical that New South Wales has a strong Public Hospital and Health System, and a strong Private Hospital and Health System. To achieve this AMA(NSW) would like to see:

1. *In relation to VMOs:*
    a. *The current legislative and policy framework for the appointment and engagement of VMOs in the public hospital system remain.*

    b. *A timely and meaningful review of the terms and conditions (including remuneration) under which VMOs currently provide services be conducted to retain current VMOs and recruit new VMOs to work in metropolitan hospitals and regional Public Hospitals in New South Wales.*

    [TOR F(vii)]

2. *In relation to Locums:*
    a. *Continuing engagement in the NSW Public Hospital System to meet short term service needs.*

    b. *The NSW Government continue to work with other jurisdictions on the locum workforce challenges including remuneration arrangements across all States and Territories.*

    [TOR F(vii)]

3. *In relation to employed medical staff, a timely and meaningful review of the terms and conditions (including remuneration under which employed medical staff currently provide services to retain and recruit staff across Public Hospitals in New South Wales.*

    [TOR F(iv)]

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[1]See paragraph 87 below.

4. *Support for the continuation of the provision of high-quality training by Colleges, including in regional areas;*

   [TOR G((i), (ii), (iv)]

5. *While recognising the right of patients to be treated privately in the public hospital system, the rights of consultants must be respected:*
   a. *VMOs and Staff Specialists must be provided with the choice to accept a private patient under their care and/or for inclusion on their lists.*

   b. *Should the Ministry of Health and Public Health Organisations continue admitting private patients under the care of consultants and / or placing private patients on a list without providing the VMO with the option to accept the patient, TMF cover[2] should be extended to those private patients.*

   [TOR D and E]

6. *In relation to the current funding arrangements:*

   a. *The NSW Government to ensure the NSW Health budget makes provision for adequate funding for public health including Public Hospitals and outpatient clinics.*

   b. *The extent to which additional services and workforce could be provided if the New South Wales and Commonwealth Governments accepted the AMA Submission to move to a 50/50 funding split of Public Hospitals and associated services.*

   c. *The limitation of the Commonwealth funding arrangements, particularly the activity cap on NSW Public Health services.*

   [TOR H]

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[2] Treasury Managed Fund Indemnity Cover is available to VMOs for the provision of services to public patients, and in limited cases, private inpatients.

https://www.icare.nsw.gov.au/-/media/icare/unique-media/government-agencies/our-funds-and-schemes/treasury-managed-fund/media-files/files/download-module/treasury-managed-fund-statement-of-cover-2017.pdf

B. INTRODUCTION

B1. HEALTH SERVICES IN AUSTRALIA

1. As recognised by the internationally renowned Commonwealth Fund in its report *Mirror, Mirror 2021 Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries,*[3] Australia is one of the best performing nations in terms of health service delivery.

2. Within Australia, it is the health system of the state of New South Wales which has repeatedly been recognised as the most effective. Despite its strength, the New South Wales Public Health System risks losing its status if it is not possible to ensure, attract and retain doctors to work in it. The workforce pressures that have been apparent for some time have been exacerbated by COVID and by the growing differential between the terms and conditions available under VMO, Staff Specialist and DiT arrangements and those offered by other States and Territories and the private system.

3. While COVID presented incredible challenges to our health system, it also provided an opportunity to demonstrate the potential for reform and change. The NSW Government Report into the COVID response[4] sets out the lessons from COVID and the opportunities for improving equity and access within the health system. The Commission may consider examples such as the creation of RPA Virtual as models for fostering innovation and improvement within the health system. We have provided below other examples of innovative models that should be considered.

B2. OVERVIEW OF THE NSW PUBLIC HOSPITAL SYSTEM

4. There are several reports into the performance of the New South Wales Public Hospital System, including by the Australian Institute of Health and Welfare (***AIHW***) as well as the AMA's own Public Hospital Report Card.[5]

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[3] https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

[4] https://www.health.nsw.gov.au/Infectious/covid-19/evidence-hub/Publications/summary-phr-report.pdf

[5] https://www.ama.com.au/articles/ama-public-hospital-report-card-2022

5. In 2021 – 22 New South Wales Public Hospitals were recognised by the AIHW as the best in Australia on performance in Emergency Departments.[6] Two AIHW reports highlighted that New South Wales Emergency Departments performed better than any other state or territory in Australia, with most patients seen on time and with the lowest wait times.[7] Additionally, New South Wales elective surgery performance was the second best in the Australia when it came to treating patients within clinically recommended timeframes (this is seconded in the AMA Public Hospital Report Card).[8] New South Wales had the highest number of Emergency Department attendances nationally, with 3,012,992 presentations, accounting for over 34 per cent of the national total. Of these presentations, 77 per cent were seen on time, which was the highest of all other jurisdictions and well above the national average of 67 per cent. New South Wales had the second highest proportion of elective surgeries completed within clinically recommended timeframes, at 82.7 per cent.

6. According to the 2023 AMA Public Hospital Report Card[9], New South Wales continues to be the best performer nationally on the percentage of triage category 3 Emergency Department patients seen within recommended timeframes, performing 14 per cent above the national average in 2023. The median wait time for planned surgery in NSW dropped to 55 days, not dissimilar to pre-COVID rates of 53 days. New South Wales was the best performing jurisdiction on the percentage of category 2 planned surgery admissions within recommended timeframes.

7. The AMA Public Hospital Report Card found however that whilst the COVID threat has waned, the New South Wales health system faces new and increasing challenges, including ambulance ramping, hospital log jam, long planned surgery waitlists, and the pressure from our growing and ageing population with complex, chronic health conditions. The New South Wales Government has dedicated significant funding to building new infrastructure, but there has not been the same resourcing dedicated to bolstering workforce numbers to staff the current and foreseeable institutions.

8. The current workforce is exhausted due to chronic understaffing. In addition, New South Wales doctors are amongst the lowest paid in Australia, as the Government continue to fail to address the need for reform of terms and conditions. Award and contract conditions

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[6] https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/hospital-workforce

[7] https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

[8] https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery

[9] https://www.ama.com.au/articles/ama-public-hospital-report-card-2022

must be updated to attract and retain the best and brightest in New South Wales Public Hospital System.

9. The AMA's Clear the Logjam campaign has found that the current funding model for the New South Wales health system is obsolete.[10] It does not adequately account for the growing, ageing, and developing needs of our population. Additionally, there is inadequate funding within preventive and community health care, which prevents hospital admissions. AMA's Clear the Logjam campaign highlighted four steps that the Government needs to address to resolve the current logjam crisis.

    a. Improve performance: reintroducing funding for performance improvement;

    b. Expand capacity: provide public hospitals additional funding for extra beds, staff and support them to expand capacity to meet community demand;

    c. Address demand for out-of-hospital alternatives: fund alternatives for out-of-hospital care, so those whose needs are better suited to be addressed within the community can be treated outside of the hospital environment. The work of general practitioners reduces the rate of avoidable admissions and readmissions tremendously and should be prioritised; and

    d. Increase funding and remove the funding cap: The Commonwealth Government's contribution needs to be increased to 50 per cent for activity. This allows States and Territories to reinvest the 5 per cent of 'freed-up' funds to improve performance and activity.

10. AMA (NSW), in partnership with Deloitte Australia, recently asked doctors about the time they allocated to the Public Hospital System to determine if changes could be made to make the work more efficient and effective what they would do with the additional time. Almost two thirds of respondents indicated that they would reduce their time working in the Public Hospital System if able to do so. Moreover, the Deloitte White Paper, *Medical Workforce Pressures in New South Wales*[11] found health workers in New South Wales will need to deliver 40% more activity per worker relative to current service levels to meet forecast needs based on health workforce projections.

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[10] https://www.ama.com.au/clear-the-hospital-logjam/phrc

[11] https://www.amansw.com.au/wp-content/uploads/2023/02/240223_Deloitte_-NSW-Workforce-Pressures-Whitepaper-1.pdf

11. The Deloitte White Paper,[12] also identified a number of major challenges facing the New South Wales Health System. Those challenges include:

- The growth in demand for services over the past decade: annual growth for primary care growing by 2.8% and hospital services by 2.2% compared to population growth of 1.3%;

- Changes in patient expectations: patients demand improved access and experience;

- There remains more to be done to improve health equity outcomes for First Nations People, rural and regional communities, lower socioeconomic communities, and culturally and linguistically diverse communities;

- Significant investments made in sectors such as aged care and disability services have yet to make clear impacts on the health sector demand; and

- Governments are fiscally unable to solve the health sector's issues only with more investment due to fiscal constraints.

12. A health system that supports all New South Wales residents to live their best and healthiest lives must:

- Enhance the patient experience;

- Improve population health and equity;

- Reduce costs to improve value; and

- Improve the work life of healthcare workers.

13. A key driver of pressure for the medical workforce is the continued growth in service volumes relative to the effective supply of the medical workforce.

[12] https://www.amansw.com.au/wp-content/uploads/2023/02/240223_Deloitte_-NSW-Workforce-Pressures-Whitepaper-1.pdf

C GOVERNANCE

14. A decade ago, AMA (NSW) was instrumental in calling for governance changes to Public Hospitals to ensure greater accountability and engagement with those working in the system. The current Local Health District (***LHD***) structure arose from the work of the National Health and Hospitals Reform Commission undertaken by the Rudd Government as well as direct consultation with the then New South Wales ALP Government.

15. Prior to the implementation of the current governance structure, doctors were concerned by the difficulties in obtaining information about the operation of Public Hospitals and in the perceived divide between doctors and other clinicians and NSW Health and the then Area Health Service Chief Executive Officers. This was referred to in the *Report of the Special Commission of Inquiry into Acute Care Service in NSW Public Hospitals* (***the Garling Inquiry***) as *"the great schism of 1054. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system. If it continues, NSW will risk losing one of the crown jewels of its public hospital system: the engagement of the best and brightest from the profession who are able to provide world-class care in public hospitals free of charge to the patient.' '*[13]

16. In response, it was agreed to reduce the size of Area Health Services and to create LHDs. Unlike Victoria, New South Wales chose to follow a networked model of LHDs, rather than the individual hospital board approach. While there were differences of opinion about the boundaries for the LHDs, over time (and particularly during the pandemic) the value of a networked health system was evident.

