ARBITRATOR APPOINTED PURSUANT TO SECTION 29L(1) OF THE PUBLIC HOSPITALS ACT 1929

VISITING MEDICAL OFFICERS CASE 1991-1993

REASONS FOR DETERMINATION

25 March 1993

TABLE OF CONTENTS

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CORAM: HUNGERFORD J.

25 March 1993

NEW SOUTH WALES BRANCH OF THE AUSTRALIAN MEDICAL ASSOCIATION v. MINISTER FOR HEALTH

Application by the New South Wales Branch of the Australian Medical Association for a determination pursuant to s.29M(1) of the Public Hospitals Act 1929 in respect of medical services provided by visiting medical officers under sessional contracts.

REASONS FOR DETERMINATION

CHAPTER 1 - INTRODUCTION

The present proceedings have involved a most extensive review of the terms and conditions for the performance of work by visiting medical officers (VMOs) under sessional contracts in providing medical services to public patients in the public hospital system of the State of New South Wales. The review was conducted before me as the Arbitrator pursuant to Pt.5C - Visiting Medical Officers of the *Public Hospitals Act* 1929 for the purpose of making a determination under s.29M(1) thereof as to the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable, in respect of medical services provided by VMOs under sessional contracts, including the date or dates on and from which any determination made shall have effect. Part 5C is reproduced as Appendix "A" to these reasons.

Application for and appointment of Arbitrator

The arbitration was initiated by the New South Wales Branch of the Australian Medical Association (the AMA) by letter dated 13 November 1990 to the Attorney-General pursuant to s.29L(1)(b) of the

Public Hospitals Act seeking the appointment of a member of the then Industrial Commission of New South Wales to be the arbitrator for the purpose of making a determination. By letter dated 15 February 1991 the Attorney-General, with the advice of the then President of the Industrial Commission, appointed me as a member of that Commission to be the Arbitrator. The Attorney-General's letter of appointment, including the AMA's application, is Appendix "B" hereto.

Preliminary proceedings - parties and appearances

On 6 March 1991 a preliminary hearing was held to receive appearances and to prepare the arbitration for hearing. The AMA and the Minister for Health (the Minister) entered appearances by their respective counsel to be heard in the proceedings in accordance with the rights given by s.29O(1) of the *Public Hospitals Act*. No other person sought leave at that stage to be represented, but on 28 October 1991 an application was made under s.29O(2) by the Doctors Reform Society of Australia (the DRS) for intervention in the proceedings for the purpose of making submissions. The intervention was opposed by the AMA but was not opposed by the Minister. For the reasons then given, which are contained at Appendix "C", leave was granted to the DRS to intervene but limited to the making of submissions in writing and speaking to them; that leave was later extended to enable the DRS to call evidence. Appearances throughout the arbitration were Mr. H.D. *Sperling* Q.C. with Ms. P.A. *Bergin* of counsel for the AMA and Mr. R.C. *Kenzie* Q.C. with Mr. M.J. *Kimber* of counsel for the Minister; the DRS was represented by Dr. T.A. *van Lieshout* who made submissions and by Mr. S. *Crawshaw* of counsel who led evidence.

The parties attended directions hearings on 20 May, 27 June and 15 July 1991 to facilitate the preparation of the arbitration for hearing, including the filing and service according to a timetable of documents setting out the determinations sought together with the grounds and

reasons in support. Those documents were quite comprehensive, and, even though the respective claims were amended later from time-to-time, I was greatly assisted by the explanations and reasons given in them in considering the issues in this case. The parties exchanged and filed further and better particulars of their cases and those particulars too were of much assistance.

Attempted conciliation

In accordance with the statutory duty cast on me as the Arbitrator under s.29M(2) of the *Public Hospitals Act* to "endeavour to bring the persons appearing ... to agreement", the AMA and the Minister, as the principal parties to the arbitration, were directed to confer. However, I was informed that no agreement could be reached notwithstanding the very many conferences held by the parties - fundamental differences in terms of principle divided them. Accordingly, I made a finding to that effect and the arbitration was programmed to commence on 12 August 1991.

Disqualification for apprehended bias rejected

In the meantime, however, the solicitors for the AMA by letter dated 9 July 1991 made an application that I should not hear and determine the proceedings on the ground of apprehended bias because I appeared as counsel for the Commonwealth Department of Health as an intervener during the previous arbitration relating to VMOs under sessional contracts conducted by Mr. Justice *Macken* in 1985. I was asked to disqualify myself and advise the Attorney-General with a request for my appointment as the Arbitrator to be withdrawn to enable another person to be appointed. Having heard the AMA on 19 July 1991 in support of its application, with the Minister adopting a neutral role by making submissions on the principles to be followed, I declined to disqualify myself for the reasons published on 2 August 1991; those

reasons are Appendix "D" hereto (see also [1991] 38 I.R. 144). The substantive hearing then commenced before me on 12 August 1991.

Present task and prior reviews

I have observed already that the proceedings involved an extensive review of the terms and conditions applicable to VMOs under sessional contracts. The last such review conducted by *Macken* J. as the Arbitrator in 1985 was much referred to and examined during the present proceedings, with his Honour having formerly made determinations under the *Public Hospitals Act* on five occasions from 1978 to 1983; prior to that, Mr. A.J. *Rogers* Q.C., as he then was, made recommendations in September 1976 following a private arbitration. The insertion of Pt.5C into the *Public Hospitals Act* to commence from 31 March 1978 established the formal means for an arbitration to be conducted enabling a determination to be made by an independent tribunal as to the remuneration and conditions to be enjoyed by VMOs. Although it may be perhaps no exaggeration to observe that the present arbitration has been the most detailed and in-depth examination ever held of the various aspects of the work and conditions of VMOs, the foundational approach and findings by Mr. *Rogers* and the later decisions by *Macken* J. have been of inestimable assistance in the task which has confronted me on this occasion.

In the result, the substantive proceedings occupied 106 days and the preliminary proceedings 5 days; the AMA called 49 witnesses and tendered 214 exhibits; the Minister called 17 witnesses and tendered 130 exhibits; the DRS called 2 witnesses and tendered 6 exhibits; and the transcript was in excess of 6,500 pages. A list of the witnesses who gave evidence is set out at Appendix "E" to these reasons. All issues between the parties were vigorously pursued by them with detailed and careful attention so that as Arbitrator I have before me, I am well satisfied, all

that could relevantly and properly be put as to the various issues. It therefore comes down to a balancing of the competing arguments advanced by counsel in terms of substantial merit and fairness in the circumstances as disclosed by the evidence; relevant also have been those matters to which I am required to have regard pursuant to s.29N(2) of the *Public Hospitals Act* as to the economic consequences of a proposed determination and the principles of wage fixation. I have endeavoured to so approach the matter.

Development of legislative scheme

Traditionally, medical services were provided in public hospitals by honorary medical practitioners who, whilst engaged in private practice, freely gave of their time and services in the treatment of public patients. It was recognised that the practitioner set the fees for private patients at a level so as to cover the honorary work and expenses incurred in relation thereto - this became known as the "Robin Hood principle." It should be remarked, however, that appointment as an honorary was generally regarded as advantageous for both the medical practitioner and the public hospital: for the honorary, he was able to have his private patients admitted to the hospital with its extensive and specialised facilities, hospital staff was available to attend to the honorary's private patients, further private patients were acquired by the honorary through the hospital's admission system, and, most importantly, appointment as an honorary represented a mark of professional approval and distinction - those benefits were considered, at least by some honoraries, to be within the "Robin Hood principle" in its wider meaning; for the public hospital, it obtained medical practitioners of advanced skill and standing, often with world-wide reputations, thus adding to the prestige and reputation of the hospital to assist in attracting private patients and high calibre resident medical and nursing staff. The honorary system also had significant

advantages for research, education and training of resident medical and nursing staff and with the honorary practitioner serving on various committees for the improved functioning and operation of the hospital. Full-time salaried medical specialists and resident medical officers were employed eventually by the public hospitals to provide services in addition to those rendered by the honoraries, and, as employees, the specialists and residents had their salaries and employment conditions determined by awards made by industrial tribunals. The honoraries, of course, were independent contractors and so outside the scope of normal industrial regulation.

The position thus obtained until Medibank as a system of national health insurance was introduced in 1975 and as part of which, but with strong objections by many honorary practitioners, it was provided that those practitioners rendering services to public patients in hospitals in an honorary capacity would henceforth be paid a sessional fee for the services so rendered by them. And so it was that the category of visiting medical officer, known as VMO, was created, although a minority of the visiting practitioners remained in an honorary capacity and still do. To give effect to the change from the honorary to the sessional fee system, the *Public Hospitals Act* was amended by the *Public Hospitals (Amendment) Act* 1978, Act No.22 of 1978, which inserted Pt.5C-Visiting Medical Officers as from 31 March 1978 (see Government Gazette No.37 of 31 March 1978, at p.109). In order to better understand the context in which Pt.5C was introduced, reference may be made to the second reading speech by the then Minister for Health, the Hon. K.J. Stewart M.L.A., as follows (*Hansard*, No.105 of 24 January 1978 at pp.11111, 11112):

> The object of this bill is to make provision in the Public Hospitals Act, 1929, for the appointment of a member of the Industrial Commission of New South Wales as an arbitrator to determine the terms and conditions of work and the rates of remuneration of medical practitioners appointed under sessional contracts to render

> medical services to hospital patients at hospitals mentioned in the second and third schedules to the Public Hospitals Act, 1929
> ...
>
> The concept of this amending legislation has been approved by the New South Wales branch of the Australian Medical Association. The arbitration provisions contained in the bill are designed to provide an acceptable method of mediation and determination with respect to the terms and conditions of work and the rates of remuneration on an hourly basis of medical practitioners who render medical services to hospital patients at incorporated hospitals and separate institutions within the meaning of the principal Act. I commend the bill to the House.

A former Minister for Health, the Hon. C. Healey M.L.A., in the same debate said (*ibid* at pp.11113, 11114):

> Historically, the bill has come into being as a result of actions that took place in the hospital services of this State in 1972 or 1973, when honorary medical officers at public hospitals decided that they would not continue to provide such services; in fact, many of them withdrew their services. As a result of Medibank coming into being in 1974 or 1975, the decision was made that doctors providing services at hospitals would be paid a sessional fee-that is a fixed fee for a certain period of time-or for a number of sessions each week in respect of each public hospital. Honourable members will remember that the medical profession displayed a great deal of concern about this proposal. Many doctors were willing to continue to provide their services to public hospitals in an honorary capacity. One section of the medical profession announced that it would not work under a system of sessional fees; it wanted a fee for services. The result was a controversy during which a number of discussions took place between this Government and federal Ministers. Also, a number of things happened within the community and the whole issue caused a great deal of concern throughout our hospital and medical services.
>
> As Minister for Health at the time, I determined that the whole question should be examined. The Health Commission of New South Wales then made certain recommendations as to the quantum of the sessional fee to be paid to doctors in respect of services given at public hospitals. The Australian Medical Association decided that those fees were not acceptable. As a result, a number of meetings were held about the matter and I attended one or two of them. However, the Australian Medical Association was adamant that it would not accept the quantum of fees suggested by the Health Commission. The former Government then decided to appoint Mr. A.J. Rogers, Q.C., to act as an independent arbitrator to determine the quantum of sessional fees to be paid to doctors giving honorary services in public hospitals. That inquiry was undertaken in April or May, 1976, but Mr. Rogers, Q.C., did not hand down his judgment until after the present Government came to office in May, 1976. Though Mr. Rogers saw things rather differently from the Health Commission, the fees that he suggested were not acceptable to the medical profession. In Sydney some doctors are still providing honorary medical services to hospitals.

> The whole question of fees to be paid to doctors for services in public hospitals has not yet been resolved.
> ...
>
> I have given the reasons why honourable members are faced with the legislation tonight. I have no objection to the legislation. I think it was a natural progression from the Rogers Q.C. hearing back in 1975-1976. It was natural that somebody should be appointed to determine the terms and conditions under which doctors in our State hospital service would work....
> ...
>
> The legislation is historic, though perhaps only in a minor way, in the sense that it enshrines a change in the payment of medical officers in State hospitals. This is the first piece of legislation, other than that provided by the Medibank legislation, which covers the payment of fees to doctors who, in the past, performed these services free. They were honorary medical officers. This legislation will bring about a complete change. That ought to go on record.

It was pursuant to the legislative scheme then enacted that *Macken* J. conducted the first arbitration in 1978. Following the 1985 arbitration, Pt.5C of the *Public Hospitals Act* was amended by the *Public Hospitals (Amendment) Act* 1986, Act No. 51 of 1986, effective from 1 July 1986 (see Government Gazette No. 99 of 27 June 1986 at p.2946) in relation to the matters to which an arbitrator shall have regard in making a proposed determination (s.29N(2)) and to provide for an appeal against a determination if the matter was of such importance that an appeal should lie (s.29QA). In moving the adoption of those measures, the then Minister for Health, the Hon. B.J. Unsworth M.L.C., explained in the second reading speech (*Hansard*, 29 April 1986 at p.2929) thus:

> I turn now to the three bills that are cognate with the Area Health Services Bill. The Public Hospitals (Amendment) Bill has two main purposes. First,... The second main purpose of the Public Hospitals (Amendment) Bill is to provide for the right of appeal against decisions of the arbitrator under section 29 (*sic*) of the Public Hospitals Act. The existing provisions of the Public Hospitals Act allow for the appointment of an arbitrator to determine matters relating to remuneration and conditions of contracts between visiting medical practitioners and public hospitals. The determinations of the arbitrator have major implications for the provision of medical services in public hospitals, both now and in the future.
>
> The provisions of this bill overcome the most unusual feature of the existing legislation which limits any appeal from the determination. The bill will permit either recognized party to the arbitration, the

Health Administration Corporation and the State branch of the Australian Medical Association, to appeal against the determination. The proposed amendment will not allow for frivolous appeals which could delay implementation of a determination. The bill also contains provisions that will require the arbitrator to consider the economic consequences of any proposed determination and have regard to the prevailing principles of wage fixation. As I mentioned earlier when dealing with the Area Health Services Bill, the proposed amendments to the Public Hospitals Act also incorporate constraints on the regulation and by-law making powers in respect of public hospitals. As with regulations and by-laws affecting area health services, a regulation or by-law relating to public hospitals will, if inconsistent with an agreement between a public hospital and visiting practitioner, have no force or effect to the extent of any inconsistency with any agreement existing between the parties. This means that no government or public hospital can, under this legislation, unilaterally change any agreement existing between public hospitals and visiting practitioners.