17. The networked approach should be adapted to provide better opportunities to utilise health facilities for different purposes. Our members advise that major metropolitan hospitals are now so overwhelmed with emergency surgical activity that they are unable to undertake planned surgery, particularly in specialities such as ophthalmology.

18. The use of private hospitals during the Pandemic and then following for wait list reduction work has provided the people of New South Wales with access to needed surgeries. While this has had a place, AMA(NSW) wants to see a strong Public Hospital System and a strong Private Hospital System, a system where patients who need access to public services can access them in a timely manner and a system where private health insurance supports the

[13] https://www.nsw.gov.au/departments-and-agencies/the-cabinet-office/resources/special-commissions-of-inquiry/acute-care-services

provision of health services in the private hospital system. If one side of the system is not strong and viable, the other will suffer. Public services should be provided in the public system, and private services in the private system.

19. The challenges to the boundaries of LHDs, and frequent tensions regarding the resourcing and support for individual hospitals, are an inevitable feature of any system in which there are limited resources to undertake important work.

20. New South Wales has benefited from the period of stability due to not undertaking repeated governance reforms. AMA (NSW) believes that there should be no changes to the current governance models.

21. That being so, AMA(NSW) does believe it is critical that LHD management and LHD Boards are responsive to, and engaged with, those who work within the Public Hospital System.

22. AMA (NSW) has undertaken many different measures of engagement within LHDs. AMA (NSW) have surveyed DiTs and senior doctors regarding their sense of being valued in the New South Wales Public Hospital System. In recent surveys the results revealed that 46% of DiTs stated they felt valued by their hospital and 54% would recommend their hospital to another colleague.[14] In comparison, our engagement with senior doctors has demonstrated some areas of concern. In a recent AMA (NSW) survey of the experience of senior doctors, 76% said they were not satisfied with the support, resources and accommodation NSW Health provides for senior doctors.[15]

23. Under the *Health Services Act* 1997 Public Health Organisations[16] (***PHOs***) are required to have in place By-Laws, and a requirement of the By-Laws is the establishment of Medical Staff Councils.[17] While many different governance arrangements have been proposed and implemented to reflect doctors and clinical staff, AMA (NSW) strongly supports the role of Medical Staff Councils which have provided an effective mechanism for medical staff to have a voice in their hospitals over many decades.

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[14] AMA(NSW) Hospital Health Check Survey 2022
https://www.amansw.com.au/hhc-2022-key-findings/

[15]AMA(NSW) Senior Doctor Pulse Check Survey 2021
https://www.amansw.com.au/senior-doctor-pulse-check-2/

[16] A Public Health Organisation includes Local Health Districts, Statutory Health Corporations and Affiliated Health Organisations in respect of its recognised establishments and recognised services (section 7).

[17] NSW Health Model By-Laws
https://www.health.nsw.gov.au/legislation/Pages/model-by-laws.aspx

D. VISITING MEDICAL OFFICERS IN NEW SOUTH WALES PUBLIC HOSPITALS

D1. AMA(NSW) and VMOs

24. As an organisation of employers AMA(NSW) is a registered industrial organisation under section 271 of the ***Industrial Relations Act* 1996** (NSW). AMA(NSW) has a statutory role under the provisions of the ***Health Services Act* 1997** (hereinafter '***HSA***') to recommend to the Minister for Health (section 87) and/or seek the appointment of an arbitrator (section 89) to determine the terms and conditions and rates of remuneration for sessional and fee-for-service VMOs.

25. In New South Wales the arrangements for the contracting of doctors in State Public Hospitals and facilities are not unilaterally determined by the New South Wales Ministry of Health (hereinafter '***MOH***'). A core component of AMA(NSW)'s role is the provision of industrial representation for all Visiting Medical Officers (hereinafter '***VMOs***') in the New South Wales Public Hospital System. AMA(NSW) makes every effort to ensure the concerns of VMOs are heard and makes representations on their behalf.

26. In any arbitration proceedings under the HSA, AMA(NSW) has a right of representation on behalf of all sessional and fee-for-service VMOs (not just those VMOs who are members of AMA(NSW)).

27. In addition to its statutory role, AMA(NSW) has a well-established constructive working relationship with the NSW Ministry of Health.

D2. VMOS IN NEW SOUTH WALES

28. Other than the Australian Capital Territory (and very limited numbers in Victoria and Queensland) New South Wales is the only State or Territory in which VMOs in the Public Hospital System are independent contractors.

29. There are approximately 8,000 VMO appointments in the NSW Public Hospital System. Approximately 5,700 of VMOs are appointed under sessional contracts, 3,000 are appointed under fee-for-service contracts and 1,000 are appointed under fee-for-service contracts at facilities covered by the Rural Doctors Settlement Package (hereinafter '***RDASP***') (see below). Some VMOs hold multiple appointments.

30. VMOs are subject to a detailed and competitive appointment process which, by virtue of the legislation, is undertaken on a regular basis.[18] In terms of the cost of administering such a system, the VMO Performance Review system provides PHOs with a discretion to reappoint VMOs who have had satisfactory performance reviews without the need to advertise and interview VMOs for seeking re-appointment.[19]

31. Visiting Medical Officers are contractors, they are not temporary staff. The manner of VMO engagement is provided for under statute. There is the provision for short term VMO appointments of up to six months to meet urgent service needs[20] but most are engaged on contracts of 5 years as is permitted under the legislation.[21]

D3. THE HEALTH SERVICES ACT 1997 (NSW)

32. Chapter 8 of the HSA governs the appointment of VMOs and the services contracts under which VMOs provide services in NSW Public Hospitals to Public Patients.

33. Part 1 of Chapter 8 defines who is a VMO for the purposes of the HSA; Part 2 regulates VMOs service contracts with PHOs; Part 3 concerns the reporting of criminal and disciplinary matters; and Part 4 provides VMOs with a right of appeal following certain appointment decisions made by PHOs.

34. A VMO is a medical practitioner appointed under a service contract to provide medical services for monetary remuneration for or on behalf of a PHO (section 78). Pursuant to the *Health Services Regulation* 2018, VMO appointments are for a period not exceeding 5 years (cl 7(1)) and in limited circumstances may be for a period exceeding 5 years but not exceeding 10 years subject to approval from the Health Secretary having regard to the circumstances of the case (cl 7(4)).

35. A service contract is defined to include fee-for-service contracts, sessional contracts, and honorary contracts (section 81). A service contract must be reduced to writing setting out the terms and conditions of the VMO's appointment (section 86(1)). An appointment made in contravention of section 86(1) is void (section 86(2)). That is, for a VMO to hold a valid appointment he/she must have a written service contract giving effect to that appointment.

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[18] NSW Health Visiting Practitioner Appointments in the NSW Public Hospital System PD2016_052
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_052.pdf

[19] NSW Health *Performance Review Policy Directive* PD2011_010
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_010.pdf

[20] Clause 5(4)(b) *Health Services Regulation* 2018 (NSW)

[21] Clause 7 *Health Services Regulation* 2018 (NSW)

36. VMOs appointed under sessional contracts are remunerated based on an hourly rate. VMOs appointed under fee-for service contracts are remunerated based on a determined percentage of the Commonwealth Medicare Benefits Schedule for services provided. VMOs who provide services at facilities covered by the RDASP are remunerated on a modified fee-for-service basis.

37. The Minister for Health may approve sets of conditions recommended by the AMA(NSW) for inclusion in service contracts (section 87 HSA).

38. The Minister or AMA(NSW) may (jointly or individually) apply to the Minister for Industrial Relations for the appointment of an arbitrator to determine the terms and conditions of work, the amounts or rates of remuneration and the bases upon which those amounts or rates are applicable for VMOs appointed under sessional or fee-for-service contracts (or both) (section 89). An arbitrator is bound to have regard to the economic consequences of a proposed Determination (section 92(2) HSA).

39. Part 2 sets out the functions and duties of the arbitrator. One of those duties is to bring the parties to agreement (section 91(2) HSA).

40. A Determination made by an arbitrator appointed under Part 2 is final and binding and forms part of the terms and conditions of the contract. Any provision of a service contract which is inconsistent with a Determination is, to the extent of the inconsistency, of no effect (Section 98 HSA).

D4 <u>VMO ARBITRATIONS</u>

41. As noted above, VMO terms and conditions of engagement are determined by an independent Arbitrator appointed under the HSA. The Ministry of Health or the AMA(NSW) jointly or individually may apply for the appointment of an Arbitrator. The Arbitrator is required to have regard to the economic consequences of a proposed Determination or Determinations.

42. The first VMO Arbitration was conducted in 1976. It was a private arbitration of the terms and conditions for VMOs providing services on a sessional basis. The first legislative provisions for arbitration were made in 1987 when the *Public Hospitals Act* 1929 (NSW) was amended by the *Public Hospital (Amendment) Act* 1978 (NSW). These provisions made allowance for the appointment of an arbitrator to determine the terms and conditions of work, and rates of remuneration for VMOs engaged on a sessional basis.

43. In 1980 the *Public Hospitals Act* was further amended to make provision for the determination of rates of remuneration for fee-for-service VMOs but not for terms and conditions.

44. In 1997 the *Health Services Act* 1997 (NSW) repealed the *Public Hospitals Act*. The HSA provided for the appointment of an arbitrator to determine rates of remuneration and terms and conditions of work for both sessional and fee-for-service VMOs (see sections 89 and 90 of the HSA).

45. Sessional VMO arbitrations were conducted in 1976, 1978, 1980, 1981, 1982, 1983, 1985, 1993, 1994, 2007 and 2014.[22]

46. In 2007 the most recent significant review of the Sessional Determination was undertaken. The most significant changes were the introduction of the regional support package and payments for cancelled lists.[23]

47. Prior to 2007, Fee-for-Service arrangements were set out in an agreement negotiated by AMA(NSW) and the then NSW Department of Health. A Fee-for-Service Determination was made in 2007 for the benefit of the system and VMOs.[24]

48. While the Arbitrator was required under the HSA to decide to make orders for the Determinations, the proceedings were conducted cooperatively by AMA(NSW) and NSW Health with the parties negotiating and reaching agreement on many of the matters presented to the Arbitrator. The Arbitrator noted the capacity of the parties in 2007 to negotiate a consent position was highly desirable, allowing the parties to tailor outcomes which are closest to their respective needs.