Essential differences between the parties

The wide scope of the present review was necessary by reason of the nature and extent of the claims made by the parties. On the one hand, the AMA sought a new determination based on the concepts and framework established by *Macken* J. in December 1985, but with substantial increases in the hourly remuneration payable for the services performed by VMOs and in the allowance for background practice costs: the increases claimed in the normal hourly sessional rate ranged from 41.5 percent ($63.00 to $89.10 per hour) for a general practitioner with less than five years' experience to 40.4 percent ($110.50 to $155.10 per hour) for a senior specialist; the increases claimed for background practice costs were respectively 150 percent ($20.00 to $50.00 per hour) and 166.6 percent ($25.00 to $66.66 per hour); and the combination of those amounts by adding background practice costs to the normal hourly sessional rate resulted in claimed increases in the total hourly sessional rate of respectively 67.6 percent ($83.00 to $139.10 per hour) and 63.6 percent ($135.50 to $221.76 per hour). On the other hand, the Minister mounted a most comprehensive and detailed case for a complete re-structuring of the terms and conditions under which VMOs were engaged: that involved a

not insignificant reduction in actual rates of remuneration, loadings and allowances, including the conditions for which allowances for on-call, call-back and background practice costs were paid, a revised formulation for ordinary sessional hours, and various measures to enable necessary structural efficiencies to be implemented.

Essentially, the difference between the parties was that the AMA accepted as appropriate and reasonable the determination when made by *Macken* J. in December 1985 and sought merely to bring it up-to-date by reflecting certain alleged changes which had occurred during the last seven years and so as to reflect current money values. The Minister, however, challenged the very basis on which his Honour acted in 1985 in terms of principle and merit and sought a new determination correcting the errors said to be made by his Honour, including the consequent anomalies, so as to provide a fair and reasonable assessment in current terms of the conditions applicable to VMOs for their sessional work.

It may be noted, as was pointed out for the Minister, that the 1985 determination granted a general practitioner with less than five years' experience an increase in the normal hourly sessional rate (including the loading of 49.3 percent to compensate for superannuation, split sessions and unpaid leave) of 92.85 percent ($28.00 to $54.00 per hour) and an increase of 655 percent ($2.65 to $20.00 per hour) for background practice costs; for a senior specialist the respective increases granted were 88.00 percent ($50.00 to $94.00 per hour) and 616 percent ($3.49 to $25.00 per hour); a combination of those increases resulted in an increase in the total hourly sessional rate for a general practitioner with less than five years' experience of 141.43 percent ($30.65 to $74.00 per hour) and for a senior specialist of 122.47 percent ($53.49 to $119.00 per hour). The on-call allowance for a senior specialist was increased by the 1985 determination by 437.15 percent, that is from $1.75 to $9.40 per hour.

Emphasis was placed too by the Minister on the alleged anomalies in the 1985 determination resulting in substantial increases in on-call and call-back payments to VMOs following the interpretation of the determination by *Hodgson* J. in the Supreme Court of New South Wales in *Hyslop v. The Liverpool Hospital*([1987] 21 I.R. 192) as affirmed by the Court of Appeal (*Kirby* P., *Hope* and *Samuels* JJ.A.) in *The Liverpool Hospital v. Hyslop (No.1)*(unreported, C.A. 87/275 of 18 May 1988); the Court there held that a VMO was entitled to payment of the on-call allowance and the background practice costs allowance during a period when medical services were rendered by the VMO on a call-back in addition to the normal hourly sessional rate and call-back loading.

The increases were said to be manifestly excessive, and contrary to proper principle and merit so as to be unsafe on which to base a new determination.

Specific criticism was directed also at the inclusion by the 1985 determination of the so called "Medicare effect" loading in the normal hourly sessional rate so as to wrongly attract the 49.3 percent loading, and the inclusion of such a "Medicare effect" loading as being pure income maintenance - the quantum of the loading as fixed by *Macken* J. was said, in any event, to be excessive and led directly to the large increases in remuneration contrary to what was reasonable.

Further criticism of particular strength was directed by the Minister at the inclusion in the 1985 determination of an automatic, but erroneous, mechanism for adjusting the normal hourly sessional rates following increases in the basic wage. As was held by *Bryson* J. in the Supreme Court ([1988] 25 I.R. 280), and upheld by the Court of Appeal (*Kirby* P., *Hope* and *Samuels* JJ.A.) in *The Liverpool Hospital v. Hyslop (No.2)*([1989] 27 I.R. 104), the true meaning of the remuneration adjustment clause in the 1985 determination required the percentage

increase in the weekly basic wage determined by the Industrial Commission of New South Wales under s.57 of the then *Industrial Arbitration Act* 1940 to be applied so as to increase the hourly rates of remuneration for VMOs by the same percentage figure. The result was that the formula in the 1985 determination gave a VMO classified as a senior specialist a total increase of $14.50 per hour, with proportionate but lower money increases for the other classifications of VMO, following two flat-amount increases in the basic wage of $10.00 per week from the *State Wage Case March 1987* ([1987] A.R. (N.S.W.) 93;[1987] 17 I.R. 105) and $6.00 per week from the *State Wage Case February 1988* ([1988] 23 I.R. 340). On the basis of a 38-hour week it was said that a VMO should have received from the two *State Wage Cases* an amount of 42 cents per hour, like employees under industrial awards, whereas a VMO senior specialist received $14.50 per hour, that is, a full-time weekly equivalent of $551.00 when the basic wage was increased by only $16.00 per week. The 1985 determination was, it was said for the Minister, therefore unjust and should be corrected.

The DRS made the basic submission that the logic implicit in the Minister's claim for a new determination was reasonable and should be accepted, except that for industrial reasons current VMO rates of remuneration should be "frozen" until such time as award rates for employed staff specialists and career medical officers "catch-up" to the VMO determination rates. Generally, the DRS put that the AMA's claim should not be granted because of the economic consequences, deleterious effect on patient care, comparisons with VMO remuneration and conditions in other States, and the principles of wage fixation.

The above outline of the parties' respective positions and attitudes towards the 1985 determination is somewhat superficial, but hopefully it

at least identifies some of the more significant points of concern. Later, as to each point, it will be necessary to examine the issues in some depth.

Much of the argument necessarily involved economic considerations and the cost to the State of payments to VMOs for their services against the background of industrial equity, and bearing in mind that VMOs were independent contractors and not employees.

Economic and cost considerations

Material relied upon for the Minister disclosed that for the year ended 30 June 1991 the actual payments to VMOs under sessional contracts amounted to $157.5 million out of a total health budget for that same year of $4.294 billion which was itself around 28 percent of the State's total budget. The cost of the AMA's claim was calculated at $76 - $80 million per annum in the year of implementation and thereafter that cost plus an amount of $11.1 million per annum in respect of cost escalation for a total of around $87 - $90 million per annum; that represented a 55 percent increase on the existing base of $157.5 million per annum. In addition, repercussive effects were envisaged in the payments presently made to VMOs under fee-for-service contracts and lump-sum contracts which, for the year ended 30 June 1991, stood at $54.5 million and $6.5 million respectively. It was put for the Minister that the present health budget was committed to deliver health services throughout the State and no internal scope existed to provide $87 - $90 million to fund the AMA's claim without seriously impacting services.

Evidence led for the AMA countered those cost implications by suggesting that the need to reduce the State's debt as a constraint on public sector expenditures may have been exaggerated, that there was a strong case for Commonwealth Government augmentation of funding, and of health funding in particular, and that the cost of the AMA's claim had been exaggerated.

As to the impact on VMO costs of the 1985 determination, which took effect on and from 1 January 1986, the figures in the Minister's evidence disclosed an increase in expenditure from around $50 million for the year ended 30 June 1985 to $200 million for the year ended 30 June 1989; the conclusion was reached that in the year 1991-92, and since the year 1988-89, the State Government has been required to fund around $150 million extra per annum to remunerate VMOs under sessional contracts.

Report of Public Accounts Committee re payments to VMOs - Parliamentary privilege

In June 1989, a committee of the Legislative Assembly of New South Wales known as the Public Accounts Committee published Report No.45 into payments to VMOs. The Report was based upon evidence and submissions from various interested and concerned persons and organisations, and contained facts, opinions and recommendations relating to the general subject matter of payments to VMOs. The Minister through his counsel tendered the Report into evidence in the arbitration on 11 February 1992 for two purposes: firstly, as an event; and, secondly, as evidence of the truth of the facts and correctness of the opinions stated in it. The AMA through its counsel objected most strongly to the tender on a number of grounds, including procedural unfairness, and submitted that it would be necessary in making out the grounds for it to examine and comment upon the contents of the Report in such a way as might be considered critical of the reasoning, opinions, findings, conclusions and procedures of the Public Accounts Committee. The tender was pressed. The relevance of the Report to the subject matter of this arbitration was clearly established. However, having formed the view that the privileges of the Parliament may well be involved to preclude the admission of the Report into evidence, arrangements were made to determine that as a

separate issue so as to enable the arbitration to proceed in a timely and orderly way.

After having the benefit of submissions by Mr. K. *Mason* Q.C., Solicitor-General, as *amicus curiae*, by Mr. G.W. *Booth*, Assistant Crown Solicitor for the Speaker of the Legislative Assembly, and by Mr. *Kenzie* and by Mr. *Sperling*, I ruled on 11 March 1992, for the reasons then given as contained at Appendix "F" hereto (see also at (1992) 26 N.S.W.L.R. 114; [1992] 40 I.R. 135), that the Report could be admitted into evidence, if otherwise admissible, as evidence of an event and thus as not infringing Parliamentary privilege; the Report, however, was rejected from evidence for the purposes of establishing the facts and opinions contained in it as being contrary to Parliamentary privilege. The Report was then received into evidence on the Minister's application on the limited basis. The use to which the Report was sought to be put by the Minister in the arbitration was stated by me in the reasons thus (*ibid* at 126):

> It was made plain by counsel that the eventual issue for determination on this point in the arbitration was the assertion by the AMA that since the 1985 determination was made by *Macken* J. there have been no relevant problems for some seven years which would require corrective action in any future determination I might make. The Minister joins issue with that proposition and seeks to show, including by reliance on the PAC Report, that problems have existed in that seven year period which the PAC Report will disclose as relevant objective events. I accept that as a legitimate and proper approach, and as not involving an infringement of Parliamentary privilege, because there can be no concern that the motives or intentions or reasoning of the Committee will be questioned or held against its members. The basis then for the tender of the PAC Report for this first and limited purpose as an event is, in my view, unobjectionable and no breach of Parliamentary privilege.

Savings and transitional provisions

My original appointment as Arbitrator on 15 February 1991 was as a member of the former Industrial Commission of New South Wales as constituted under the then *Industrial Arbitration Act* 1940 (the 1940 Act). The substantive hearing of the arbitration commenced on 12 August 1991

and was part-heard when 31 March 1992 was proclaimed as the appointed day on which the *Industrial Relations Act* 1991 (the 1991 Act) was to commence: see Government Gazette No. 40 of 27 March 1992 at p. 1978. The 1991 Act repealed the 1940 Act, including the abolition of the Industrial Commission and its replacement by the Industrial Court of New South Wales and the Industrial Relations Commission of New South Wales. The 1991 Act relevantly provided in cl. 4 of Sch. 2 - Savings, Transitional and Other Provisions, as follows:

> 4.On the appointed day:
>
> (a) ...
>
> ...
>
> (c) a person holding office as any other judicial member of the former Industrial Commission immediately before that day is taken to be appointed as a Judge of the Industrial Court (other than Chief Judge or Deputy Chief Judge) and as a Deputy President of the new Commission;
>
> ...

Clause 2(1) of the said Sch. 2 to the 1991 Act provided that "(t)he regulations may make provision of a savings or transitional nature consequent on the enactment of this Act". The Industrial Relations Regulation 1992, which commenced on the commencement of the 1991 Act (Government Gazette No. 40 of 27 March 1992 at p. 1998), contained the following savings clause with respect to arbitrators under the *Public Hospitals Act*:

> **Savings with respect to arbitrators under Public Hospitals Act 1929**
>
> **126.(1)** In this Clause:
>
> **"arbitrator"** means a person appointed as an arbitrator under Part 5C of the Public Hospitals Act 1929 (Visiting medical officers).
>
> (2) The enactment of the Industrial Relations Act 1991 does not affect:
>
> (a) the appointment of an arbitrator holding office on the commencement of that Act; or

(b) any proceedings pending, on the commencement of that Act, before an arbitrator under Part 5C of the Public Hospitals Act 1929 or anything done by an arbitrator before that commencement.

(3) A reference in Part 5C of the Public Hospitals Act 1929 to:

(a) the Industrial Commission of New South Wales or a member of that Commission is to be read as a reference to the Industrial Relations Commission or a member of that Commission; or

(b) the Industrial Commission in court session is to be read as a reference to the Full Industrial Relations Commission; or

(c) section 57 of the Industrial Arbitration Act 1940 is to be read as a reference to section 14 of the Industrial Relations Act 1991; or

(d) section 14(8)(b) of the Industrial Arbitration Act 1940 is to be read as a reference to section 382 of the Industrial Relations Act 1991.

Accordingly, as a member of the newly created Industrial Relations Commission, I regarded my appointment as Arbitrator as unaffected by the enactment of the 1991 Act so as to enable me to continue the arbitration and make a determination. The hearing therefore proceeded until its conclusion on 6 November 1992 when the decision was reserved.

Acknowledgement

I would wish immediately to express my gratitude to counsel and to those instructing them for the assistance and ready co-operation given in conducting what was clearly a major arbitration, with its own peculiarities and complexities, and with significant public interest implications.

A detailed consideration of the various issues calling for decision follows.

CHAPTER 2 - THE CLAIMS AND THEIR RATIONALE

The inability of the AMA and the Minister to resolve many of the issues between them was said earlier to be due to a fundamental difference of principle. It is of no mere passing relevance to emphasise that because it is helpful in an understanding of the nature and extent of the respective claims. In a real sense they are almost at opposite ends of the spectrum. However, placed somewhere between the claims are the provisions of the existing determination made seven years ago in 1985, relied upon by the AMA to base its present claims but seriously challenged by the Minister as being fundamentally flawed, and as containing anomalies and errors so as to be unsafe on which to base consideration of any new determination. It is necessary, therefore, to view the respective claims and their rationale against the provisions of the existing determination.

Provisions of 1985 determination

Set out as Appendix "G" hereto is a copy of the determination made by *Macken* J. on 19 December 1985. The provisions of that determination, other than those in cl.9, Ordinary Remuneration setting out the normal hourly rates payable under a sessional contract, are those currently applicable to VMOs engaged on a sessional basis. By reason of the remuneration adjustment provisions of cl.9 referable to a basic wage adjustment following a decision of the Industrial Commission in Court Session in a *State Wage Case*, the current normal hourly rates for the classifications of VMO set out in cl.9 are respectively $63.00, $71.00, $88.50, $102.50 and $110.50.

The AMA's approach

The original application by the AMA sought a new determination for terms and conditions to be as specified in the existing 1985 determination but with "the rates in the determination increased by such

amounts as to the arbitrator shall seem fit" (see Appendix "B"). During the preliminary proceedings, Mr. *Sperling* outlined the scope of the AMA's claim as follows:

> SPERLING: Your Honour, we have noticed the schedule to the request for the appointment of an arbitrator that what is said by the Australian Medical Association on behalf of visiting medical officers is that there should be determination pursuant to the statute incorporating the terms and conditions which are already in existence under the determination of Macken J. made in 1985 subject to a review of the rates which appeared in that determination.
>
> Historically, your Honour two things have happened, perhaps three things have happened since 1985 which are of particular importance and I do not mean to be exhaustive, the indexation clause by which rates have been adjusted under Macken J's determination ceases to operate in view of a different way in which National Wage Cases determined the matter which fell there to be considered.
>
> In the interim staff specialists who performed virtually the same work as visiting medical officers have enjoyed an increase in award rates of something in the order of 50 percent and also during the interim there have been substantial changes in the nature of the work carried out by visiting medical officers which provides the basis for work value approach to any reassessment.
>
> Your Honour, the association is anxious to bring on for hearing a determination of the rates as soon as may be practicable. I should mention there are just two exceptions to the terms and conditions of Macken J's determination which we would have in mind to ask to be modified. They are obviously the indexation clause and secondly there is a disputes resolution provision in the determination which has been found in practice for many years to be unworkable and the opportunity is to be sought to bring that into line with more modern arbitral provisions but these matters I mentioned for completeness.

The grounds upon which the AMA relied to support its case were stated thus:

1. Remuneration for work done under sessional contracts should not be less than the corresponding remuneration paid for the same or similar work to staff specialists under award provisions approved by the NSW Industrial Commission. It is less.

2. The remuneration for work by Visiting Medical Officers should be higher than for staff specialists, by reason of the characteristics of engagement as a Visiting Medical Officer, including the part-time nature of the engagement, the relative lack of security of tenure and security of volume of

work, and the additional stresses involved in providing services in the context of a private practice.

3. The remuneration under sessional contracts should be reviewed in the light of changes in work value.

4. The component for background practice costs should accord with the current level of such costs. It does not.

5. The rates under sessional contracts, including those under the 1985 Determination have been less than true value, in consideration of so-called "privileges". Such "privileges" have depreciated since 1985 by reason of a decline in and access to facilities in public hospitals, difficulties in obtaining admissions for elective treatment, restriction of admissions for budgetary reasons and a further shift away from private insurance to dependence on the public health system.

6. The remuneration under sessional contracts determined by Mr. Justice Macken in 1985 should be reviewed having regard to events which have occurred since that time; in particular, the increase in remuneration under fee-for-service contracts, the increase in remuneration of staff specialists, the current level of background practice costs and the further matters referred to in foregoing paragraphs.

7. There should be a new Indexation clause, the existing clause having ceased to operate.

8. There should be a new Disputes clause, the existing clause having proved to be unworkable.

The AMA's claim was amended during the hearing from time-to-time, and its final form is reproduced as Appendix "H" to these reasons. It will be seen that the claim as finally pressed, by comparison with the original claim, sought changes beyond increased rates of remuneration and revised indexation and disputes settlement clauses, although essentially the form and structure of the 1985 determination was sought to be retained. Apart from matters of remuneration (which cover ordinary hourly sessional rates, background practice costs, on-call and call-back payments, payment for cancelled sessions, travelling expense allowance, committee work, public holiday payment and indexation of rates) the AMA sought changes to various conditions-type matters, namely the definition of a "senior specialist", automatic entitlement to classification as a senior

specialist on the effluxion of time only, deletion of any reference to "clinical privileges", a more specific and detailed provision for the method and time of payment of remuneration, more definitive provisions regarding suspension and termination of a sessional contract, additional provisions as to unpaid absence, a revised settlement of disputes clause and a confidentiality provision to prevent publication of the actual remuneration paid or payable to a VMO except under certain specified conditions. The changes sought were quite detailed and it is not really convenient to attempt here to specify them, rather it is preferable to deal with them later each as a separate matter when it can be analysed as part of the total argument put for that matter. Nevertheless, and as a general observation, the issues raised by the AMA's claim as to both remuneration and conditions of work involved significant improvements in benefits for VMOs over and above what might be thought to be the somewhat generous improvements obtained by them from the 1985 determination.

The Minister's approach

The specific determination claimed by the Minister was made available during the preliminary proceedings, together with the grounds and reasons in support of it. It was immediately apparent that the Minister sought a wholesale re-structuring of the existing determination in almost every respect. Particulars of each of the provisions claimed were filed, and, although impracticable to set them out here, it is helpful I think to state the general grounds relied upon by the Minister in support of the proposed determination, as follows:

> A. The Public Hospitals Act 1929 as amended (Section 29M(1)(a)) requires that the Arbitrator determine the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable, in respect of medical services provided by Visiting Medical Officers under sessional contracts.
>
> B. It is consistent with the provisions of the Public Hospitals Act that the determination include the actual terms and

conditions under which Visiting Medical Officers will work pursuant to sessional contracts.

C. It is desirable and in the public interest that this be done, especially in light of the difficulties encountered (particularly since 1985) in the translation of determination provisions into enforceable contractual terms applying between Visiting Medical Officers and Area Health Services and hospitals.

D. The incorporation of the terms and conditions of work into the arbitrated determination will facilitate the resolution of disputes between individual Visiting Medical Officers and Area Health Services/Hospitals, particularly in relation to matters of interpretation, without the need to lodge a fresh application for determination by arbitration pursuant to the Public Hospitals Act.

E. The existing remuneration structure contains the following vices that must be addressed in the interests of fairness, equity, proper accountability, ease of administration and budgeting and overall achievement of greater structural efficiency.

(a) Vices arising from determinations prior to 1985

1. Double counting in claiming private practice component (allowed in 1979) when this was already a factor in the 1976 determination. (See Rogers determination at page 48.1).

2. Double counting in claiming private practice expenses in circumstances where private medical fees have historically been set at a level designed to cover these expenses and leave a reasonable nett average hourly earning rate. (See Rogers determination at page 14.6 - 15.2 and 16.7 - 20.3 - especially 19.1).

3. Loss of control on the part of hospital administration as a result of the introduction of clause 6(h) in 1983 and the use of this provision by the majority of VMOs thereafter, especially following the decision in 1985, thus further reducing capacity to manage costs and undermining the formula for maintaining control otherwise found in the Determination.

(b) Vices in the 1985 determination

1. The Medicare Effect - double counting in including a Medicare Effect loading as part of the normal hourly rate when that rate is tied to the Award Staff Specialist (see transcript of proceedings pages 636-7 and 639-641).

2. The granting of a Medicare Effect loading in any event. The loading appears to be based upon principles of income maintenance and nothing else. The loading has been providing benefits for six years to an ever increasing proportion of VMOs who were not affected by any alleged impact of the introduction of Medicare.

3. Providing that the Medicare Effect loading is to be included as a component of the normal hourly rate - that is before the relevant percentages for superannuation, leave and extended/split sessions loadings are added to give a base hourly rate. This has the effect that the loading granted for the Medicare Effect is compounded by a margin of approximately 50%. This compounded figure then finds its way into both callback and oncall allowances per median of their being expressed as percentages of the normal hourly rate.

4. Providing that the Medicare Effect loading was to be scaled (ie instead of awarded as a flat sum) see Public Accounts Committee - Report on Payments to Visiting Medical Officers (hereinafter referred to as "the PAC Report") Table 5.1 and page 82. This has a further compounding effect. (See Macken J pages 17.5 - 18.5 - refusing to grant the loading as a flat sum for all classifications on the assumption that the loss attributable to Medicare Effect bears upon a particular classification or classifications more than it does to others).

5. The conversion of the previously awarded nominal private practice loading (granted notwithstanding the fact that Macken J had regarded the case as not being made out in 1979) into a substantial dollar sum:

   (i) on the basis of evidence before the Tribunal which was not sufficiently scrutinised;

   (ii) without regard to whether the rates awarded represented costs incurred as a result of performing a sessional contract;

   (iii) without any regard to the double counting effect earlier raised by Rogers QC.

6. Converting the on call allowance back into a percentage and increasing the on call allowance from $20.86 for the first 12 hours and $1.75 per hour thereafter to 10% of the base hourly rate - that is the rate being fully loaded subject only to private practice component. This decision:

   (i) ignores the fact that the on call allowance is a disability allowance not related in theory to an hourly rate.

   (ii) results in a compounding when the on call allowance is paid as a percentage of the base hourly rate (ie $94 in the case of a Senior Specialist at the time of the 1985 determination).

   (iii) massively increased the level of costs of on call payments (see the PAC report page 52).

(iv) contrary to the stated intention of the arbitrator at page 29.9, did not bring the VMOs "in line with" senior specialists employed under Award. (See page 100 of the PAC Report and - as to the lack of equity in fact achieved see paragraph 5.76). Macken J was attempting to achieve a like result to that of Senior Specialists paid, inter alia, for being on call at all times. Given the differential in wage rates between staff specialists and VMOs this result could only be achieved if based on an assumption such as that appearing at paragraph 5.79 (page 101.8) of the PAC report - that is on the basis of an assumption that VMOs would only be on call for something less than 40 days per year.

(v) obviously did not take into account the effect of such significant increases in the on call rate on decisions by VMOs to appear (or remain) on a hospital's on call roster, and their consequential resistance to attempts by hospitals to readjust rosters in the interests of greater efficiency;

(vi) resulted in a complete absence of any proper or proportional relationship between the cost of having VMOs on call and the services provided to hospitals by callbacks. (ie no value for money)

7. Call back allowance - although Macken J did not alter the call back loading (previously fixed at 10% for ordinary hours and 25% for other hours) anomalies result from his decision re call back in that:-

(i) the percentages (though unchanged) are now calculated on the rate including the Medicare Effect - having results similar to those seen in the on call loading; and

(ii) at page 31.9 of the decision Macken J provided that in effect a call back would be deemed to have occurred unless queried by the hospital administration. This had the effect of placing VMOs in the situation where they were able to determine the applicability of the call back provision with the hospital administration only retaining some ex post facto rights of review.

8. Background Practice Costs were increased from a nominal sum fixed in 1979 to a substantial figure. This decision:

(i) was given in circumstances where lip service only was paid to the Rogers QC determination - ie. no reference at all was made to the fact that the private practice component was taken into account by Rogers QC in making the determination (Macken J at 21.2);

(ii) ignored the principle really established by Macken J himself in 1979 in which he accepted that it was legitimate that the public purse should bear such background private practice costs which result from the performance of work under sessional contract (decision page 21.9).

(iii) in any event ignored the fact that the AMA evidence consisted mainly of the results of surveys conducted in 1976 and 1978 and updated to 1985 values and gave inadequate recognition to changes since the mid 1970s impacting on cost including growing incidence of sharing of premises as between medical practitioners and the fact that some specialists, eg. anaesthetists have minimal background practice costs; and

(iv) ignored or undervalued the significant benefits gained by VMO's from working in public hospitals - eg no facility charges for treating patients and other intangible benefits.

9. Generally the 1985 determination granted significant increases to VMOs, undermining the utility of the structure then in place and highlighting the other inadequacies of the existing structure, in particular with respect to record keeping and accountability in general.

(c) Vices appearing after the 1985 determination

1. The interpretation of the 1985 determination by the Court of Appeal as requiring simultaneous payment for call back hours and on call hours (See the PAC Report pages 106 - 108). This interpretation - (which depended upon the proposition that, while the 1985 determination re-introduced the pre 1981 concept of on call payment being 1/10th of the hourly rate, it did not re-introduce the pre 1981 provision which made it clear that the on call payment was not to be paid during periods for which the VMO was being paid for a call back - an expressio unius type of argument) is contrary to the proposition that on call and call back are mutually exclusive.

2. The interpretation by the Supreme Court of Macken J's determination to the effect that the call back payment picks up the background practice costs. (see PAC report pages 112 - 113 and pages 202-3).

Under the determination the minimum call back payment (in the case of a Senior Specialist between 8.00a.m and 6.00p.m. Monday to Friday) is $137.52 (namely $103.40 being call back payment with a minimum of 1 hour $94.00 plus 10%) plus $34.12 representing call back travelling time payment being

20 minutes (1/3rd of $94. plus 10 %). The private practice loading is then calculated including a 20 minute component for travelling time. On top of this the on call allowance is paid for a period again including travelling time. The anomalous result is that travelling time is included as part of the minimal rate for call back, it is included as a component of the private practice loading and it is also included as a component of the on call allowance.

The position is similar for a call back between 6.00p.m. and 8.00a.m. save that the loading is 25% and not 10 % (see page 203 of the PAC report).

3. The decision of the Supreme Court that the 1987 National Wage increase of $10 per week be directly reflected in a change in the base hourly rate for VMOs with a consequent increase in the ordinary remuneration rate from $33 (granted by Macken J in 1985) to $36.30 rather than $33.25 - a figure which is then further compounded in the ways earlier explained and gives rise to further significant increases in remuneration.