49. The last arbitrations were in 2014 and resulted in minor amendments to the provisions regarding timeframes for the submission and payment of claims in both the Sessional and Fee-for-Service Determinations.

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[22] Overview of VMO Arrangements in NSW 1976 – 2011 (Annexure A)

[23] *Australian Medical Association (NSW) Limited v Minister for Health* [2007] NSWIRComm 263 https://www.caselaw.nsw.gov.au/decision/549f7ac33004262463a970bc

[24] *Ibid.*

50. The NSW Government's Wages Policy has not only limited wages[25] but also negotiations regarding terms and conditions as offers of remuneration increases were subject to no extra claims provisions.

51. AMA(NSW) has most recently been negotiating with the MOH in 2023 for improved terms and conditions for Fee-for-Service VMOs. The last remuneration agreement for Fee-for-Service VMOs has expired and in principle, AMA(NSW) has engaged with the MOH in relation to its proposal regarding remuneration, subject to agreed improvements in terms and conditions. If agreement is not reached, AMA(NSW) will proceed to arbitration. Attention will then turn to negotiated (or arbitrated) improvements in Sessional VMO arrangements.

52. Of considerable concern to AMA(NSW) is that the current Determinations do not reflect modern working arrangements, and the associated efficiencies to be gained are lost to the Public Hospital System.

D5 SESSIONAL VMO ARRANGEMENTS

53. The features of the *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination* 2014 are as follows:[26]

    (a) VMOs are engaged to provide clinical services to public patients, participate in teaching and training as may be required by the PHO, participate in committees as may be reasonably be required, and participate in the on-call roster;
    (b) Ordinary hours for service provision are to be agreed between the VMO and PHO;[27]
    (c) One of three remuneration options will apply;
    (d) A review of ordinary hours is to take place each year and agreement is to be reached regarding service provision for the coming year;
    (e) Annual performance review;
    (f) Payments will be made for cancelled operating times in prescribed circumstances;
    (g) Remuneration at the established hourly rate for each ordinary hour specified in the contract, an allowance is payable for background practice costs, superannuation as per the *Superannuation Guarantee (Administration) Act* 1992, an on-call allowance

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[25] The NSW Government wages policy applied to remuneration for VMOs as well as salaried medical staff.

[26] *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination* 2014
https://www.health.nsw.gov.au/careers/conditions/Awards/sessionaldetermination.pdf

[27] NSW Health Information Bulletin Remuneration Rates for Sessional Visiting Medical Officers IB2021_055
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2022_053.pdf

is payable when the VMO is rostered to be on-call, and payment for services provided pursuant to a call-back is determined by reference to when the service is provided;

(h) Additional payments may be made to Regional VMOs;

(i) Leave is unpaid;

(j) VMOs must keep a record of services provided and submit claims within defined times;

(k) Treasury Managed Fund Indemnity Cover;

(l) A dispute resolution process.

54. VMOs providing services under the Sessional Determination are required to be engaged under the applicable Model Service Contract for Sessional VMOs either as an individual or with the VMO's service entity. [28] As noted above, the terms of the Determination form a part of the terms and conditions of the contract.[29]

D6 FEE-FOR-SERVICE VMO ARRANGEMENTS

55. The features of the *Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination* 2014 are as follows:[30]

(a) VMOs are engaged to provide clinical services to public patients, participate in teaching and training as may be required by the PHO, participate in committees as may be reasonably be required, and participate in the emergency after-hours roster;

(b) A services plan is to be agreed between the VMO and PHO;

(c) VMOS are remunerated by reference to a percentage of the relevant Commonwealth Medicare Benefits Schedule (***CMBS***);[31]

(d) A review of the services plan is take place each year and agreement is to be reached regarding service provision for the coming year;

(e) Annual performance review;

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[28] NSW Health Policy Directive, Model Service Contracts – VMO and HMO
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_008.pdf

[29] *Health Services Act* 1997 (NSW) Section 98

[30] *Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination* 2014
https://www.health.nsw.gov.au/careers/conditions/Awards/feeforservicedetermination.pdf

[31] NSW Health Information Bulletin Remuneration Rates for Fee-for-Service Visiting Medical Officers IB2019_026
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2021_054.pdf

(f) Payments will be made for cancelled operating times in prescribed circumstances;

(g) Additional payments may be made to Regional VMOs;

(h) Leave is unpaid;

(i) VMOs must keep a record of services provided and submit claims within defined times;

(j) Treasury Managed Fund indemnity cover;

(k) A dispute resolution process.

56. VMOs providing services under the Fee-for-Service Determination are required to be engaged under the applicable Model Service Contract for Sessional VMOs – either as an individual or with the VMO's service entity. [32] As noted above, the terms of the Determination form a part of the terms and conditions of the contract.[33]

D7 RURAL DOCTOR ARRANGEMENTS

57. In addition to the Sessional and Fee-for-Service Determinations, there is in place a Rural Doctors' Settlement Package. [34]

58. In 1987 rural general practitioners took industrial action against the State Government in response to the Federal Government's announcement that the after-hours loading for general practitioner consultations was to be removed and other item numbers claimed by rural general practitioners would be altered. General practitioners providing services in rural areas on a fee-for-service basis were being paid less than their colleagues in larger centres who were offered the option of sessional remuneration as a term of the settlement of the 1984/85 Doctors' Dispute.

59. In 1988 settlement of the action taken by rural general practitioners was reached, and the terms set out in the Rural Doctors' Settlement Package. In or about 1995, the package was extended to apply to specialists providing services in Rural Doctor Settlement Package Hospitals.

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[32] NSW Health Policy Directive, Model Service Contracts – VMO and HMO https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_008.pdf

[33] *Health Services Act* 1997 (NSW) Section 98

[34] NSW Health Information Bulletin Rural Doctors Settlement Package Clarifications Reference Guide IB2023_002
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2023_017.pdf

60. The Rural Doctors' Association of NSW is responsible for the Rural Doctors Settlement Package. AMA(NSW) works closely with the RDA(NSW).

D8 VMO ARRANGEMENTS IN PUBLIC HOSPITALS

61. Recent criticism in the media of VMOs and their role in the Public Hospital System have demoralised many. Feedback from survey respondents to the AMA(NSW) Survey of VMO, Staff Specialist and Locum Arrangements included comments as follows:

> *'I* [am a part of] *a specialist service in....remote.....NSW and we are completely dependent on VMOs. Without them the service would cease to exist and there is no local alternative. It is difficult enough trying to recruit specialists to the bush and by discrediting our entire VMO workforce the government has simply made it impossible'*; and

> *'I really hope someone can successfully explain to the health minister that VMOs and locums serve very different roles in the hospital system and to conflate them is insulting and demonstrates grave ignorance. I have served my local regional community as a VMO for more than a decade, participating in a regular overtime roster.'*

62. VMOs are independent contractors who are only paid if they work. The work available to be undertaken by the VMOs is the same irrespective of the number of VMOs – they do not bring with them an additional burden of disease or injury. Instead, the only possible reason for limiting the number of VMOs in a department is a desire to reduce or hide the unmet burden of disease, also known as *the hidden waiting list*. AMA(NSW) is increasingly hearing from members frustrated by administrators who refuse to approve additional staff. Further feedback from survey respondents highlights the frustrations.

> *'Our requests for additional VMOs to run a sustainable of at least 1-6 roster have been ignored due to budgetary reasons. The primary reason seems to be not wanting to fund any extra operating lists. A suggestion has been made that in order to increase our VMO pool - we should be sharing our existing operating time. This would not help the ever-increasing wait lists'*; and

> *'The hospital system does not give us enough routine operating lists to stay on top of the waitlists, but then employs outside locums to do rushed lists on patients they haven't seen; whilst the hospital department continues to run covering on call, outpatients consults and theatres with no investment in the number of consultants*

in over 25 years. The refusal to employ more people, despite busier departments and on call is to try to block patients to be able to access to the waiting lists.'

63. VMOs provide necessary on-call services to NSW Public Hospitals. While what this entails will vary depending on location and specialty, the evidence provided by Dr Salindera, VMO General Surgeon at Coffs Harbour Health Campus, to the NSW Parliament *Health Outcomes and access to Health and Hospital Services in Rural, Regional and Remote New South Wales Inquiry* regarding the key role of VMOs in the provision of on-call services in regional areas is informative:

> *'I was on call in that week [*last week*] for four days straight. I provided care during the day. I had elective operating lists – clinics – in the mornings and emergency operating in the afternoon. I was required to attend the hospital. I was called at 11pm and then at 12pm [*should read 12am*] and then we prepared the operating theatre. I operated on an emergency surgery at 2am. That surgery took me through until 5am....I went home. I had breakfast and I was back at 8.30am...we prepare for this and we are ready for this. Then I take my break when I can get it, but certainly you have to deliver care. That is what on-call surgery is and, as I said, as the senior consultant you have to be there. It is not an operation that can be done without you being there. So you need to be there. You need to be available to supervise and this is what we train for.'* [35]

64. The role of VMOs in on-call service provision is a core component of service provision in the Public Hospital System. To ensure VMOs continue to provide these services, the system needs to ensure regular lists are available to those who provide on-call services. Many VMOs complain to AMA(NSW) about regular cancellation of lists or quite simply elective lists not being made available at all.

65. The use of zero-hour VMO contracts have been used across the system albeit not universally. This has created uncertainty for many VMOs. While it may be a useful means for PHOs to manage budgeted expenditure, what it means for VMOs is an inability to secure finance, a lack of certainty about available work and longer-term security not just for the VMOs but for their families, making decision to commit to a hospital or region almost impossible.

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[35] Transcript of evidence before NSW Parliament Portfolio Committee No 2 – Health, *Health Outcomes and access to Health and Hospital Services in Rural, Regional and Remote New South Wales* 19 March 2021 https://www.parliament.nsw.gov.au/lcdocs/transcripts/2514/Transcript%20-%20RRR%20health%20outcomes%20-%2019%20March%202021%20-%20CORRECTED.pdf

'Until very recently the use of "zero-hour" VMO contracts was common, with one consultant living locally being employed for 5 years as a "zero-hour" contract. When funding was made available to employ 1FTE further, this was then split into 4 x0.245 FTE positions (which was not made known prior to the awarding of jobs). The result of this has been to keep people on a tether, waiting for more funding to become available. They then look for work elsewhere to supplement this income, and are not available to cover shortfalls, recently necessitating locum use. Recent increase in funding only came about as we were poised to lose accreditation as a training facility.'

66. The demands of consultants when rostered on-call in regional and rural areas is often more significant than it is in metropolitan areas. In metropolitan areas, there is often a more senior Registrar rostered on who can work more independently whereas in regional and rural areas there are few senior registrars working and the junior medical staff (if any) are often more junior and unable to work independently. As such, when a consultant is called, be they a VMO or a Staff Specialist, they will more frequently need to attend the hospital.

67. For example, at Tamworth Rural Referral Hospital, efforts have been ongoing for many years to recruit new consultants to join the Anaesthetic Department. These efforts have not been successful with many applicants citing the onerous nature of the on-call arrangements as a disincentive when they would work in metropolitan areas and do less on-call or undertake work as a locum and get paid more for the same work.

68. While it is occasionally said that VMOs are not required, and do not, contribute to non-clinical duties such as teaching, quality assurance and other activities, this is simply not the case. The Determinations provide that VMOs can be required to participate in teaching and training (and do so), quality assurance activities and other so-called 'non-clinical' duties. The issue that is frequently raised by VMOs is that PHOs do not want to pay them for participation in these activities and therefore ask them not to undertake them and focus solely or largely on direct patient care.

69. VMOs are required to submit claims in VMoney for services they have provided, and they are paid based on same. VMOs are paid for the services they provide and are accountable for their time.

70. In 2011 the NSW Auditor-General conducted a review of Visiting Medical Officer and Staff Specialist arrangements.[36] As noted by the Auditor-General, VMOs must account for their

[36] NSW Auditor-General's Report Performance Audit Visiting Medical Officers and Staff Specialists https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/2011_Dec_Report_Visiting_medical_officers_and_staff_specialists.pdf

time. Concern was raised about the fact that verifying and processing VMO claims for payment was largely manual and labour-intensive. The recommendations made regarding VMO claims were actioned. The VMoney system commenced in 2014 and over 7,000 VMOs use VMOney and 6,500 claims are processed each month[37]. Further, in 2014 a joint application was made by the Ministry of Health and AMA(NSW) to amend the Determinations regarding the submission of claims and orders made to amend the Determinations accordingly.[38] There is an audit system in place for the regular review of VMO claims.[39]

71. While it appears many PHOs do not invoke the annual review provisions under the Determinations, this is means for PHOs ad VMOs to engage in a meaningful review of service provision on an annual basis and for adjustments to be made to service provision plans if required. Under both Determinations the PHO and VMO are to meet annually to review the provision of services in the preceding 12-month period and whether there is any need for an adjustment to the budget.[40] This is in addition to and separate to the annual Performance Review process.

72. The disputes process under the Determinations are a cost-effective means to bring a VMO and PHO together to work to resolve issues. While perhaps not as widely used as it may have been for some years, AMA(NSW) has been encouraging members to make use of the process. The disputes process was streamlined in 2007 and provides a three-step process for the resolution of disputes: the opportunity for discussion between the VMO and PHO, if that fails, then the parties proceed to mediation, and if that fails there is an option of binding arbitration.

73. Examples of the issues about which VMOs have exercised their rights under the disputes' mechanism include on-call arrangements and the equity of same, billing issues, payment for the provision of services while on-call, payment of the on-call allowance (for sessional VMOs), concerns regarding the perceived failure of the PHO to follow proper process in performance and other matters.

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[37] https://www.ehealth.nsw.gov.au/solutions/workforce-business/financial-asset/vmoney

[38] *Minister for Health v Australian Medical Association (NSW) Limited* [2014] NSWIRComm 59 https://www.caselaw.nsw.gov.au/decision/54a640003004de94513dca87

[39] NSW Health Audit Tool Guideline *Visiting Medical Officer (VMO) Claims Management* (November 2015) https://www.health.nsw.gov.au/careers/conditions/Documents/vmo-claims-audit-tool-guide.pdf

[40] Clause 5 (5) – (9) of the Sessional VMO Determination 2014; Clause 5 (9) – (13) of the Fee-for-Service VMO Determination 2014

74. Throughout the COVID-19 Pandemic, including during formal shutdowns of the Public and Private Hospital Systems, VMOs continued to participate in on-call rosters and provide much needed emergency services albeit that they were not otherwise paid for their ordinary hours of work due to service shutdown. An interim arrangement was put in place for payments to be made for times that VMOs made themselves available for quality assurance and other activities. AMA(NSW) does not have access to the data as to how many VMOs made claims under this interim arrangement, but anecdotally we know there are many who did not.

75. When hospital shutdowns were lifted, VMOs undertook the needed wait list reduction work across the system to ensure patients in NSW could have their surgery. For many this included working through traditionally quieter periods of December and January to ensure patient access.

76. The Health Services Union has made much of the claim that VMO costs exceeded $1 billion in 2022, the below table extracts data from the NSW Health Annual Reports demonstrates that salaries and on-costs for employed staff have also increased over the same period at much the same rate. It is not possible to identify from the Annual Reports whether the VMO costs include locum costs.

NSW HEALTH ANNUAL REPORT	Total labour costs (incl VMOs)	Salaries and on-costs	VMOs
2022	$17.2 bill	$16.185 bill	$1.005 bill
2020	$15.9 bill	$14.500 bill	$915,000
2018	$13.4 bill	$19.397 bill	$820,651
2016	$12.9 bill	$12.207 bill	$742,502
2014	$11.7 bill	$11,014 bill	$675,552

E. LOCUMS

77. Locums are a critical part of the NSW Public Hospital System. Locums are not excess workforce. Locums provide much needed medical services and respite for medical practitioners in the NSW Public Hospital System.

78. Locums have been and continue to be engaged to meet short-term service needs including cover for periods of leave (planned and unplanned) or an uptick in service demands. Due to outdated industrial arrangements which can make recruitment and retention of VMOs and / or Staff Specialists difficult, locums have in some locations become a part of 'business as usual' in NSW Public Hospitals.

79. It is difficult to get a clear understanding of the numbers of locums engaged in the Public Hospital System or on what basis and where they are engaged. While the respondents to the recent survey regarding the provision of locum services were limited, of the 107 who said they had provided locum services, 80 said they did so under a VMO contract, 8 under a staff specialist contract, and the balance under other contractual arrangements including through locum agencies.

80. AMA(NSW) recently made an application under the *Government Information (Public Access) Act* 2009 (***GIPA***) to the Hunter New England Local Health District (***HNELHD***) for contracts for locums engaged to provide services in the Anaesthetic Department at Tamworth Rural Referral Hospital. In circumstances where the HNELHD was in agreement with the VMOs that reliance on locums needed to be reduced and greater efforts made to attract and retain permanent workforce, the HNELHD representatives were unable to provide information about how much money it had spent on locums in recent years, and in response to the GIPA application, AMA (NSW) was advised the scope was too broad and it was not possible to distinguish between contracts issued to locums and contracts issued to VMOs appointed under standard arrangements.

81. The answer to the concern about the number of locums and / or the costs is not to stop locum arrangements altogether. The arrangements have their place and ensure staff can take much needed leave, particularly in regional and rural areas where there are fewer staff to provide cover for attendance at required professional development courses and conferences, holidays or even a much-needed weekend away, or to cover positions left vacant by resignation while recruitment is undertaken.

82. It may be possible to reduce current rates of locum use by engaging more VMOs or Staff Specialists, but it is a struggle to recruit to these roles due to the out-dated nature of the

industrial arrangements and remuneration. The challenge is that many communities in regional and rural areas, to one extent or another, rely on locums to meet business-as-usual service provision because the current industrial instruments are out-dated, and the remuneration and other terms and conditions are not such to attract and retain specialist medical practitioners to live and work in those communities. The comments of recent survey respondents include the following:

> *It is hard to attract staff permanently with so many locums in service. Also people leave to do locum shifts making it hard to run services and make changes.*

> *Our Department is lucky in that we have had strong leadership that has avoided the need for locums but I know of many around us where they cannot recruit medical staff and are struggling.*

83. Much has been made by some of the rates paid to locums, citing $5,000 a day. NSW Health prescribes locum rates for non-specialist medical staff engaged on a short-term or casual locum basis.[41] In AMA(NSW)'s Submission to the *NSW Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Regional, Remote and Rural New South Wales*, a call was made for an increase in these locum rates in rural and regional areas in circumstances where discrepancy between locations makes it difficult for hospitals and PHOs to compete on an equal footing. Many doctors in hospitals report missing out on locums who choose sites that pay higher rates.

84. There are no prescribed rates for specialists providing locum services. The market will largely set the rate.

85. AMA(NSW) is aware that there are hospitals where locums are engaged to provide services when consultants at those hospitals could have undertaken the work but were not offered the work. Yet, at these same hospitals, when VMOs request locum cover so they can take much needed leave, their requests are refused. Conversely, at the same hospital and other hospitals, calls by VMOs for locums to cover leave are often declined.

86. The challenge of locum remuneration is not unique to New South Wales, it is a national challenge, particularly post COVID-19 Pandemic as medical workforce shortages are more acute across Australia. Locums will travel interstate to provide services and, as they are entitled to do, will seek the most favourable terms they can secure. The Ministry may look

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[41] NSW Health Policy Directive Remuneration Rates for Non-Specialist Medical Staff – short term / casual (locum) (https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_046.pdf)

at prescribing specialist locum rates in NSW but if other jurisdictions across the country offer more competitive rates and terms and conditions, workforce shortages in New South Wales will become more acute. A national solution is required. It would be erroneous to proceed on the assumption there is an adequate supply or oversupply of locums:

> *At one stage we tried to find a locum but could not find one with the requisite experience. So we just worked harder ourselves.*

F. AN URGENT NEED FOR INDUSTRIAL REFORM

F1 CONSULTANTS IN NSW PUBLIC HOSPITALS

87. In October 2023 AMA(NSW) surveyed medical practitioners working as consultants in the New South Wales. Of the 752 survey respondents 51% were VMOs, 34% Staff Specialists and 10% worked as both a VMO and a staff specialist. Many are long-time members of the New South Wales Public Health System, with 38% having worked for more than 20 years in the public system, 18% for 15 – 20 years and 21% for 10 – 15 years.