F. The determination sought by the Minister incorporating the proposed sessional contract for Visiting Medical Officers, addresses and remedies the above mentioned vices and:-

(a) achieves the objectives set out in paragraph E above; and

(b) gives effect to or otherwise addresses significant recommendations of the PAC Committee.

G. The determination and proposed sessional contract are consistent with the statutory requirements found in Section 29N(2) of the Public Hospitals Act, 1929 as amended requiring the arbitrator, in making a determination, to have regard (inter alia) to the economic consequences of the proposed determination and the principles of wage fixation for the time being adopted by the Industrial Commission of New South Wales.

H. The determination and draft sessional contract will provide for certainty and consistency of treatment for Visiting Medical Officers as from the date of operation.

I. The determination and proposed sessional contract will obviate the need for recourse to courts of law or equity as a means of dispute resolution, giving rise to attendant cost savings and the finalisation of disputes in an appropriate context.

J. Such further and other grounds as seem just to the arbitrator.

Although the Minister's claim was amended during the hearing, the thrust remained consistent throughout as being to overcome alleged vices arising from the determination made in 1985 and so as to achieve the

objectives "of fairness, equity, proper accountability, ease of administration and budgeting and overall achievement of greater structural efficiency".

In opening the Minister's case, Mr. *Kenzie* outlined the position in this way:

> Quite apart from all of that the Minister will say that the conclusions reached in the 1985 determination are either so flawed or, alternatively, based on such uncertain foundations that the 1985 determination could not be regarded as any sort of foundation or platform to set up presumptions for the purposes of this arbitration.
>
> This is certainly so in the important area of remuneration, and we will shortly come to the 1985 determination and tell your Honour why we put those submissions. In any event, the Minister will say that the prescription sought by the Minister, as opposed to what I will call colloquially the Macken update as sought by the AMA, in fact, is a fairer, more suitable one for the 1990's and more in tune with the legislative requirements, as well as being more in tune with the relative position of other branches of medical practice - for example, staff specialists in New South Wales and visiting medical officers round Australia.
>
> We will submit that you are really required to consider the scheme put before you by the parties, including the scheme put before you by the Minister, and decide whether that scheme is appropriate as the subject of a determination, regardless of the fact that particular clauses in the current 1985 determination are either not squarely attacked or are not shown themselves to have been specifically the subject of problems - in other words, you would not reject the new scheme which invited an approach suitable for the 1990's simply because, when you look at the old scheme, you saw no problem with clause 19(5) or 21(6) or the like.
>
> It is true to say in our case we do not attack each and every part of the determination; but it is rather a new scheme. There are certain parts of the old determination, very important parts, which we do attack or would attack if we had to.
> ...
>
> It is a clean slate and a new determination although it picks up - in some clauses you will find it reflects the existing determination; but as a package, as it were, it is a new package. It changes in very real respects the system under the 1985 determination and designedly so and proceeds on the basis that your Honour would look at that and form the view as to whether the existing determination is a determination that should be made or, alternatively, the Minister's determination.
>
> If your Honour thought the Minister's determination was one which was more suitable your Honour would make that and your Honour would not decline to make that determination simply because there

was no evidence that clause (a) or (b) of the former one was hopelessly flawed. The task is a forward looking task. It is not a backward looking task.

You do not approach it by saying - have a look at the 1985 determination; can I find anything wrong with the accountability clause, and the like; and because I cannot - well, I am going to leave it there. The approach is a more general one than that; and apart from anything else the question which the arbitrator is now required to ask is a different question from that which the arbitrator was required to ask in 1985 or 1983, and by that I mean that in this arbitration the arbitrator is specifically directed to matters which have to be addressed in the determination.

They are not matters which were required to be addressed in earlier determinations, and in the 1985 determination they were said to be matters which it was really difficult to address in any real sense. So the question addressed by the arbitrator was different and, in any event, the legislative changes required you to take a fresh approach.

...

...the alternative is to say - look at 1985 and then you ask whether the components of that were reasonably put forward and reasonably taken account of and ask the question as to whether the 1985 determination was valid or apparently valid on its face in a sense that it was based upon material properly put before the arbitrator and represented a decision that was open to the arbitration on the face of the evidence, however generous or ungenerous it might have appeared to be; and then you move forward.

You move forward by unloading your components so far as is necessary or building upon them by work value, State wage increases insofar as they have not been forthcoming, special case considerations if appropriate and fresh evidence perhaps; and then you see if you can rebuild the rate, having regard to the fact that in 1991 there is the additional complication specifically being directed towards the economic consequences of the determination. So you can go through that series of steps and you wind up in 1991 saying - well, yes, build it up, carry it all forward and you get to X result.

The alternative, of course, is to say - well, look, what is the appropriate rate on the basis of evidence which is going to be adduced before me in these proceedings as to the rate in 1991?

Now, our approach both in relation to remuneration and structure is the latter. Our friend is riding two horses. We say that it is only necessary to go back and look at the other horse - that is, the 1985 determination as progressed forward through time, if our friend has no case under the 1991 approach.

If his approach under the 1991 formulations is correct - well, he has got no need, and neither has anyone else, to go back and go through the tortuous, agonising and no doubt hotly contested process of seeing whether Mr Justice Macken was entitled to full review that he did in 1985 to try to work out what the Medicare effect was, what it meant, why it was done the way it was done in the determination,

whether it should be maintained, whether it should be varied having regard either to the unsatisfactory nature of the reason, if established, or as affected by the legislation and so on.

Our friend's case is our friend's case, and he wants to ride two horses. We have seriously considered the question of whether there is some means within the arbitrator's present power to separate the two horses so that a sensible analysis can be made of what should happen today without going back to the past; and it is certainly something which our friend knows and which you should know we have under active consideration.

However, we cannot compel my friend as to how to run this case. It may be, and the likelihood is, as presently advised, that notwithstanding what we have to say about the appropriate course you will be taken back to 1985 and invited to bring the matter forward. We say that is an entirely unnecessary exercise because if our friend is right in 1991, then he is right. If he is wrong in 1991 it would not matter, in our respectful submission, whether he had ten Mr Justice Macken decisions based on a different statute which were all right then, but which would lead to a result which could not be substantiated under the present statute.

It would not matter because the arbitrator, in our respectful submission, would be bound to say - that is all right; but you have got to come back to 1991 and the present day. Now, like a lot of things in this case, this is not easy.

The Minister's final claim, incorporating various amendments made during the hearing, is contained at Appendix "I" hereto.

Issues joined

Notwithstanding previous unsuccessful attempts during the preliminary stages of the arbitration, a further endeavour was made at the commencement of the hearing to bring the parties to an agreement in whole or in part - that further endeavour also was unsuccessful. What was agreed, as senior counsel said, was - "I believe I can assure your Honour that there is nothing your Honour can do at this stage either actively or by allowing further time which would serve any purpose in relation to section 29M, subsection 2.... we believe it would be best if the matter were to proceed at this stage." And so the hearing proceeded.

It seems apparent to me that fundamentally the Minister was seeking in relation to remuneration for VMOs and the structure of a new determination as to conditions that a package approach should be adopted

on the basis of the evidence adduced as to appropriate provisions at this time and looking to the future. The AMA, on the other hand, mainly approached the task by relying on the 1985 determination as a base and building on it to overcome any problems which had emerged in the meantime and to meet changes which had occurred. In a sense then, the Minister's approach made it unnecessary to examine the circumstances and reasoning leading to the 1985 determination and what that determination provided, whereas the AMA's approach required that that exercise be undertaken. Of course, and as Mr. *Kenzie* suggested, going back to 1985 in a re-examination of the issues then current would require much additional time and effort in the present proceedings which might otherwise be thought to be unproductive, and, in the way these proceedings have gone ahead, the 1985 determination has been very much debated. However, and in fairness to the course adopted by Mr. *Sperling*, it seems to me that a consideration of the 1985 determination and its circumstances, to some extent at least, was necessary because there can be no doubt that in a consideration at this time of an appropriate determination for VMOs that the terms and conditions which have existed for seven years must be of relevance.

As to the 1985 determination, Mr. *Sperling* said in opening the AMA's case:

> There has been a refraining from including in the legislation a provision equivalent to that which operates in the industrial field, and that is to be perceived, we would submit, as intentional and to convey a very sensible policy that the tribunal in these determinations, the arbitrator in these determinations, should adhere to, but prior to determination a considerable status by way of a particular presumption of its correctness, both in principle and in result, unless there are special circumstances shown and should implement, in effect re-enact that previous determination except to the extent that there has been a proven change in conditions.
>
> Now, there have of course been in many respects changes in conditions that have occurred in relation to the role of visiting medical officers in the public hospital system since 1985, not only by way of work value but by way of relativity with their colleagues who

are employed as staff specialists, all of which are relevant to be taken into account in updating the 1985 determination in the way in which we propose. But we do rely upon this principle as affording the 1985 determination a very strong prima facie position as being correct in reason and in result and as appropriate to be re-enacted with such modifications as may be necessary to reflect the changes that have occurred in the meantime.

Now, I leave that point to indicate to your Honour what our attitude is in response to the case which has been presented on behalf of the Minister in relation to the 1985 determination. Now, I appreciate that this is in opening and not a final address, and it is not the last word. But I do propose to take the course of examining the 1985 determination in some detail, so far as reasons are concerned, in order to show the basis upon which we claim to be entitled to move forward from that position, which involves in effect a defence of the reasoning in that determination by way of response to the criticisms that have been made of it, both in submission and from the witness box in the course of the Minister's case.

We ask your Honour to receive these submissions in opening because the issue is so basic, so basic to our approach, relying as it does in one way that we put our case, upon the validity of that 1985 determination.

In his final address, Mr. *Sperling* emphasised the position by submitting that "the AMA relies upon the determination by his Honour Mr. Justice Macken in December of 1985" and that "there is a presumption that the determination by his Honour Mr. Justice Macken was right. Indeed, one would require very strong evidence, indeed, to rebut a presumption that that determination was right."

I deal later in these reasons with the 1985 determination as to the extent to which it should and has affected my conclusions on the present claims. As a general comment, I have found the 1985 determination in a number of important aspects to be so flawed and anomalous as to make it unsafe on which to base a new determination. Suffice it to say at this stage that *Macken* J. was required to consider the question of remuneration, and terms and conditions of work for VMOs under sessional contracts in the context of a very serious and major dispute between the Governments of the Commonwealth and of New South Wales and the AMA, as representative of the VMOs, in which the VMOs withdrew their services from public hospitals from March 1984 to April 1985. That 1984-

5 doctors' dispute, which resulted in considerable disturbance to the hospital system in the State, related to the introduction of Medicare in February 1984 and to amendments made in April 1984 to the *Health Insurance Act* 1973 (Cth.) concerning a limitation of the fee to be charged by a VMO attending a public patient in a hospital to the Medicare schedule fee. Statutory regulation was also effected as to the conduct of a visiting practitioner of a hospital in relation to the performance of work. The medical profession generally expressed the concern that those changes attempted to control the private practices of VMOs. Eventually, agreement was reached in early-April 1985, a part of which agreement recognised the need for a review of the remuneration paid to VMOs under sessional contracts. And so the proceedings took place before his Honour and a new determination finally issued in December 1985. The 1984-5 doctors' dispute was thereby settled.

Notwithstanding the circumstances existing in 1985 and the context in which the determination was then made by his Honour, the way in which the present claims were put necessarily required their consideration in light of the provisions of the 1985 determination as to its appropriateness as a basis for the making of a new determination. However, and I think this to be quite important, a consideration of the claims ought not be, and has not been, restricted to the context of the 1985 determination - it happens to be the immediately preceding review - but rather the whole history of the regulation of VMO remuneration and conditions from inception in 1976 to date has been the relevant exercise undertaken in these proceedings. In the final analysis, of course, and however helpful and informative previous reviews may be, the claims fall to be decided essentially in accordance with the evidence and submissions now presented, and in the setting of 1992-93.

CHAPTER 3 - HISTORICAL BACKGROUND AND CONTEXT

Whilst the claims require consideration in the current and up-to-date setting of 1992, it seems to me to be necessary, but certainly helpful, to outline the public hospital system and its developments, as the environment in which VMOs render services to public patients, and the relationship which VMOs have to that system.

Public hospital system - history

The historical background and development of the public hospital system in New South Wales and of the involvement of the medical profession in it was traced in a most informative way in the written submissions made by the DRS as presented by Dr. *van Lieshout* by reference to the final report in September 1984 of the "Committee of Inquiry into Rights of Private Practice in Public Hospitals" (Penington Inquiry - Australian Government Publishing Service, Canberra 1984: 20-37). The submission noted the position as it had developed from the establishment of "convict hospitals" in which salaried medical officers treated those transported from Great Britain and their guards; free treatment was afforded also to the ordinary settlers in the colony. It seems the more affluent settlers obtained private domiciliary medical care, although not all of the colonists could afford that. And so the original "colonial health service" came to be augmented with services rendered by medical officers in private professional practice. A fee was charged to those patients able to afford it, but otherwise the medical officers did not charge. The honorary medical system was born.

Dr. *van Lieshout*, again by reference to the report from the Penington Inquiry, spoke of the developments which occurred during the nineteenth century in the establishment of "public hospitals" which benefited from improvements in the physical environment and in nursing and medical standards. Those early public hospitals were supported by

voluntary subscribers and government subsidies, but they obtained also some income from "private patients" whilst remaining essentially as charitable institutions with honorary medical officers providing medical services without charge in return for the treatment of their private patients in the institution. The "Robin Hood principle" was thereby established. Gradually, however, and as more and more reliance was placed on government funding, particularly for equipment and facilities, laws were enacted for the regulation and management of the public hospitals.

The early part of the twentieth century saw considerable advances in medical science and technology which very much became centred in the public hospitals, and those same advances saw the necessary specialisation of the medical profession. Hospital services too became specialised, with the establishment of centres of excellence in areas such as mental health, the infirm and chronically ill, and institutions concerned with women's, children's and infectious diseases. The general hospitals and the specialised institutions attracted demand by the community generally as their facilities and equipment reached high standards with committed medical and nursing staff. The honoraries continued to perform a major role in the public hospital system on a part-time basis, but gradually full-time staff specialists and career medical officers were appointed to the salaried staff of the public hospitals. It became apparent that the honoraries and the salaried medical staff in their particular areas of practice performed work which was substantially the same in nature and scope, and that remains the position today. Nevertheless, the honoraries essentially worked part-time in the public hospitals providing a free service to public patients; the honoraries' private patients, for whom a separate fee was charged, were able to enjoy the benefits of the public hospitals' facilities.