88. Of the survey respondents, 57% worked in a Department that was comprised of VMOs and Staff Specialists, 27% had only VMOs in their Department and 16% had only Staff Specialists in their Department. The strength of the New South Wales Public Hospital System lies in the balance of VMOs and Staff Specialists.

> *'In regional areas, but also in the metropolitan regions, a mix of staff specialist and VMO arrangements are the only way of ensuring adequate care for both inpatients and outpatients.'*

89. Regardless of the arrangement under which respondents worked, there was a consistent message that both the VMO Determinations and the *Staff Specialist (State) Award* are out-dated. As one respondent stated:

> *'Both the staff specialist and VMO awards are anachronistic, and are inferior to other states... In particular, the on-call rate fails to recognise the remote service we provide as Specialists responsible for our trainee specialists on the ground. The shift of workforce to provide public-in-private work has left a major deficit in the public hospitals. We need to incentivise the return of Specialists to the public hospitals through better working conditions and remuneration, otherwise we will lose more to the private sector or interstate/overseas.'*

F2 OUTDATED INDUSTRIAL INSTRUMENTS

90. While this Commission is not the forum for the reform of the relevant industrial instruments, the Commission's Terms of Reference invite submissions on the sustainability of the NSW Health workforce to meet future demands and deliver efficient, equitable and effective health services.

91. As noted above, the last substantive review of the VMO Determinations was in 2007[42] and for the Staff Specialist State Award, 2006[43].

92. The terms and conditions under both arrangements are overdue for review. The New South Wales State Government's Wages Policy effectively ensured no reform for over 10 years.

93. An example of the outdated nature of the Industrial Instruments is that the VMO Determinations do not currently provide for payment to VMOs for the provision of services from locations other than the hospital.

94. When VMOs are on-call they may be paid an on-call allowance of $14.90 per hour if they are engaged on a sessional basis. Fee-for-Service VMOs are not paid an on-call allowance. The on-call allowance is not and was never intended to compensate VMOs for the provision of services. VMOs rostered on-call will be paid for the provision of a service if they attend the hospital but if they do not physically attend the hospital, they are not remunerated. Under existing arrangements, VMOs are entitled to claim 20 minutes travel time each way, and then for the time or service provided when they arrive at the hospital. While VMOs, acting in the best interests of patients and their colleagues, increasingly provide review from home or their rooms rather than traveling to the hospital unless this is warranted or specifically requested, they are not remunerated for these services.

95. There are some specialities where the provision of services from a location other than the hospital is not possible in most cases, for example anaesthesia and obstetrics. However, there are other specialities where this is possible. In the recent AMA(NSW) 2023 Senior Medical Officer Survey 497 survey respondents answered the question about whether they able to provide services that directly involve patient management from a location other than the hospital, namely, services that involve the review of a patient record, test results other clinical information, the making of decisions regarding the management of the patient and documenting same without attending the hospital, and of those 497, 72% responded in the affirmative.

96. When asked about advances in technology and service provision, 33.4% of survey respondents said that advances in technology had reduced the need for them to attend the hospital to provide services. Of the 501 respondents, 295 said they were and 208 were not able to access the eMR (electronic medical record), results and other clinical information when not physically present at the Hospital. This is a matter that needs to be addressed as a matter of priority.[44]

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[42] Australian Medical Association (NSW) Limited v Minister for Health [2007] NSWIRComm 263

[43] Re Staff Specialists (State) Award [2006] NSWIRComm 124

[44] https://www.amansw.com.au/vmo-arrangements-under-review/

97. There are undoubtedly efficiencies to be gained from facilitating the provision of services from locations other than the hospital. For example, the ability of medical practitioners to review the eMR, test results and engage with staff and in some cases, patients virtually, means decisions can be made about the need or otherwise to take a patient to theatre in the middle of the night. When it was necessary for doctors to attend in all cases, necessarily steps were taken to prepare theatre and call staff in for surgery which can now be avoided in appropriate cases. Further, engaging with consultants in real time review of test results can help for informed decisions to be made about the necessity or otherwise for further tests, thereby saving time, resources, and costs.

98. Yet the industrial instruments for VMOs and Staff Specialists make no provision for the payment for the provision of services from locations other than the hospital. In the Australian Capital Territory VMOs are paid for 'digital call back'. [45] Under the ACT Determination, a VMO who is on-call and called-back to provide a service and can do so using appropriate digital resources without the need to leave their residence or other location remote to the hospital. Review of information that would be conveyed effectively verbally by phone is not considered to be a digital call-back.

99. AMA(NSW) is advocating for the inclusion of the same or similar provision in the VMO Determinations in New South Wales. To date, the MOH has declined to participate in negotiations to amend the Determinations to make allowance for same.

100. AMA(NSW) has been approached by craft group regarding a service to screen patients. Under the proposal, nurses on site with the patient will take the images and they will be sent to a specialist medical practitioner to review and determine who needs to be seen and when, and who does not need to be seen. This system is currently in place at one public hospital in New South Wales, and the specialist who reviews the scans and then decides the care for the patient, cannot claim for payment under the current VMO Determination.

101. A General Surgeon working under VMO arrangements at two public hospitals told AMA(NSW) that he provides services from locations other than the Hospital and documents his clinical decisions in the patients' medical records. He gave the example of being contacted by a consultant for a second opinion. The VMO was able to access the radiology and blood results immediately and discuss the patient's care with the consultant. A decision was made, the VMO documented same in the medical record and the patient's management proceeded much more quickly than if the team had to wait for him to get to the hospital.

[45] *Health (Visiting Medical Officer Core Conditions) Determination* 2020 (ACT)

102. The VMO Determinations and the Staff Specialist (State) Award originated from a time when health care services were predominantly delivered from 8am to 6pm Monday to Friday, save of course for emergencies. This is no longer the case.

> *'Workforce is leaving public healthcare as afterhours work is not paid or recognised- we run 6 Ots [*operating theatres*] every weekend and 8 every evening to do planned and unplanned work. This has increased 200% over the last 10 years. The award is not fit for purpose.'*

103. VMOs and Staff Specialists are often asked to undertake 'regular' work in the evenings or on the weekends. While there is provision for the payment of loadings for work undertaken pursuant to a call-back for VMOs, this work is often not done pursuant to call-back and VMOs are paid less for this work than colleagues who are rostered on-call and provide services pursuant to a call-back.

104. The Staff Specialist (State) Award is an industrial instrument based on a model of service provision that has medical practitioners employed on a full-time basis at the one hospital, 9am to 5pm Monday to Friday. There are few Staff Specialists, particularly among the younger consultant cohort, and even the mid-career cohort, who are looking to work, or are working on this basis. Many Staff Specialists seek a balance working across the public and private systems, not predominantly in one or the other.

105. The growing discrepancy between earnings in the private and the public needs to be addressed as the following comment demonstrates otherwise more practitioners will spend more time in the private and less in the public or leave the public altogether.

> *As an anaesthetist the NSW Public Hospital system is way behind the mark in the offering they currently have. Private work has expanded enormously in terms of sessions and more importantly, hours available each week. The pay differential is too great to make the public offering worth considering in any great quantity - especially given the maximum working capacity and ideal work mix for most anaesthetists.*
>
> *As an example...the Private sessions per month have increased from $450/month a decade ago, to $950/month currently. The public sessions have grown from $600/month to $750/month. Each day the morning private and public sessions are 5 hours, but the afternoon session is 5 hours public and 8 hours private. This means that a "full" private day is worth 1.5 public days in terms of hours...This means that a 3-day per week anaesthetist with 1:2 split public : private works 36 hours a week, but to earn the same would have to work a 7 day public week!...The landscape is diabolical for the public hospitals trying to staff Anaesthetic departments (not*

because the anaesthetists are lazy and good for nothing, as they would have you believe) but because the public system is littered with inefficient middle managers ... who further disincentivize our natural instinct to give back to the system which trained us.

G. PRIVATE PATIENTS IN THE PUBLIC SYSTEM

106. VMOs do not provide services to private patients under the terms of their VMO Contracts and are not remunerated by PHOs for services they may provide to private patients.

107. VMOs and Staff Specialists have the right to admit and treat private patients in NSW Public Hospitals.

108. Increasingly, VMOs and Staff Specialists are expressing concern to AMA(NSW) about the lack of involvement they have in the process of patient election, and often, particularly when patients are admitted through Emergency, that they are not provided with the opportunity to accept or refuse the admission of private patients.

109. It is not uncommon for a patient to be asked to make an election to be treated as a private patient after a decision to admit the patient and, not uncommonly, after surgery. Technically this is permitted under the National Health Reform Agreement and private patient revenue is a source of funding for the Public Hospital System, however this leaves the consultant in a vulnerable position. Medico-legally, the consultant is left exposed and responsible for the patient under their private medical indemnity insurance, and financially out of pocket in circumstances where patients refuse to pay fees in circumstances where the surgeon and / or anaesthetist was deprived of the opportunity to provide the patient with informed financial consent and the patient unable to make an informed choice whether to proceed privately or as a public patient.

110. This is an issue not only for surgeons but also anaesthetists who frequently find themselves providing services for free to these patients who they have not agreed to treat privately, and the PHO declines claims for payment because the patient was private (albeit unknown to the anaesthetist at the time of provision of the service and at the time of making the claim for payment).

111. In the last few years, many medical indemnity premiums have significantly increased and, in some cases, exponentially so depending on speciality. VMOs have told AMA(NSW) that they are considering formally refusing to accept any private patients in Public Hospitals, and if their wishes are not respected, they will leave the Public Hospital System, because the inability to participate in decisions about which patients will be admitted under their care is potentially resulting in medical indemnity premiums that are prohibitively expensive.

112. Further to the above concerns, consultants are left exposed to potential liability under the *Health Insurance Act* 1973 in relation to private patient in public hospital arrangements. In response to a recent AMA(NSW) survey,[46] several respondents raised concerns about the lack of any visibility over their billings for private patients when that billing is undertaken by PHOs. Consultants are responsible for private patient services billed under their Medicare Provider Number and if services are incorrectly claimed by the PHO they are responsible for repayments and penalties paid to the Commonwealth. While there are processes in place that are intended to ensure consultants are involved in billing decisions, consultant feedback to AMA(NSW) indicates that these practices are not followed in their entirety, or at all.

113. Private patient election should be made at the earliest possible time and, if not then, AMA(NSW)'s submission is that a retrospective change of election should not be permitted after surgery.

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[46] Private Patient Billings in NSW Public Hospitals 2023 https://www.amansw.com.au/private-patients-in-public-hospitals-the-results-are-in/

H. TRAINING AND SUPPORT FOR DOCTORS-IN-TRAINING

114. Medicine operates on an apprenticeship model where both the science and the art of medicine are passed down from generation to generation. Doctors are rightly proud of the traditions associated with this model. When done well, the collegiate system of training passes on values such as the importance of placing the needs of the patient at the centre of care, the importance of whole person, best practice in delivering quality care and the significance of supportive relationships with colleagues.

115. Colleges accredit Public (and Private) Hospitals as training sites for their trainees. Most of the training is undertaken in the Public Hospital System.

116. The dual role of training and service delivery creates an unusual work environment. DiTs need to undertake a period of work in the hospital system to gain general registration[47] and then need to continue to work in that system, predominantly the Public Hospital System, to gain entry to a specialist training program.

117. The remuneration paid to, and terms and conditions under which, DiTs work in New South Wales are some of the lowest in Australia.

118. While AMA (NSW) has not undertaken detailed research, feedback from members indicates that the impact of the poor terms and conditions are a factor in:

    a. Doctors preferencing what they perceive as more desirable locations in the inner city, leaving growing and critical workforce vacancies in outer metropolitan areas and regional areas;
    b. Doctors prioritising locum work or even locum careers due the financial reward;
    c. A reluctance to pursue careers in specialities such as general practice, geriatrics, psychiatry, due to poor longer-term remuneration prospects.

119. For those reasons and due to the importance of valuing and rewarding doctors working in the health system, there is an urgent need to review the current award arrangements to bring both the remuneration and the terms and conditions into line with other jurisdictions.

120. The important role of Colleges in providing high quality training to trainees in New South Wales and across the country cannot be understated. AMA(NSW) would like to see greater cooperation between Colleges and PHOs to offer flexible training opportunities to trainees,

[47] Section 52 *Health Practitioner Regulation National Law* 2009 (NSW)

more support for trainees undertaking placements in regional areas including encouraging them (and supporting them) to consider a career in a regional area longer term.

I. CONCLUSION

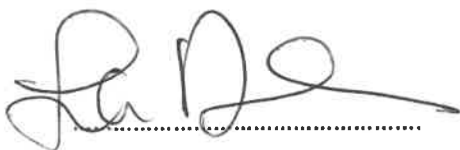
121. The New South Wales Public Hospital System is a strong system and for those who work in the system, they should be proud to do so. That is not to say that there are not areas for improvement.

122. As stated at the outset of this submission, one of the great strengths of the New South Wales Public Hospital system is the flexibility that a mix of VMO, Staff Specialist and other arrangements as needed, provide for the provision of medical services. There is an urgent need for review and reform of all arrangements to ensure that the New South Wales Public Hospital System is at the forefront of the innovative provision of healthcare in Australia, and to ensure that the medical workforce is recognised and appropriately rewarded for the services and support they provide to the system.

123. A review of funding arrangements is critical to ensure adequate funding now and into the future as the challenges of a growing and ageing population become more acute.

124. The breadth of AMA(NSW)'s membership places it in a unique position to understand the strengths of the current health system in New South Wales, and the challenges before it and AMA(NSW) looks forward to working with the Commission as the Inquiry continues.

Dated: 31 October 2023



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Fiona Davies

Chief Executive Officer

Australian Medical Association (NSW) Limited

Annexure A

OVERVIEW OF VISITING MEDICAL OFFICER ARRANGEMENTS IN NEW SOUTH WALES 1976 - 2011

(Prepared by Scott Chapman and Dominique Egan, TressCox Lawyers)

VISITING MEDICAL OFFICER DETERMINATIONS

1. Legislative Provisions regarding Arbitrations

1.1. In 1976 the terms and conditions for Visiting Medical Officers (*VMOs*) providing services on a sessional basis were the subject of a private arbitration conducted by Mr AJ Rogers QC (as he was then).

1.2. Following the private arbitration, the *Public Hospitals Act* 1929 (NSW) was amended by the *Public Hospitals (Amendment) Act* 1978 (NSW). Section 29M was inserted to allow for the appointment of an arbitrator on application by either the New South Wales Branch of the Australian Medical Association (as it was then) or the then Health Commission for the purposes of determining the terms and conditions of work and the rates of remuneration on an hourly basis for sessional VMOs.

1.3. In 1980 the *Public Hospitals (Amendment) Act* 1980 inserted section 29M(1A) which provided that an arbitrator could be appointed to determine the rates of remuneration for VMOs providing services on a fee-for-service basis. The amendment did not confer on an arbitrator the power to determine terms and conditions of work for fee-for-service VMOs.

1.4. In 1997 the *Health Services Act* 1997 (NSW) repealed the *Public Hospitals Act* and provided for the appointment of an arbitrator to determine rates of remuneration and terms and conditions of work for both sessional and fee-for-service VMOs (see sections 89 and 90).

2. Sessional Arrangements

2.1. As noted above, the first arbitration of sessional arrangements occurred in 1976 by way of private arbitration. The arbitration followed the agreement reached between the Federal and New South Wales Governments to abolish the honorary system for the treatment of public patients and its replacement by a system under which VMOs would render services medical services to public patients on a sessional basis. Mr Rogers QC was appointed as arbitrator to make recommendations regarding:

(a) The basis and rates of remuneration;

(b) The nature and extent of leave to which VMOs were to be entitled; and

(c) The conditions and benefits to be included in contracts for services.

2.2. Mr Rogers QC recommended that remuneration be fixed on annual base rate of a VMO providing services for one session (that is, three and a half hours) per week based on

one or two visits to the hospital per week. For a 'split session' whereby three and a half hours service resulted from three or more visits to the hospital, the VMO was paid a loading of 10%. VMOs were required to provide services for not less than one session and not more than ten sessions per fortnight. The hourly sessional rate was determined by converting the annual base rate to a weekly rate and then converting to an hourly rate.

2.3. Mr Rogers QC examined the arrangements staff specialists including the initial fixation by the Industrial Commission in Court Session in 1966 in *In re Medical Officers – Hospital Specialists (State) Award*, and the subsequent examinations by Richards J, Cahill J and Kelleher J regarding work value and staff specialists. Mr Rogers QC differentiated between specialists and general practitioners when determining the rate of remuneration, and within those classifications, further classifications were made (for a summary see page 147 of the Hungerford Reasons for Determination).

2.4. Mr Rogers QC appeared to disregard the 'Robin Hood principle' when fixing remuneration rates. He made it clear he fixed remuneration in accordance with principles of fairness and propriety without concern for 'double counting' – that is, that VMOs private fee structure compensated them for their previously honorary now 'public' work.

2.5. The features of the Determination were as follows:

(a) Superannuation was paid (5.25% on the base sessional rate);

(b) No recommendation was made in relation to the payment of private practice costs due to the variation in the practices of difference practitioners – Mr Rogers QC recommended an enquiry by the Commonwealth and State Governments;

(c) An on-call allowance of one tenth the normal sessional hourly rate for each hour the practitioner was rostered on call (for one hospital only – if a VMO was on-call at more than one hospital it was only payable at one hospital);

(d) If the VMO was called back while on-call the VMO did not receive the on-call allowance for the period of travel and call back;

(e) periods of call back included 20 minutes travel (each way) with a minimum payment for one hour at the applicable hourly rate;

(f) loading of 10% (within hours of 8am to 6pm Monday to Friday) and 25% for call backs between 6pm and 8am and weekends;

(g) VMOs were entitled to be absent on public holidays without loss of remuneration and if services were provided on a public holiday VMOs were to be remunerated at twice the normal hourly rate;

(h) long service leave was granted to VMOs;

(i) VMOs were granted five weeks annual leave per year and three weeks study leave per year with an accumulation of 2 weeks each year to a maximum of 6 weeks noting that many specialists had to attend conferences within Australia and overseas to maintain skills and knowledge.

The 1978 and 1980 Determinations

2.6. The 1978 and 1980 arbitrations under the *Public Hospitals Act* did not result in significant amendments to the features of Mr Rogers QC's Determination. Both resulted in increases in remuneration.

1981 Determination

2.7. In 1981 a number of amendments were made to the then existing determination and a new Determination was issued which differed in a number of respects to the previous determinations:

(a) VMOs were to provide services for an agreed number of set hours (rather than sessions and split sessions of between 1 to 10 sessions per fortnight);

(b) The minimum contract hours in a four weekly period was one and the maximum 70 hours;

(c) There was no payment for leave or when services were not provided on a public holiday;

(d) Periods of on-call were paid at a rate of $10.00 per period (a period was not to exceed 24 hours);

(e) One specialist rate was set rather than the previous sub-classifications with the specialist classification;

(f) Loading for services provided on a public holiday was fixed at the normal hourly rate plus 50% loading;

(g) Extended sessions were paid at the normal hourly rate.

2.8. The following payments were included to give a total hourly rate:

(a) Superannuation loading of 7.5% of the base rate;

(b) Private practice loading of $1.90 per hour for general practitioners and $2.50 per hours for specialists as part of the hourly rate;

(c) Leave loading of 36.8% to take into account annual leave (5 weeks), sick leave (2 weeks), long service leave (2 weeks), conference leave (3 weeks) and public holidays (2 weeks) = total of 14 weeks.