The significance of that history to the present case was to disclose the long and ingrained role of visiting medical practitioners in public hospitals in an honorary capacity and in which the hospitals were dependent almost solely upon the services provided by the honoraries in order to be able to treat public patients. It emphasised also, albeit in an initial and perhaps explanatory way, important issues which arose for consideration in the present case as to the "Robin Hood principle", comparison between VMOs and staff specialists, clinical privileges, a standard form of contract, a pre-determined number of contract hours, involvement in committee work, and, but by no means least, the applicable principles in determining rates of remuneration.

Public hospital system - recent reforms

Evidence was given by Karen Janne Crawshaw, Director-Legal Branch of the Department of Health, as to those factors which led successive governments in recent years to review and refine the statutory framework for the public hospital system. Ms. Crawshaw said that at the base of those factors was the desire to ensure appropriate controls over the conduct of the system in the interests of structural flexibility and efficiency. The factors identified by her were -

- increasing demands upon the public hospital system through population growth, technology development and changes in population demographics;
- pressure to achieve maximum value for every "health dollar" in the prevailing economic circumstances;
- developing community awareness that medical consumers had certain rights; and
- increasing trend to medical negligence litigation and the corresponding focus upon risk management within the system.

I have earlier referred to the important changes introduced in 1975 as part of the advent of Medibank as a system of national health insurance, whereby it was agreed between the Governments of the Commonwealth and of New South Wales to abolish the honorary medical system and replace it with a system which would remunerate the visiting practitioners, to be known as visiting medical officers, by a sessional payment. The task undertaken by Mr. *Rogers* during the private arbitration in 1976 involved an accommodation of the changes which had begun to emerge in the public hospital system, including his observation that "the evolution of medical fees has been haphazard in the extreme and continues to be so" and the impact of the "Robin Hood principle".

Ms. Crawshaw specified in some detail in her evidence the particular statutory changes made in the last decade as affecting the public hospital system. I do not see the need here to repeat that, other than to highlight the major and directly relevant aspects. Firstly, the *Public Hospitals Act* was amended in 1984 to insert ss.27A and 29AD to impose a duty on the governing body of a public hospital to achieve and maintain adequate standards of patient care and services provided by the hospital, and to ensure the efficient and economic operation of the hospital consistent with such standards; later in 1984, that Act was further amended to insert s.28A to enable the Minister to make model by-laws for public hospitals. Secondly, in 1986 a major legislative reform of the health system took place with the enactment of the *Area Health Services Act* 1986, together with cognate amendments to the *Public Hospitals Act*, which provided for the comprehensive management of health services within a specified area by a statutory corporation controlled by a board; to ensure ultimate control of area health services by government, the boards were made subject to ministerial direction and control, again with similar amendments made to the *Public Hospitals Act* as to ministerial control

over hospital boards. In concluding her remarks on the legislative changes, Ms. Crawshaw said that "the thrust of legislative reform of the health system in the eighties has been to ensure that Government and hospital administrations are appropriately empowered to respond at both a macro and micro level to economic, technological, legal and consumer imperatives, with their attendant resource and structural efficiency implications for the system."

Ms. Crawshaw, in an unchallenged way in her evidence and which I therefore accept, related the legislative developments with the need to consult the medical profession in the following way:

> In tandem with the development of greater legislative controls by Government of the health system, has been legislative acknowledgment of the need to consult the medical profession in exercising such controls. To this end Division 6A was introduced into the Health Administration Act 1982, establishing a Medical Services Committee.
>
> This Committee comprises 10 medical practitioners, including four representatives from the N.S.W. branch of the A.M.A.. Its major function is to advise and consult with the Minister and Department generally on matters (other than industrial matters) affecting the practice of medicine in N.S.W. Specifically the Act provides for the Committee to advise and consult on:
>
> "(i) existing and proposed legislation, including proposed amendments to existing legislation, affecting or likely to affect patients or medical practitioners or both, in their respective capacities as such; and
>
> (ii) existing and proposed administrative arrangements, including proposed changes to existing administrative arrangements, affecting or likely to affect patients or medical practitioners or both, in their respective capacities as such."
>
> Both the Public Hospitals Act and the Area Health Services Act also make specific provision for mandatory consultation with the Medical Services Committee on proposed regulations and by-laws affecting visiting practitioners.
>
> Such consultation has had successful results. In August 1989, following extensive consultation with the Medical Services Committee the Government introduced a package of delegated legislation comprising the Area Health Services Model By-law and a complementary Area Health Services (Visiting Practitioner) Regulation and parallel amendments to the Public Hospitals

Regulations. This package had the full endorsement of the Committee.

The Model By-law provides, specifically for medical staff input into area administration with the establishment in each Area of Medical Staff Councils, comprising all visiting practitioners and staff specialists appointed to its hospitals. These Councils provide advice to the relevant Board on medical matters. In addition, Area Boards are required to invite representatives of the Councils to their meetings, and have Medical Staff Council representation on their committees.

The By-law, together with the relevant Regulations, also establishes appropriate procedures and an administrative infra-structure which encourage legally and clinically sound decision-making in relation to both visiting practitioner and staff specialist appointments. Specific requirements both in relation to initial appointment or re-appointment and in relation to the credentialling of visiting practitioners and staff specialists are set out. Credentialling refers to a process whereby the relevant board determines the clinical privileges of individual practitioners, i.e. the kind and extent of work a medical practitioner is permitted to perform in a particular hospital. The By-law also makes provision for the review of clinical privileges both at the request of a practitioner, or at the instigation of the hospital administration.

The process of credentialling throughout the public hospital system has assumed great importance in recent times both as part of sound risk management, and as part of the overall service planning and development function of area and hospital administrations.

It is clear from the above that the medical profession, and specifically visiting practitioners, in the public hospital system, have legislative guarantees that they will be afforded the opportunity for input on decisions affecting them both at the broader government level and at the level of individual hospital or area administrations.

Not only do visiting practitioners have legislative guarantees of consultation, but there exists in the Public Hospitals and Area Health Services Acts legislative guarantees that the agreements they make with individual areas or hospitals will prevail over inconsistent legislative provisions, including provisions existing at the time of the agreement and those passed subsequent to the agreement. These guarantees are contained in section 29T of the Public Hospitals Act and section 33 of the Area Health Services Act. Accordingly, it is incumbent on the arbitrator to have careful regard to the legislative mechanisms already in place, as his determination of terms and conditions of service contracts to the extent that they are inconsistent with legislation may override the expressed intention of the Parliament or Executive Government.

As the then Minister, the Honourable Peter Collins, M.P. said in his second reading speech on the Public Hospitals (Visiting Practicioners) Amendment Bill 1988, one of the main aims of the legislation was:

> "to require that all conditions applying to a visiting medical officer's appointment to a hospital are included in a conclusive written contract which may not be unilaterally altered."

For this reason the Minister, as part of his claim in these proceedings, has been prepared to place before the arbitrator a comprehensive draft service contract and have it subjected to the full scrutiny of the arbitration process.

That evidence was important, in my view, in setting the context in which I was required to give consideration to the Minister's present claims as to the content and form of a service contract which would be appropriate between a VMO and a public hospital or area health service, as the case may be. Those claims, as I have earlier intimated, were strongly resisted by the AMA in the proceedings and as to which there was considerable evidence and debate of a philosophical and conceptual nature. I think it sufficient at this stage to observe in general terms that the position taken by the AMA may very much be seen in the context of the public hospital system and of the role of the honorary medical officer, the present-day visiting medical officer, as it existed prior to 1975 and before the major changes to national health insurance were made in 1975 and as affected by the legislative changes made in the 1980s. For instance, there was strenuous opposition by the AMA to a determination being made which provided for a specified number of hours of duty to be rendered by a VMO, on the basis of which he would be remunerated, as distinct from remuneration for the actual number of hours worked very much according to his own professional discretion; there was too strong opposition to a determination being made which in any way recognised the statutory right of a public hospital or area health service to determine or vary the clinical privileges enjoyed by a VMO notwithstanding the impact on a hospital of economic circumstances or of changes which should be made to the services provided by a hospital as a result of factors such as population growth and distribution; and there was opposition by the AMA

as well to a determination being made which required a VMO to maintain a record of services provided in a particular form so as to enable checking and audit by the hospital or area health service concerned.

The Executive Director - Finance and Administration of the Department of Health, Kenneth Reginald Barker, gave extensive evidence and which I found to be helpful. It concerned the financial management and accountability of public hospitals in a comparative way from 1985 to 1991 in terms of the reforms made during that period to the public hospital system. Mr. Barker, like Ms. Crawshaw, referred to the legislative changes. He dealt also with reforms in the area of financial management, covering issues such as financial allocations, forward estimates, net funding, global budgeting, financial reporting, staff profiles, productivity savings, enhancement funding, resource allocation formula, current year and annual budgets, loan/savings policy, budget devolution, accrual accounting, risk management/insurance, information technology and health outcomes. Relevantly in terms of the effects of the reforms on VMOs, Mr. Barker concluded in his evidence:

> The above reforms reinforce that the management challenges of the NSW Health system in 1991 are substantially different to 1985.
>
> Health managers have and will become more accountable for how available funds are utilised. To ensure this occurs, previous management constraints have been removed and better management tools are/will be provided.
>
> The Parliament/community will also accept greater accountability/performance on how funds provided are utilised and the benefits that accrue in respect of the health status of the residents of New South Wales.
>
> Health managers are aware and will require continual reminding that the amount of dollars to be spent on Health is finite and in fact expressed as a percentage of GDP is considered about right.
>
> From the State's point of view, the recession and declining State revenues require every Department to operate within budget.

Literally interpreted this means every health manager must be able to control activity to budget and use available resources effectively and efficiently.

Bottom line accountability is a key indicator in evaluating management performance. A failure to control funds is adequate grounds for dismissal.

The budget process allows managers time to plan their services to funds. Requests for bail outs and unjustified supplementation are a reflection of poor management.

In fact in the Premier's 1991/92 allocation letter to Ministers and the Department's allocation letter to Areas/Regions advice is given "requests for any supplementation, and any budget overruns irrespective of the explanation, will be viewed as a failure by yourself, your Executives and managers to have planned and controlled services to budget adequately".

The reforms identified are seen to reinforce the need for Visiting Medical Officers to be aware not only of the funds available to their hospital of appointment, but also to participate on how such funds are to be utilised and to have upfront negotiations on the amount of services they can provide for the money that is available. They must also accept that on an individual basis, the amount of funds available each year may change due to patient mix. The fact that Health dollars are limited and the system of financial management has strong sanctions on those public sector managers who fail to control their budget reinforce the need for budget compliance. Those in over-resourced areas must also accept a reducing budget as funds are moved in line with the Resource Allocation Formula.

These financial demands on managers require that they must be able to effectively utilise funds at their disposal and ensure their community is receiving the most appropriate health care available. They can no longer adopt the line that Health is an essential service and the government must find the money to fill the perceived need.

In terms of accountability, the reforms reinforce the need that a better form of accountability needs is to be presented in seeking reimbursement of expenses which can be tied into the upfront contract and the patients seen and times of such services. This accountability is seen to be no different to other professionals and contractors.

In respect of timing of annual agreements, providing the forward estimate process continues (at this time indications to the contrary do not exist) it would be expected that such negotiations, at least from a minimum level, should be possible around Easter each year for the next year with the final details to be arranged after receipt of the formal allocation in July/August of each year.

It will be apparent then that the Minister's claims were put forward in a climate of substantial change to the public hospital system and to the delivery of medical services to public patients during the last decade

against the public hospital system as it had developed over very many decades and in which the honorary medical officer exercised a pre-eminent, if not a predominant, role. The Minister's claims for a re-structured determination sought to address those changes, but with resistance from the AMA. That resistance was amply demonstrated, together with the basis for it, by the VMOs who gave evidence in respect of the Minister's claim for a sessional contract to contain a pre-determined number of hours during which paid services were to be rendered. The detailed evidence will be discussed later when that claim is dealt with, and for present purposes of context it is sufficient merely to summarise the evidence as being that the VMOs considered as paramount their professional and ethical responsibility to a patient to provide the most effective and beneficial treatment regardless of available health care resources. In other words, the VMO was and must be the "patients' advocate".

Medical ethics and resource allocation

In the cross-examination of Diana Glen Horvath, Area Director of Health Services for the Eastern Sydney Area Health Service, the practical impact of the Minister's claim as to a specified number of hours in a sessional contract was discussed. The following exchange occurred with Dr. Horvath:

> Q. Let me suggest to you that the expectation would be that a doctor would simply go about his work in the ordinary way, seeing his patients, admitting them to hospital, treating patients who are allocated to him through the hospital system, without a thought to whether his time was on target, under, over, until the time came in the following month to put in a claim form, wouldn't that be the ordinary case?
> A. It is at the moment. That is what I would like to change.
>
> Q. But would you not accept, having regard to professional practice as you know it, that doctors would continue with their habitual methods of treatment, referring patients to hospitals, carrying out the treatment that they thought they needed, without regard to

whether they were within time, on time, out of time, for the month, isn't that what you would expect?
A. What I would expect is that individuals would not be watching the clock in terms of the individual patients that they were caring for but that they would know whether they habitually came on Wednesday afternoon or not and that if they started from that and started to attend an additional clinic, as they do now, that they would be aware that would be more than what was expected and what their contract said. I think that an allowance within a contract to negotiate some times where you are dealing with the unexpected or what is occurring gradually is vastly different from a decision on the part of the VMO to add some task to his daily week because he has an interest in the particular area or because he believes that the hospital is wrong in moving away from providing a particular type of service. Now, that happens now and we catch up with it after the event and have to try to do something about it.