1982 Determination

2.9. In 1982 the main changes were as follows:

(a) Contracted hours were expressed in terms of hours per calendar month rather than hours per four-weekly period;

(b) The provision stipulating that VMOs who worked fewer hours than those specified in the contract received no reduction in monthly remuneration remained, but no additional payment was to be made to VMOs who worked a greater number of hours (other than on-call or during a call back) in any month;

(c) The number of contract hours was to be determined on the basis of the average of the number of hours the VMO rendered services during the previous six month period (excluding on-call and call back). Unpaid leave was included in the calculation of hours;

(d) If there had been no operative contract in the prior six month period, the number of contract hours per calendar month was one, however, VMOs were paid at the normal hourly rate for all services provided in excess of the one hour;

(e) Contract hours were adjusted on the basis of (c) and (d) every six months;

(f) Normal hourly rates of remuneration were increased by 14% with an additional 6% increase deferred;

(g) The on-call allowance was increased from $10 to $20 and the maximum period during which the allowance could be claimed was reduced from 24 to 12 hours;

(h) To facilitate the calculation of hours, VMOs were required to keep a record of the date upon which services were rendered and indicating commencing and finishing times;

(i) The settlement of disputes procedure could only be initiated by the AMA or Health Commission and not, as previously, the individual VMO or hospital.

1983 Determination

2.10. The significant changes were as follows:

(a) An increase in the base remuneration rate of 10.3% being the deferred 6% increase plus a 4.3% increase following the 1983 State Wage Case;

(b) AMA pressed to preserve the averaging concept and the Health Administration Corporation sought its abolition in favour of payment for hours actually worked. A decision was made that a VMO could make an election between the two methods but once an election was made it could not be altered during the six month period;

(c) On-call payments were set at $20.86 for the first 12 hours plus $1.75 per hour thereafter.

1985 Determination

2.11. Medicare was introduced in February 1984. Following its introduction, the specialist doctor dispute arose in New South Wales and many VMOs withdrew from treating public patients in public hospitals. In large part, the dispute focussed on the adverse impact of the change in mix of public and private patients in public hospitals on VMOs' income. The long and the short of it was that there were now more public patients. During the course of the dispute, the Minister for Health made application for the appointment of an arbitrator.

2.12. Justice Macken was appointed as the arbitrator. The major changes were as follows:

(a) The definition of 'specialist' was varied;

(b) A provision for the payment of cancelled sessional time was included. If a hospital cancelled a session without giving 28 days notice for anaesthetists and surgeons, and 14 days' notice for other VMOs, then there was an entitlement to be paid for the cancelled time;

(c) On-call payments were amended. Payments was now made at 10% the normal hourly rate for each hour rostered on-call;

(d) Where a VMO returned to the hospital other than as a consequence of being on-call or call back, payment has to be authorised by the Chief Executive Officer of the hospital;

(e) The minimum payment for a call back was one hour plus actual travelling time (up to a maximum of 20 minutes each way);

(f) Call back commenced when the VMO left his place of residence or place of contact to commence the call back;

(g) New base rates to take account of the 'Medicare effect', $36 per hour for general practitioners and $63 per hour for specialists, including the 49.3% loading, gave normal hourly rates of $54 and $94 respectively;

(h) Private practice costs were removed from the rolled-up normal hourly rate. The amount for background practice costs was increased from $2.67 per hour to $20 per hour for general practitioners and from $3.49 per hour to $25 per hour for specialists;

(i) Hospitals undertook to pay VMOs within one month of receipt of accounts;

(j) VMOs were to be paid for attendances at committee meetings. Medical Staff Council and Board of Directors meetings were unpaid. Payment was made in same proportion as individual VMO's private to public patient ratio;

(k) It was agreed, not required, that the new rates of remuneration would be applied from 1 December 1984. Increases to background practice costs were not retrospective.

2.13. It is worth noting that Justice Macken had regard to and contrasted the position of sessional VMOs with that of fee-for-service VMOs in all hospitals other than teaching hospitals. Under the Settlement Package (see Appendix M to Hungerford) fee-for-service remuneration was to be offered at the following rates to all VMOs at hospitals (other than teaching hospitals):

(a) 85% of the Schedule Fee where there are no resident medical officers or registrars at the hospital;

(b) 70% of the Schedule Fee where a hospital has resident medical officers but no registrars; and

(c) 60% of the Schedule Fee where there are registrars in the same discipline at the hospital.

Each of the three broad disciplines (medical, surgical and anaesthesia) at a hospital were to be able to elect whether they wished to remunerated on a fee-for-service or sessional basis.

Justice Macken observed that the effect was to markedly increase the remuneration of all VMOs except those in teaching hospitals.

2.14. Macken J made note that the effect of the introduction of Medicare was to increase the proportion of public patients as against private patients. Hungerford J was of the view that the effect of Medical on private fees charged was not a relevant consideration.

The Hungerford Arbitration

2.15. As noted above, Hungerford J was critical of Macken J's Determination of 1985.

2.16. The features of the Hungerford J 'determination' were as follows:

(a) the applicable terms and conditions of the Sessional contract arrangement must be reduced to writing;

(b) VMOs were required to engage in teaching and training activities. It was noted that Dr Hovarth's evidence was that following the introduction for payment for the provision of medical services there had been a decline in participation in the corporate activities of hospitals;

(c) Despite application by AMA(NSW) Hungerford J was not prepared to extend payment for committee meetings to Medical Staff Council meetings, grand rounds or other CME programmes because they were necessary to the proper needs of the Hospital and would be replaced by a largely uncontrolled VMO voluntary attendance at meetings for the which the Hospital would incur substantial financial outlay;

(d) Loading for leave of 26.83% in lieu of the then existing 36.8% (Annual leave: 5 weeks p.a.; public holidays 2 weeks p.a.; sick leave 1 week p.a.; study and conference leave: 2 weeks p.a.; long service leave 1 week p.a.) Loading = 52 – 11 = 41.
11x 100 = 26.83%
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(e) As a consequence of the effect of the *Superannuation Guarantee (Administration) Act* 1992 and its consequences for State Government employment, superannuation was excluded;

(f) In 1976 there was provision that allowed a VMO to be reimbursed for the additional cost of travelling to another hospital other than that at which he ordinarily provided services. At the time there was no allowance for background practice costs. It was agreed that as there was now provision for background practice costs it should not be included separately but was a component of background practice costs;

(g) A record of services was to be provided by the VMO and public health organisation were to make payment to VMOs with 30 days of receipt of an account;

(h) A change from payment for actual hours or the averaging system to payment on the basis of 'up-front contract hours' to be called 'ordinary hours' (excluding on-call and call back) and provision for an annual review of hours and in the absence of agreement regarding hours, the VMO to have the right to terminate on 4 weeks notice;

(i) When determining remuneration, the principles of structural efficiency and work value were examined and applied and a special case was found to have been made out to a proportionate degree;

(j) Base hourly rate excluding allowances and loading – loading awarded of 36.83% (being leave loading of 26.83%, extended sessions 5%, split sessions 5%);

(k) A payment for cancelled sessions is not required given the requirement for payments on an upfront hours basis (a payment was included by agreement in 1985);

(l) Hourly rates:
   (i) GP of less than 5 years experience: $46 base rate, plus loading $63.00;

   (ii) GP of 5 years to less than 10 years experience: $50.25 base rate, plus loading $68.75;

   (iii) For a GP who is a FRACGP or has at least 10 years experience $59.25 base rate, plus loading $81.00;

   (iv) For a specialist: $67 base rate, plus loading $91.75; and

   (v) For a senior specialist: $72 base rate, plus loading $98.50.

2.17. The claim for background practice costs was as follows:

(a) The AMA claim was for a new allowance of $66.66 per hour for specialists and $50 per hour for GPs. Annual adjustment was sought in accordance with CPI (the maximum cost approach);

(b) The Minister's claim was based on actual expenses incurred, and an allowance of $10.28 for a surgeon and $5.73 for an anaesthetists, physicians and GPs was sought (the attributable cost approach);

(c) Hungerford J preferred the 'attributable cost' approach.

(d) Background practice costs were payable during a call-back but not subject to the call loadings of 10%, 25% or 50% as the case may be.

(e) Hungerford J did not agree to index background practice costs by reference to CPI as it will no doubt move for reasons quite unrelated to practice costs.

(f) Hungerford acknowledged that some amount should be included in the on-call allowance for telephone consultations even though the on-call allowance was essentially designed to meet the disability of being on-call and thereby restricting activities of a social and family nature.

2.18. In terms of call backs:

(a) The minimum payment for a call back is one hour to include travelling time to a maximum of 20 minutes each way.

(b) Call backs include times when called back but not on-call;

(c) The definition of a call-back was to be amended to make it clear that it is to occur in respect to a request by a hospital or AHS;

(d) A loading of 50% was payable for a call back commencing on a public holiday; a call back commencing on a day that is not a public holiday but including into such a holiday, shall be paid a loading of 10% or 25%.

The decision of the Full Bench in 1993

2.19. The Full Bench acknowledged that apart from the different nature of their contractual work with hospitals, staff specialists generally perform the same work, and are of equal capacity and standing as their VMO counterparts.

2.20. In relation to background practice costs, the decision acknowledges that background practice costs are designed to compensate the VMO for a proportion of the costs of conducting the practice. The assessment should bring into account an element which reflects compensation not for all matters of cost but a reasonable proportion of salary and other costs such as occupancy and office equipment. The attributable cost approach adopted by Hungerford J was not accepted, as it was held that this approach excluded a number of costs said to be attributable only to private patients.

2.21. On-call roster imposes obligations with respect to accessibility by telephone or pager, a restriction of locality within reasonable proximity of the hospital and a necessary condition of sobriety. It was noted that the likelihood of call in is very rare.

2.22. During the course of the hearing of the appeal the parties were directed to participate in mediation to try and reach agreement regarding non-remuneration matters. This mediation conducted by Sir Laurence Street occurred in the absence of lawyers. The outcome of the mediation was documented in the Contextual Overview document.

2.23. Following the delivery of the decision in 1993, the following orders were made:

- A new Determination is made which has the following effect:
  - A new base hourly rate of $84 for senior specialists, with other rates to increase proportionately;
  - 2.5% to be added to the superannuation factor for those VMOs under sessional contracts entered into prior to the date of the new determination and continued thereafter;
  - The long service leave factor in the rates is restored (2 weeks per annum);
  - Background practice costs of $25 per hour for surgeons and $15 per hour for other classifications;
  - The new determination to take effect from 1 January 1994;
- The parties to draft and file by 31 January 1994 (sic) a revised determination to give effect to the judgment including those that were agreed as a part of mediation.

2.24. There were a number of issues that the AMA and Minister for Health asked the Commission to clarify after the delivery of the decision, and which arose during efforts to draft a revised determination as directed. Those issues and there determination, were as follows:

- The Contextual Overview document while of significance to the parties was not critical to the resolution of the appeal and was not the subject of scrutiny or debate by the Full Commission in the sense that it may be said to carry the approval of the Full Commission.
- The 2.5% superannuation supplement was intended to ensure that the relevant VMOs receive 7.5% superannuation. It necessarily follows that it will reduce consonantly with increases under the Superannuation Guarantee Scheme.

- The superannuation supplement is only available to those VMOs who were participating in sessional contracts at the date of the Determination and who continue to work as VMOs under an unbroken series of replacement contracts.

- Background practice costs are confirmed at $25 per hour and $15 per hour.

2.25. The decision of the Full Bench was reflected in the terms of the 1994 Sessional Determination.

1994 Determination

2.26. The features of the 1994 Determination were as follows:

(a) A standard form written service contract was to be entered into between the VMO and public health organisation;

(b) VMOs were required to engage in teaching and training activities;

(c) Loading for leave of 26.83% in lieu of the then existing 36.8% (Annual leave: 5 weeks p.a.; public holidays 2 weeks p.a.; sick leave 1 week p.a.; study and conference leave: 2 weeks p.a.; long service leave 1 week p.a.) Loading = 52 – 11 = 41.
11x 100 = 26.83%
41

(d) As a consequence of the effect of the *Superannuation Guarantee (Administration) Act* 1992 and its consequences for State Government employment, superannuation was excluded other than for VMOs with an appointment as at 1 January 2004[1];

(e) In 1976 there was provision that allowed a VMO to be reimbursed for the additional cost of travelling to another hospital other than that at which he ordinarily provided services. At the time there was no allowance for background practice costs. It was agreed that as there was now provision for BPC it should not be included separately but was a component of BPC;

(f) A record of services was to be provided by the VMO and AHS were to make payment to VMOs with 30 days of receipt of an account;

(g) VMOs were entitled to opt between remuneration methods: budgeted actual hours, specified procedures or actual hours.

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[1] The position with respect to superannuation was later amended following settlement of proceedings before the Court.

(h) Provision for an annual review of hours and in the absence of agreement regarding hours, the VMO to have the right to terminate on 4 weeks notice;

(i) Base hourly rate excluding allowances and loading – loading awarded of 36.83% (being leave loading of 26.83%, extended sessions 5%, split sessions 5%);

(j) A payment for cancelled sessions was not included (a payment was included by agreement in 1985);

(k) Hourly rates: $75.25 for GP of less than 5 years; $82 for 5 to less than 10 years; $97.75 FRACGP or 10 years; $109.50 specialist; $117.50 senior specialist;

(l) Disputes mechanism.

2.27. The Determination, Contextual Overview and Standard Form Contract were filed with the Commission.

The 2007 Determination

2.28. The features of the Determination were as follows:

(a) Professional Support for Regional Practitioners – VMOs working at regional hospitals (as defined) who provide a certain number of hours of service and/or has a defined on-call commitment and live within a certain radius of the hospital concerned, receive reimbursement for expenses associated with professional development up to $15,000 per year;

(b) Annual review of hours also included an annual review of performance;

(c) Payments for cancelled sessions in certain defined circumstances;

(d) Time limits were placed on the time within which a Local Health District must consider an application for senior specialist status;

(e) The superannuation provisions were amended to reflect the requirements of the Australian Taxation Ruling SGD 2006/2;

(f) VMOs providing a service pursuant to a call back were entitled to be paid the on-call allowance at the same time as providing service pursuant to a call back;

(g) Interest was payable on VMO payments if payments were not made by a public health organisation within 45 days of receipt of same;

(h) Public health organisations were expressly given the power to terminate a VMO's contract if conditions are imposed on the VMO's registration that preclude or substantially preclude the provision of services under the contract;

(i) Provision was made setting out the arrangements for Treasury Managed Fund professional indemnity cover for VMOs;

(j) The disputes mechanism was simplified and the timeframes tightened.

3. Fee for Service Arrangements

3.1. Until 2007 there was no Fee-for-Service Determination. VMOs working under FFS arrangements had a detailed contract which set out the terms and conditions of the VMO's appointment and contract. The contract was a 'standard for contract' for the purposes of the *Health Services Act* (and its predecessor the *Public Hospitals Act*).

1985 Doctors' Dispute

3.2. As a part of the settlement of the 1985 Doctor's Dispute, the Commonwealth agreed to meet the additional costs flowing from the introduction of fee for serve remuneration for the treatment of public patients (other than in teaching hospitals). Fee-for-serve remuneration was to be offered as follows:

(a) 85% of the Schedule Fee where there are no resident medical officers or registrars at the hospital;

(b) 70% of the Schedule Fee where a hospital has resident medical officers but not registrars;

(c) 60% of the Schedule Fee where there are registrars in same discipline at the hospital.

3.3. The choice of fee-for-service or sessional arrangements was to be available to VMOs within major country and metropolitan hospitals. The Commonwealth's contribution to the settlement provided the NSW Government with an additional $16 million per annum for payments to doctors.

3.4. These arrangements were set out in NSW Department of Health Circular 85/148 dated 31 July 1985.

3.5. In or about 1995, following the making of the 1994 Sessional Determination, AMA and NSW Department of Health negotiated amendments to the Fee-for-Service arrangements. The negotiated agreement was documented in the Agreement between the NSW Branch of the Australian Medical Association and the NSW Department of

Health ('the Agreement'). Annexed to the Agreement were an agreed standard form Fee-for-Service Contract and Fee-for-Service Contract Overview.

3.6. Under the terms of the Agreement, the fees payable to Fee-for-Service VMOs increased as follows:

(a) 95% of the Schedule Fee where there are no resident medical officers or registrars at the hospital;

(b) 80% of the Schedule Fee where a hospital has resident medical officers but not registrars;

(c) 70% of the Schedule Fee where there are registrars in same discipline at the hospital.

3.7. Fee-for-Service VMOs were required to enter into a standard form contract, and provided they did so, were entitled to be paid an additional 15% of the relevant Schedule Fee for all emergency after-hours medical services.

3.8. The Agreement provided VMOs with the right of election between three options if they were providing services exclusively in hospitals where the Rural Doctors Package applied:

(a) Fee-for-Service arrangements;

(b) Sessional arrangements; or

(c) Rural Doctors' Package arrangements that were, until the Agreement, confined to general practitioners in those hospitals.

3.9. Fee-for-service VMOs were also to be paid for administrative responsibilities in accordance with clause 4(7) and for teaching and training in accordance with clause 4(6) of the Sessional Determination for agreed hours at the total hourly rate relevant to the VMO's classification. We note that this was not reflected in the Standard form contract and was an amendment expressly made when the first Determination was issued in 2007 (see below).

3.10. The Fee-for-Service Standard form contract was, in many respects, similar to the Sessional Determination (in so far as its provisions could be applied to Fee-for-Service VMOs. For example:

(a) VMOs were required to maintain a record of services and submit same within an account for payment. VMOs were to be paid within 30 days of receipt.

(b) A VMO's services plan was to be reviewed annually.

(c) Disputes mechanism reflected the disputes mechanism under the Sessional Determination.

3.11. The main features of the 2007 Determination were as follows:

(a) At the time of the annual review, the public health organisation shall also review a VMO's service and performance, and consult the VMO regarding his or her on-call commitment and the scope of the officer's practice and the resources required to support that officer's practice.

(b) VMOs are to be remunerated for cancelled lists in certain circumstances.

(c) VMOs are entitled to be paid at sessional rates for time spent participating in teaching and training, in committee work, and for the cancellation of theatre lists.

(d) Higher rates of remuneration for regional VMOs who provide emergency after hours services.

(e) Professional Support payments on similar terms to the Sessional Determination.

(f) Should public health organisations fail to make payment to a visiting medical officer within the required time, interest shall be payable at the applicable Supreme Court rate.

(g) A public health organisation has the express right to terminate a fee-for-service visiting medical officer's contract of service if conditions are placed upon the visiting medical officer's registration such that he or she is substantially precluded from providing services under the sessional contract.

(h) Provision was made setting out the arrangements for Treasury Managed Fund cover for VMOs;

(i) The dispute mechanism was simplified and the timeframes tightened.

3.12. FFS VMOs are not entitled to superannuation as they are not deemed to be employees for the purposes of the *Superannuation Guarantee (Administration) Act* as is the case for sessional VMOs.

4. <u>Rural Doctors arrangements</u>

4.1. In 1987 rural general practitioners took action against the State Government in response to the Federal Government's announcement that the after-hours loading for GP

consultations was to be removed, and other item numbers affecting rural GPs would also be altered, including the removal of payment for ECG reading and the removal of payment for administering IV fluids.

4.2. Rural GPs outside regional centres were being paid less that their colleagues in larger towns who had been offered the option of sessional payments resulting from the 1984-1985 doctors' dispute settlement. Settlement was ultimately achieved in July 1988 and the Rural Doctors Settlement Package documented the terms of the settlement.

4.3. In or about 1995, the package was extended to apply to specialists providing services in Rural Doctor Settlement Package Hospitals.

Attachments

1. Visiting Medical Officers case 1991 - 1993: Hungerford J's Reasons for Determination

2. Visiting Medical Officers case 1991 – 1993: Appendices to the Reasons for Determination

3. Orders made by the Full Commission dated 24 December 1993

4. Reasons for the decision of the Full Commission

5. Full Commission's Speaking to Minutes of Determination and Order Statement dated 25 March 1994

6. 1994 Sessional Determination

7. Sessional Determination Contextual Overview

8. Sessional Standard Form Contract dated 1994

9. Public Hospitals (Sessional Contracts) Determination 2007

10. Terms of Settlement of the NSW Doctor's Dispute

11. Agreement between the NSW Branch of the Australian Medical Association and the NSW Department of Health

12. Fee-for-Service Standard Form Contract

13. Fee-for-Service Contextual Overview

14. Public Hospitals (Fee-for-Service Contracts) Determination 2007