What I am saying is that if people are in a position to know where the boundaries are, they can plan their week, they know what they are doing in the week, they have to attend their rooms, their private hospitals, their public hospitals, they are not unmindful of the pattern of the week. They may go over a little here or there, that is understandable on both sides, but if they start to take on an extra block of time it means they create a system where they don't necessarily know when that is happening. That is what I am trying to deal with in planning.

...

Q. So that where there is a fixed hours contract or an actual hours contract, you are not going to alter the pattern of professional behaviour on the part of the VMO by that device?
A. I would not want that device to interfere with the individual doctor/patient relationship. However, you are making the assumption that that is the only way in which we get services that are remunerated under sessional payment. There is a great deal of service provided by VMOs which is not necessarily on their own patients, may well be not only in relation to consultation on other people's patients but involving them in a ward round with several other practitioners, all of whom are seeing their patients in a unit and there have to be then some decisions - because Fred decided to join that ward round on that day, whether that was necessarily part of the service to the patient, not necessarily his own, although there may be one or two, whether I see that is the pattern of patient care within the institution. I am also talking about whether I would paying two VMOs to operate in theatres on the one patient. There are circumstances in which I need two specialists but I don't necessarily feel that it is up to the individuals to determine that from now on one of them will assist the VMO and both will receive a sessional payment for the same visit. So, the issue of a doctor caring for his or her individually allocated patients is one thing but that is by no means the full range of services that are provided under the heading of clinical care to public patients.

To a like effect, Terrance James Clout, Area Director of Corporate Services for the South Western Sydney Area Health Service, gave the following evidence under cross-examination:

> Q. So that the situation is this, isn't it, that irrespective of the hours in the contract the visiting medical officer is just going to go on treating patients in the ordinary way, that is obtaining whatever treatment he can for them that he believes to be in their interests and that is available in the hospital subject to practicality without regard at all to the hours in his contract?
> A. It is precisely that which the Minister's claim aims to address because that assertion assumes that it is only the visiting medical officer who has a state or a responsibility in determining what services can be provided and that is clearly not the case. The reality is that there are - the hospital has to determine, in consultation with practitioners, what services can be provided. If a visiting practitioner decides that he or she is going to continue providing services above and beyond that for which resources are available there are a number of implications, one of which is and probably the most important of which is, that some other patient which, it is the policy of the particular department, should be receiving treatment will not be able to be treated because there are no resources available for the treatment of that patient because more has been provided to one patient than has been agreed by the hospital in consultation with the medical staff is able to be provided.
>
> Q. Mr Clout, there is no difference between us about the hospital having the authority and the capacity to control the work that is done in the hospital by means of admission policy, discharge policy, theatre policy, protocols on treatment, that is common ground?
> A. It is not common ground with respect because that is only one component of the services provided to patients and it is only one component of the costs associated with that treatment. Once a patient is in the hospital, if your proposition is followed through, then the doctor can provide as many hours of service to the patient in the hospital as he or she determines at their absolute discretion they should provide without regard to the implications of that from the point of view of the cost associated with that.
>
> Q. Mr Clout you would accept, would you not, that in the overwhelming proportion of cases doctors would only provide treatment to patients in the hospital which they bone fide believed it was in the patient's best interests to receive?
> A. Yes.
>
> Q. So we are talking, are we not, about cases where the visiting medical officer believes, bone fide, that it is in the best interests of the patients that certain treatment should be provided, we are envisaging a situation in which the doctor deliver that treatment to the patient in the hospital as a matter of practicality because the bed is there and available, the theatre happens to be available, there is no hospital protocol that says this hospital will not deliver that kind of treatment. In that situation he is going to deliver that

treatment to that patient irrespective of the hours in his contract, isn't he, if that is a patient in his care?
A. I don't think that that is an agreed position or a position I could agree with. Because if a doctor considers that it is - there are two components to the treatment, that which is essential, that is which is highly desirable and that which is desirable. Now, unfortunately, the situation that we have in the public hospital system and probably in the private hospital system as well in this country in this day and age, is that you have to make hard decisions. Unfortunately some of those harsh decisions relate to drawing a line not above that which is essential but somewhere between that and - that which is essential and that which is desirable. And the decision in respect of where that line is to be drawn is a decision that has to be taken on clinical grounds, no question about that but not simply by the doctor. It has to be taken on the basis of the clinical grounds as agreed and determined by the doctor, his colleagues, his medical head of department and the medical superintendent because if that is not the case then the cost of one there providing not only that which is essential and highly desirable but also what might be considered desirable may have the effect of services that are essential to another patient not being able to be afforded and that is the real situation.

The apparent dilemma in achieving necessary structural reforms in the health system, an objective of the Minister's claim, in terms of a VMO's ethical responsibility to a patient has been the subject of much learned consideration of late. In a leading article entitled "The Ethics of Resource Allocation" published in The Medical Journal of Australia (Vol.153 of 15 October 1990), Dr. Horvath, who was also Chairman of the Health Care Committee of the National Health and Medical Research Council, wrote:

> In the allocation of any public resources our concern should be primarily with justice. This involves giving to each person his or her due. In allocating health care resources our concern is largely with distributive justice - to distribute amongst members of the community those benefits and burdens due to them. The basis of distributive justice is the notion of fairness. It is probably fairest for a person who has a need for health care to have equitable access to whatever effective care our society can reasonably afford.
>
> ...
>
> We will all surely, in the future, be held accountable for the just allocation of health care resources, in a fashion which maximises health outcomes, and on an ethical base which our society affirms. If we as a profession continue with our policy of shroud waving, we will forever remain the small businessmen of the health care system, without a policy role in the biggest decisions of the decade.

In her statement of evidence, Dr. Horvath observed - "The fact of the matter is that the hospital management has a duty to determine what the hospital needs in the way of medical services including VMO services. It is the VMO's duty to determine what services an individual patient needs. Therein lies the distinction. ....The key issue lies in the need for the hospital management to manage. Management must be able to determine at least the approximate quantum of services it wants (and can afford) and not be constantly shedding staff, reducing pharmacy stock levels or deferring building repairs and maintenance in order to pay for unexpected increases in VMO payments. This does not prevent some negotiation around the margin, but the picture of reducing other expenditure headings to top up the VMO payments is indefensible in the absence of some up front negotiations."

The dilemma, as I have described it, was dealt with in a publication of The Royal Australasian College of Physicians (the RACP) entitled "Ethics: A Manual for Consultant Physicians" published in 1992 as follows at p.28:

> 14. Physicians' Involvement in Health Policy
>
> Physicians should make their expertise available to policy makers at all levels to assist in the formulation of health policy. If they believe that health policy decisions will be detrimental to individuals or groups within the community, they should make their views known.
>
> Acting as advisers to policy makers will often require physicians to take an impartial stance, that is, a stance that will give equal consideration to the interests of all those affected by the decision. The Hippocratic tradition, on the other hand, includes the assumption that doctors have a responsibility to act in their patients' best interests. Impartial policy decisions may adversely affect individual patients or categories of patients for whom the physician cares. This means that conflicts of interest can arise. On the one hand, physicians may wish to be advocates for their patients while, on the other hand, they might feel that they should not oppose decisions that may result in a more effective use of available resources.

There are no easy formulae to resolve these conflicts. Much depends on whether physicians are consulted as experts in their particular field of patient care, or whether they are consulted as health care experts in general. In the latter role, it would be necessary for physicians to be able to adopt an impartial point of view.

If consulted as a patient advocate, that is, as someone who, because of his or her particular expertise, is best able to represent the interests of particular patients, then arguing on behalf of these patients and pressing for additional resources would be appropriate. In all cases, however, physicians should examine their own motivation carefully as pressing for their own patients or units could be self-interested.

The dilemma for the individual VMO, in terms of the allocation of resources as affecting ethical responsibilities, was dealt with by an *ad hoc* Committee on Medical Ethics of the American College of Physicians in its Ethics Manual 1984 as follows at p.31:

RESOURCE ALLOCATION

The physician has a particular responsibility to his patients in a world of increasing limited financial resources. The guiding principle must be that the physician should concentrate his energy and attention on providing the patient with the best possible medical care within the context of practicing humanistic, scientific, efficient medicine. In the event that external pressures resulting from limited institutional resources prevent the physician from providing optimal care, he must decide whether it is appropriate to advise the patient of the nature of the situation. In the final analysis, no external factors should interfere with the dedication of the physician to provide optimal care for his patient.

However, what was there said should be read in light of what the Committee earlier said at pp.13, 18 and 19:

PATIENT ADVOCACY AND CONFLICTING INTERESTS

Unlike the covenant of personal medical care the physician is ordinarily the advocate and the champion of his patient, upholding the patient's interests above all others. All too frequently, however, the physician is forced to serve conflicting interests. For example, he must consider the cost to the public in disability awards, the public health in reporting certain infectious diseases, and the public safety in examining the handicapped for drivers' licenses. He may act for research and teaching on the one hand and for the patient on the other. He may advocate unusually expensive care for his individual patient while promoting strict economy overall. He may at one moment serve society in the painful but necessary task of allocating limited resources, and in the next moment, quite properly, reverse his role and function as the patient's advocate

under these circumstances. The patient's welfare must always be the physician's prime concern, but no one can avoid these moral dilemmas. In such cases the physician must act with sensitivity and without duplicity making it clear to the patient and understanding it himself when other interests are being served and to what extent secrecy and trust have been infringed.

...

OBLIGATIONS OF THE PHYSICIAN TO SOCIETY

Like any other good citizen, the physician should strive for the well-being of the community and of society. He should work toward ensuring the availability of adequate medical care for all individuals and should support community health endeavours. In particular, he should seek to use all health-related resources in a technically appropriate and effective manner and to husband limited resources. He should conduct himself so as to merit the respect of his community, both as a professional and as an individual citizen. He should help his community increase its capacity to recognize and deal with social and environmental causes of disease.

In addition, the physician has the following special obligations:

1. To be aware of the availability and accessibility of health services to the people of the area in which he practices and to participate in reasonable efforts to correct defects in such availability and accessibility.

2. To encourage, support, and assist efforts to provide the general public with accurate knowledge relative to its health and health care needs.

3. To act for the protection of society by reporting those diseases required by law to be revealed to responsible public health authorities.

4. To be aware of limitations of health service resources, such as material and personnel, and to participate with others in exercising restraint in the expenditure of these resources.

5. To be aware of the costs of care and to provide care in the most efficient manner.

The AMA tendered the July 1992 issue of the AMA's Code of Ethics and submitted that it resolved the "dilemma" in favour of the medical practitioner providing the best care available. In denying any dilemma, Mr. *Sperling* submitted in his final address:

In truth, there is no dilemma. Once procedures are in place to limit hospital admissions and treatment to match available funds, the VMO is free to secure from the hospital whatever treatment he believes is in the patient's interests, subject of course to those

procedures and limitations. The public hospital system may need encouragement to extend itself to the limits of its resources. (see Dr. Stening). If so, that should occur. Otherwise, it will fail to deliver what it has planned to deliver within the context of available funds. By wringing the most he can out of the system, subject to the procedures and limitations in place, the VMO serves both the interests of his patients and the interests of the system.

The proof of the pudding is in the eating. The evidence of the AMA witnesses shows -

(a) They regard themselves as obliged to be the advocate for individual patients in getting whatever treatment they can for them. In that regard they are constrained by the restrictions on service that are in place.

(b) They participate in the planning of such restrictions (bed allocations etc) and for treatment (eg. theatre time). They also participate in other aspects of cost control, related to the efficient use of funds, such as departmental activities, ad hoc efficiency programmes, theatre committees, etc.

Warwick Anthony Stening, a neurosurgeon VMO with appointments at the Prince of Wales Hospital, Prince of Wales Children's Hospital and St. George Hospital, gave evidence-in-chief on this ethical issue as follows:

...

Now, if we are looking at the second point you made, which is the drawing of the doctors into an alliance with the hospital, I think that that is a very bad precedent because in the hospital situation, particularly with the budgetary constraints and the necessity to raise resources by administrators, there is only the one advocate for the patients and that is the doctor and if the doctor is prevented from being the patient's advocate by such a mechanism then I think that he is abrogating his overall responsibility, the very reason why he went into medicine in the first place, which is to provide treatment and alleviate suffering for patients.

I think there should be an adversarial system where the doctors are driving from the point of view of supporting the interests of the public and the patients versus the administration - if it came to the point that the resources are finite and have to be allocated and if the process stops there, that concept, then I think the public will suffer.

...

Q. Do you belive that there is any room consistently with your professional ethics to have a role in deciding that certain patients should not be admitted for elective procedures at certain times by reason of budgetary constraints on the hospital?

> A. I would not like to be involved in such a decision. I belive that my role is to decide, if there are competing interests, to promote the interests of my particular patient at a particular time. For instance, if I believe that delay would be deleterious to that particular patient I should not take any of those other matters into consideration, I should simply argue his case as strongly as I can. Now, it may get to the point where another patient in another discipline has a greater claim on the one remaining bed than mine but that should be the result of a process of information exchanged between the doctors, between that patient's admission and mine, and we decide who should get that bed. I don't believe that I should be recommending non-admission for budgetary reasons alone. That is not my role.

In my view, it is not reasonably open in the setting of the 1990s to simply deny any dilemma in the practice by a VMO in the public hospital system in securing for patients whatever treatment the VMO considers appropriate regardless of a careful and continuing attention to the availability of scarce resources. Dr. Horvath called it "distributive justice" based on the notion of fairness, and, in acknowledging there were no easy formulae to resolve conflicts, the RACP considered that physicians "should make their expertise available to policy makers at all levels to assist in the formulation of health policy." That view was consistent with Mr. Clout's approach to VMOs, in terms of the Minister's claim for specified contract hours, to consult with the public hospital as to the services which can be provided. In a period of scarce resources and the desire to maximise health outcomes, it seems to me to be unremarkable for any determination I might make to reflect that reality by appropriate provisions. I do not see, as Dr. Stening apparently did, that "there should be an adversarial system," rather the process of consultation and negotiation, even participation, as advanced by Mr. Barker, Dr. Horvath and Mr. Clout has much to commend it. Indeed it is in line also with the approach of the Committee of the American College of Physicians to patient advocacy, conflicting interests and the obligations of the physician to society in "a world of increasing limited financial resources."

Honorary to visiting medical officer

The transition in 1975-76 from honorary medical officer to visiting medical officer status in terms of an appreciation of the present claims in relation to a re-structuring of the determination, on the Minister's approach, or for continuing the existing provisions, on the AMA's approach, is of quite some importance. It goes some of the way in explaining the opposition expressed by the various VMO witnesses called by the AMA to the Minister's claim for a specified number of paid contract hours. Other structural efficiency measures proposed by the Minister, such as a uniform form of contract, maintenance of a record of services provided, inclusion of specific clinical privileges in the sessional contract and various other measures relating to the nature and responsibility of VMOs in rendering services, were either opposed by the AMA or said to be unnecessary for inclusion in a determination. Again, the change from honorary to visiting status, in my view, provided a meaningful context in an understanding of the present attitude by the AMA to such claims.

The relationship between an honorary and a public hospital was considered by the Court of Appeal, in a case concerned with vicarious liability for medical negligence, in *Ellis v. Wallsend District Hospital*((1989) 17 N.S.W.L.R. 553) in which *Samuels* J.A., with whom *Meagher* J.A. agreed, relevantly observed (*ibid* at 595):

> He testified that honorary medical officers received no payment from the hospital for services performed there. They were allowed to use the hospital's operating theatres for their own patients on a roster basis. In consideration for this right, they were obliged to be on call for emergency admissions and to care for the hospital's public ward patients free of charge. An honorary would admit patients from his private practice by either telephoning the hospital or giving the patient an admissions request form, as Dr Chambers did in this case, to take to the hospital. The hospital would then book the patient in for surgery at a time which coincided with a period during which the doctor was rostered to use the operating theatres. The doctor's fees in respect of services performed for these patients were regarded by the hospital as a private matter between the doctor and his patient; the hospital made no charge to private

> or intermediate patients (of which the appellant was one) for services rendered by doctors.
>
> At the cost of some repetition, the evidence discloses the following. Dr Chambers, being an honorary medical officer, was subject to the by-laws and rules of the hospital. Public patients could be assigned to his care; he was obliged to treat them free of charge. But the honorary medical staff made the assignment, reporting their decision to the Board of Directors (r78). And the honorary medical staff prepared the "roster of times during which [they] shall be available for duty" - presumably on call for emergency admissions - forwarding it to the board for consideration (by-law 44). His use of operating theatres for patients he admitted from his private practice was restricted to specified periods; but again this roster was prepared by the honorary medical staff (by-law 44). Visits to his patients in the wards had to be, wherever possible, at times that would not inconvenience the hospital routine. Grievances in respect of treatment of his patients in the hospital had to be reported. He was required, if necessary, to perform medical examinations of hospital personnel and be available for consultation by other members of staff at any time in respect of all cases. If he summarily discharged a patient on any of the grounds included in by-law 83 he had to report the fact to the chief executive officer.

His Honour concluded (*ibid* at 596) that the hospital possessed a measure of control over the work of the honorary, although the degree was slight and the hospital could control neither the treatment the honorary prescribed nor the manner in which he performed surgery in its theatres. It is significant also that his Honour concluded "that members of the honorary medical staff were bound to treat public patients and to be on hand for emergencies, but they themselves distributed the patients and drafted the rosters, and although the board may well have had some implied power of veto or revision it is probable that it was rarely exercised. The authority of the board appears to me to be confined to the formal minimum necessary to be reserved in order to ensure the administrative cohesion and integrity of the organisation in the hospital ...".

In the course of his reasons supporting the recommendations made following the 1976 private arbitration, Mr. *Rogers* recorded (Pt.2 at pp.9, 10):

> In 1975, the Commonwealth Government and the Government of New South Wales entered into an Agreement, which involved the abolition of the Honorary Medical Officer system and the future

provision of free hospital treatment. Clause 15.1 of the Agreement provides that remuneration for medical services to hospital patients shall be:-

(a) by salaries as determined by the appropriate salary determining authority in New South Wales.

(b) by sessional payment; or

(c) in special circumstances by contractual arrangements not involving fees for service paid by the patient.

It is a consequence of this arrangement that the Arbitration has been held.

Part time medical practitioners supplying service to hospitals are now known as Visiting Medical Officers.

The reforms made by government during the 1980s to the public hospital system are to be seen, it would appear to me and as Ms. Crawshaw recognised, as ensuring "appropriate controls on the conduct of the system in the interests of structural flexibility and efficiency." In a system, as *Samuels* and *Meagher* JJ.A. found, whereby the honoraries "distributed the patients and drafted the rosters" and the authority of the hospital's board was "confined to the formal minimum necessary to be reserved in order to ensure the administrative cohesion and integrity of the organisation in the hospital", it would no doubt be almost inevitable for changes to the long-standing system made in 1975 and into the 1980s to be accompanied by difficulties. And so it was. It is worth recording in that respect what *Macken* J. said in his December 1985 reasons for determination (at pp.3-5):

> The reason for the refusal of the A.M.A. to participate in proceedings based on the application of the Minister for Health, and the interval between the hearing of November 1984 and the resumption of hearings in May 1985, is to be found in the disturbance to hospital practice in New South Wales arising from Medicare and amendments to the statutes governing hospital charges and doctors' billing procedures.
>
> That history is long and tortuous and needs no detailed recitation in these reasons. It is sufficient to say that, following my Determination of 14 December 1983, the *Health Insurance Act*, 1973 was amended to empower the Minister to make Regulations in relation to "the conduct of a visiting medical practitioner of a

hospital (whether at a hospital or elsewhere) in relation to the performance of work which is capable of being performed at the hospital by the visiting medical practitioner." I was told that the wording of the statute concerned the medical profession as it had about it the appearance of an attempt to control the private practices of visiting medical officers. By March 1984 resignations of V.M.O.'s from the public hospitals began in earnest, notwithstanding discussions then being conducted between the A.M.A. and the Government concerning this legislation.

Stoppages of work commenced with A.M.A. approval in early March 1984. In April 1984 the Penington Enquiry into private practice in public hospitals was announced. On 12 April 1984 the *Health Insurance Act* (Commonwealth) was further amended so as to provide that no more than the scheduled fee be charged to a hospital patient by a medical officer appointed to a hospital.

The intensity of the dispute increased so that by May 1984 a number of orthopaedic surgeons had resigned from the public hospital system and other specialties began to follow suit. On 17 June 1984 the A.M.A. resolved to call for an indefinite withdrawal of all emergency services to begin on the 20 June 1984, however, it stopped short of calling for the mass resignation of all V.M.O.'s. Apart from emergency procedures, the end of June 1984 saw an effective ban on elective surgery in most of the large hospitals and the number of resignations by orthopaedic surgeons had further increased. A measure of agreement was reached between the A.M.A. and the Government in early 1985 and, as part of the settlement then discussed, there was recognised the need for a review of the remuneration paid under sessional contracts. It was also agreed that modified "fee-for-service" contracts should replace sessional contracts in certain country and non-teaching hospitals. By September 1984 200 - 300 V.M.O.'s had resigned and by January 1985 this figure had further increased and included the majority of procedural specialists at Sydney teaching hospitals. By April 1985 1,363 V.M.O.'s had resigned. On 2 April 1985, the Commonwealth and State Governments announced a seven-point package designed to settle the dispute. The majority of A.M.A. members accepted the package and many resignations were withdrawn. As part of that package there arose the need for the determination of a satisfactory rate of remuneration for V.M.O.'s who wished to continue to work on sessional contracts in teaching hospitals. The settlement package that was agreed to included a number of points of a non-industrial character but its implementation was contingent upon the A.M.A. proceeding to arbitration with respect to the level of the hourly sessional rate. An interim increase in the sessional rate, in the sum of $12.50 per hour, was agreed to but "any further increase in the level of the sessional fee can only be made through the established arbitration procedures." It was against that background that, on 10 September 1985, an arbitration commenced to make a new Determination.

Dr. Horvath referred to the problems which arose during the post-doctors' dispute era as being "typified by an atmosphere of distrust and 'us and them' mentality"; she said that "whilst still participating in the

system, (VMOs) have withdrawn from it in the sense that many have opted out of their leading role in the traditional collegiate activities and no longer actively participate in hospital management/clinical planning decisions designed to bring about the most efficient and effective delivery of health care services in the system." She continued in her written statement of evidence:

> The 1985 New South Wales doctors' dispute has left very deep scars. The situation is one of distrust and there is a general questioning and an air of unease and disquiet. In this environment sessional payment determination has become a bit like the Tax Act. It is no longer just a description of the contractual relationship between VMO and hospital, it is a document to look for holes in and to get around. Such an attitude and approach has resulted in the development of practices and behaviour on the part of some VMOs that undermine or at least limit the capacity of the particular department or unit to function economically and efficiently. Examples of such practices are as follows -
>
> (i) the practices of the surgeons and the anaesthetists in relation to theatre sessions and cancelled sessions referred to above.
>
> (ii) the general unwillingness to undertake tasks that are not remunerated for in some way (some VMOs even want extra payment for the time taken filling in claim forms or keeping appropriate records for payment).
>
> (iii) the timing of ward rounds create significant problems, for instance, if a VMO rounds at 7 a.m. or 7 p.m., and demands the attendance of the RMO staff, the hospital is up for the RMOs overtime costs as well as the VMOs costs.
>
> (iv) it is not unknown for some VMOs to have regular "call-backs" at 6.15 p.m., after rooms and on their way home (the coincidence of this is not unlike the coincidence of sick leave adjacent to weekends).
>
> In my view an upfront hours commitment as the central feature of the VMO contract should bring the VMOs back into the public hospital system in a true sense and lead to, in time, the VMOs resuming their important place in hospital administration - actively participating in all major decisions affecting the nature and direction of medical services in particular hospitals, and positively contributing to the process of seeking the most efficient means of allocating scarce resources to the clientele of the public hospital system. Every effort needs to be made to restore proper relations between the VMOs and the hospital system and I believe that the Minister's proposal with the requirement for upfront hours negotiation will go a long way towards laying the foundations for

the restoration of proper professional relationships between VMOs and hospitals based on co-operation and, in time, trust.

The relationship between VMOs and the public hospitals, in the circumstances outlined by Dr. Horvath, emphasised, in my view, the appropriate and proper context in which a new determination in terms of structural efficiency measures falls to be considered. In a similar vein, Stuart Spring, Chief Executive Officer of the Northern Sydney Area Health Service, dealt with the present relationships in the public health system *qua* the Minister's claim in the following way:

> Having reviewed the Department of Health's Submission in relation to this Arbitration, I am in substantial agreement with the proposals and the reasons given. In making this statement I believe that the structural variations to the Visiting Medical Officer Remuneration for duties during routine hours, improved record keeping, and a more specific contract that can follow the arbitration, has the potential to improve the relationships between managers and clinicians by re-introducing a greater degree of certainty between both parties as to their obligations and expectations.
>
> It is generally apparent that many managers and clinicians are holding back on reviewing some long standing issues of contention until the arbitration is finalised - issues that do not seem resolvable within the current guidelines and conditions that stem from the earlier judgments.
>
> The Public Hospital system has been under significant strain for at least the last decade and whilst the relationships between most clinicians and most managers is very professional and positive, some issues continue to erode the goodwill that exists and cloud attempts to win support for many of the major challenges facing the Health system generally. A major issue that needs resolution is the Visiting Medical Officer Remuneration arrangements.

Dr. Spring illustrated the difficulties experienced as between managers and VMOs, and commented that the industrial aspect was present because whilst proposed changes had been accepted by individual VMOs a marked reluctance occurred when the changes were put to them as a group. Dr. Spring specified in some detail illustrations to make his point. For instance, he cited the case of a VMO who claimed on-call payments from Mona Vale Hospital whilst consulting in Bathurst and Tamworth for two days each month, and, when challenged by the

hospital's medical administration, responded in a letter in the following terms -

> My own position is as follows. If the hospital decides that I will not be on call between certain periods I will be totally unavailable. This will mean that I will take no telephone calls in respect of patients admitted to the hospital, nor when my on-call commitment resumes will I agree to be responsible for any patients who appeared in the hospital during the times when the hospital chose not to have a plastic surgeon on call.
>
> Furthermore I would seek to obtain the advice of the Australian Medical Association as to whether it is within the bounds of the Macken Determination for a hospital to unilaterally decide what the hours of on-call will be in any specialty so as to suit their budgetary requirements.

Dr. Spring expressed the view that many of the problems could be met once the outcome of the present arbitration was known. It seems, on Dr. Spring's uncontradicted evidence, which I do not doubt, that many of the difficulties were administrative in nature but showed that some VMOs were unwilling to vary their practice patterns, and, although the proposed changes could be introduced under the present determination, it would be at a cost in terms of staff relationships so that a new determination was awaited. Clearly, in my view, that explained why the Minister had been so detailed in the structural efficiency measures sought in the determination, the importance of which was demonstrated by a letter from a VMO concerning proposed changes to the on-call rosters in the Northern Sydney Area Health Service as follows:

> The A.M.A. has been attempting to renegotiate V.M.O. contracts with the Department of Health since October 1987. Any negotiations have as a starting point the Status-Quo, therefore any decision by either party that unilaterally alters the Status-Quo is an intolerable breach-of-faith, that quite probably could torpedo negotiations. The current negotiations have already been threatened by such interferences as the notorious Baxter documents, the P.A.C. and the now discredited "Goldie Committee".
>
> If the management at Mona Vale Hospital seeks unilaterally to change the V.M.O. roster or otherwise at this time attempts to make changes to disadvantage V.M.O.'s, it seriously threatens and could cause the A.M.A. to abandon the negotiations with the

Department. This has the potential to throw the N.S.W. Public Hospital System into absolute chaos.

The various VMO witnesses who gave evidence were tested as to their relationships with the public hospital system and as to the nature and degree of their involvement in efficiency and budgetary type matters. It was clearly apparent there was a wide and marked range of differences between VMOs on those aspects, particularly as to the need for co-operation with hospital administrators in the proper allocation of the financial resources available. Before particularising that, however, I should comment there was no question as to the individual commitment of a VMO to the public patient under his care, and in that respect I accept the following observations made by Mr. *Rogers* in 1976 (Pt.2 at pp.4-6):

> It is also opportune to mention at this point something that I have borne in mind throughout in making recommendations on the matters submitted to me. The medical practitioners in relation to whose conditions of work I must make recommendations, include men whose reputation and skill ranks them in the most pre-eminent in the field, not only in the country but in the world. The specialists are practitioners who have spent years in acquiring the skills that they practice from day to day in the hospitals. As the field of medical knowledge is enlarged, the standards of skill required from the practitioners rise, the burden is ever increasing. In the result, it requires considerable time and effort on the part of the practitioners, both to maintain and to enlarge their skills, to keep up with ever new developments in the fields to which they have devoted themselves. This requires that they should spend many hours in the study of the literature pertaining to their speciality and as a very real need, they must attend conferences pertaining to their speciality, both in Australia and overseas.
>
> I have also borne in mind that in addition to the exercise of the skills practised by them, practitioners are called upon to work at hours which are frequently unpredictable and at time, extremely inconvenient. Above all, when called upon to practice their skills, they must at all times be conscious that the future welfare and indeed frequently the very life of the patient under their care, is in issue. In the result, their work is not only demanding of skill but coupled with the gravest responsibility. Inevitably, the stresses and strains imposed by a proper performance of duties will be of a high order.

The totality of the evidence before me affirmed the comments there made by Mr. *Rogers*. However, and as I earlier said, the public hospital system has developed much since 1976, and an overall view of the

evidence leaves me in no doubt that the modern practice of medicine and the proper functioning of the public hospital system require direct attention to resource allocation and management to an hitherto unprecedented degree. The VMOs, no doubt because of the historical functioning of the public hospital system and their role in it by controlling and organising themselves the treatment of patients, have unreasonably resisted the changes which have occurred and are still occurring. The evidence of Ms. Crawshaw, Dr. Horvath and Dr. Spring identified the relevant changes and highlighted many of the problems which had occurred. Significant too have been the financial management and accountability changes as detailed by Mr. Barker who traced the radical changes as to the system of budgeting and financial reporting within the health system, the move to global budgeting in 1988 and a system making hospital managers responsible for compliance with budgets. The effect of those changes on the professional practice of medicine in terms of ethics was dealt with by Dr. Horvath. The viewpoint of the hospital administrator was put by Mr. Clout. It is apparent, as was submitted for the Minister by Mr. *Kenzie*, that the various changes to the public hospital system, particularly in light of the cost of delivering health services, have been designed to ensure comprehensive control over the system, including by the participation of VMOs in a consultative capacity; the various structural efficiency measures sought in the determination are intended to facilitate that process.

I accept the thrust of the changes in the context of the practice of medicine in the 1990s in an environment where resources are clearly limited. It is no part of my role to be concerned with the allocation of resources, that is clearly a policy and a management issue, but where the decisions have been taken and implemented, as they have been here

during the last decade, then it is my role to consider the present claims in that existing context.

Mr. *Kenzie* was at pains to make it plain that the form of determination sought was neither intended nor directed to limiting the professional medical aspects of a VMO's treatment of a public patient; as he put it - "It is not disputed by the parties that VMOs should continue to be free to exercise significant discretions with respect to the clinical management of patients and the Minister's claim seeks to improve efficiencies with respect to the delivering of medical services in the public hospitals whilst preserving the capacity of VMOs to exercise discretion based on their judgments as to relative clinical needs." Whilst opposing the Minister's form of contract, Mr. *Sperling* nevertheless acknowledged the changes which had occurred in the public hospital system and the substantial involvement of VMOs in those changes. As Mr. *Sperling* put in his final address - "...an enormous amount of evidence to show that the public hospital system has been improved very substantially in its efficiency, that it is delivering an accelerated level of volume and services for a non-expanding amount of money and that is the situation that is very much contributed to by visiting medical officers in their contribution to the efficiency of the system." The issue then, it seems to me, was not the changes themselves but rather the environment so created under which VMOs render services and the need for appropriate provisions in any determination recognising that environment.

VMOs' differing attitudes to change

Whilst I accept on the evidence, as earlier intimated, that VMOs include practitioners of the highest professional skills, standing and reputation, and given the undoubted commitment of very many VMOs to the public hospital system as it has been evolving, the evidence established that the commitment and co-operation to the system was by no

means universal. The point was amply demonstrated by Michael Christopher Beatty, a general practitioner holding a VMO appointment at Murwillumbah District Hospital, from the following exchange in his cross-examination:

> KENZIE: Q. Doctor, from the position of President of the Visiting Medical Officer Group and Chairman of the Medical Staff Council I suppose you come into contact with quite a substantial number of VMOs?
> A. Yes.
>
> Q. It is clear where you stand in the scheme of things; you are a person as you have told us who is committed to co-operation and rationalisation to the extent possible?
> A. Yes.
>
> Q. You have certainly come across other people, VMOs, who share your views?
> A. Yes.
>
> Q. There would be people within your own experience, VMOs, who share your views but have not been as interested as yourself in actually coming forward in an administrative sense and giving effect to their views in a practical way?
> A. Yes.
>
> Q. There are some VMOs that you have come across who have really a lesser commitment to co-operation than you have?
> A. That would be true, yes.
>
> Q. There would be some VMOs, I suppose, who might or might not have a pre-disposition one way or the other in relation to the general question of co-operation with the hospital administration who would have particular views about their capacity within their own speciality or sub-speciality to do very much to help?
> A. Yes.
>
> Q. That would be right, would it not?
> A. That would be right.
>
> Q. You get a person operating within a particular sub-speciality who, as a matter of general experience, would tend to jealously guard the parameters of that sub-speciality?
> A. Yes.
>
> Q. That is a matter of experience, is it not?
> A. Yes.
>
> Q. You, as a general practitioner operating in the areas that a number of specialists operate, might have one view about the appropriateness of participation in an area of speciality but that view may or may not be shared by a specialist?
> A. That's right.

Q. That would be a matter of common experience for you?
A. Yes, that would be true.

Q. There are, regrettably, some Visiting Medical Officers who still carry the scars of the 1984 dispute and have certain resentment of the Department of Health and hospital administration as a whole?
A. Right.

Q. That is reflected, in some cases, in a lack of enthusiasm about co-operating with hospital administration, would you agree?
A. I would think so, yes.

Q. We are looking at a fair sort of spread of enthusiasm about the matter you are interested in, would that be right?
A. Yes.

Dr. Beatty explained that the hospital had about 100 beds, and the total visiting medical staff numbered 39 of whom 13 were general practitioners and 26 were specialists.

Brett Gerard Courtenay, an orthopaedic surgeon with VMO appointments to St. Vincent's Hospital, War Memorial Hospital at Waverley and Sacred Heart Hospice at Darlinghurst, expressed in evidence his strong belief that it was absolutely essential in 1992-93 "for VMOs to involve themselves up to the hilt in budgetary and efficiency matters"; Dr. Courtenay in fact had responsibility for the budget of the orthopaedic department at St. Vincent's Hospital. In terms of commitment, Dr. Beatty acknowledged the great pressures in maintaining medical services within budgetary restraints in order to achieve the necessary balance between the services provided and the capacity of the hospital or the community to pay for them; he acknowledged his commitment to the administrative aspects in the running of the hospital. Dr. Courtenay agreed there were VMOs who may or may not be committed to greater efficiency within the public hospital system. On the other hand, some VMOs regarded their role as being limited to the treatment of patients whereas the role of the hospital administrator was limited to financial and administrative matters; Geoffrey Noel Howsam, an opthalmologist with VMO appointments at Albury Base Hospital and

The Mercy Hospital, colourfully described himself in that respect as a "dinosaur" because he had come from the honorary system. Even as to St. Vincent's Hospital, Dr. Courtenay agreed there was a varying range of views amongst VMOs in relation to co-operation with management in the proper use of resources and some VMOs in the profession might be described as "dinosaurs" who took "the old view that, look doctoring is for doctors and administration is for administrators." Raymond Stanley Hyslop, an obstetrician and gynaecologist with a VMO appointment at Liverpool Hospital, gave evidence to a similar effect, and said - "I can appreciate very much the hospital's problem with certain members of staff, but in my opinion the sort of manual dexterity out-strips their clinical judgment and there are those who indulge in surgical extravaganzas which require enormous resources, but I feel these problems should be solved by hospital management at the coal face. They have the powers. They have the ability to do things about these." In such cases, Dr. Hyslop suggested the persistent offender "should be taken aside and some compromise struck about clinical judgment with the financial restraints applicable at the time."

Donald Stewart Child, a consultant to the Department of Health in connection with the present arbitration and formerly from 1956 to 1987 with Royal Prince Alfred Hospital in positions from a resident medical officer to Assistant General Superintendent in 1961 and General Superintendent from 1967, dealt with the discretions which presently were available to VMOs in the manner in which they conducted their public hospital practice as affecting cost and efficiency. He did so by reference to the Minister's claim for a specified number of contract hours and said:

> Whilst I agree that some mechanisms do exist in the hands of contracting authorities to limit VMO activity in order to achieve a

satisfactory budgetary outcome there are problems (and potential problems) which remain. One of the difficulties associated with the present arrangement is that, because of the retrospective method of claiming, contracting authorities are unable to assess performance against budget and it is quite conceivable that budgetary overruns may be hidden until late in a particular financial year. It is a fact of life that VMO budgets were overrun in the last financial year by approximately $6 million.

To correct such deficiency recognised late in a financial year results in large scale reductions over a short period with considerable and uneven effect on service provision. The reduction falls disproportionately on elective work, particularly surgery. Rapid corrective action has the capacity to cause significant disruption.

A more even reduction in activity may not yield a proportional reduction in expenditure as the present system would allow a VMO to increase the number of hours in attending the reduced numbers of patients admitted. Such increased attention to individual patients may not necessarily be a bad result from the patient care aspect but it cannot be controlled. What follows is that attempts to control expenditure may not be successful. Another advantage to be gained from "up front" negotiation is the ability to utilise the budget allocation to emphasise or change the services of greatest priority and, if necessary, to selectively utilise the skills of the most competent VMO. This is completely consistent with the promotion of efficiency within the system, something which is of particular importance today having regard to the fact of scarce resources and the tightening of monetary policy.

In a not dissimilar fashion to Dr. Child, Dr. Spring as to VMO conduct said:

However it is certainly the case that in some hospitals that employ Staff Specialists and Visiting Medical officers, working side by side, there has been resistance to Medicare or other work being transferred from VMOs to Staff Specialists or allowing Staff Specialists to increase their role.

One example of this is Hornsby Hospital where there was a Staff Specialist in Intensive Care with Anaesthetic qualifications. The Visiting Medical Officer - Anaesthetists took the view that vacant lists of VMOs should be largely taken up by other VMOs rather than the Staff Specialist - although some access was ultimately agreed. In the end, however, the Staff Specialist resigned and became a Visiting Medical Officer in a country area.

Michael Christopher Kennedy, a physician in general medicine and practicing in cardiology and pharmacology, had a VMO appointment to Manly District Hospital. He gave evidence as to differing practices of VMOs in relation to the effect on discharge practices, call-backs, emergency cases, telephone advice, teaching load, frequency and duration

of ward rounds, on-call rosters, attendance at committees and other meetings, frequency and length of out-patient clinics, and general clinical discretions and judgment. Dr. Kennedy took the view that the identified differences as between VMOs should be tolerated and accepted by the public hospital system because they were sufficiently subject to peer review.

Peter John Burke, a general surgeon with a VMO appointment to Western Suburbs Hospital, dealt with the involvement of VMOs in hospital administration in his statement of evidence as follows:

> I understand from discussions with the legal representatives of the AMA that the Minister has in his case suggested that visiting medical officers do not provide the same assistance to the hospital as they did prior to the dispute in 1984/1985.
>
> At Western Suburbs Hospital the Medical Superintendent who was a staff appointment ceased duties in 1986. Since that time two visiting medical officers, one physician and one surgeon, have taken on the role and managed the hospital from a medical superintendent's viewpoint. That has been the case for the last six years. One of the VMOs also chairs all of the committees and attends all of the committees that are relevant to the administration of the medical and clinical side of the hospital. In my experience all VMOs at Western Suburbs Hospital have a commitment to and assist in the committees of the hospital in one way or another.

Under cross-examination, Dr. Burke gave the following evidence:

> Q. You could very quickly give the hospital an idea of what your requirements were over a six month period on average, could you not?
> A. In retrospect, not in prospect.
>
> Q. Do you not think that if you took a look at your past activity within the hospital it would provide you with relative consistency in terms of the figures that you --?
> A. I have just jotted down the figures that you have given me for two consecutive years. The first one there were 30 call-backs. I received a total of $52,000. The second year there were 48 call-backs. I received a total of $48,000. Now, you know, what is the predictability in that? This year, the last twelve months, it is 27 call-backs. I do not know how much I have been paid because I have not got those figures. Perhaps you have; but how can you point to any sort of predictability? You ask me to comment on your figures. I cannot say what I am going to do this month or this day. All I can tell you is that I will fill the form in accurately and fairly

and honestly and when I have done that and I have done a fair job of work on the patients I was asked to deal with I expect to get fair payment. Now you can put it any way you like as far as work contracts with hours predicted in advance and I am sure that the accountants can draw up something and if they don't like my averages, they can average it out over all of the surgeons on New South Wales but it doesn't intend to reflect those sort of conditions which I want to see in the contract which is, I will do a fair bit of work on the surgical patients I treat and I expect a fair rate of remuneration in return.

Q. At the end of the day you are the one to decide which will give rise to the result, is that right?
A. I don't think that's true at all. I put down the amount of time I spend at the hospital. I get paid accordingly. The resident rings me and says that he has got some problem with the patient in casualty, he needs my services and I go straight in.
If he rings up to discuss something I might be able to decide whether it is important for me to come in, that is why the hospital has hired my services.

Q. Your position is that it is for the personal practitioners to decide how much medical service is required in relation to patients?
A. In relation to a particular incident or a particular patient, yes.

Q. At the end of the month or the year when you decide to render an account to the hospital, the administrator is faced with the task of paying that account, whatever it turns out to be?
A. He either believes me or he doesn't. If he is looking for some further checks, my account is already checked by the Director of Surgical Services. He peruses every surgical account such as is handed to the hospital. If he has any reason to query it, then that's his job to do so. If there is a problem in relation to an individual that can be addressed. I don't accept that there is a problem in relation to the surgical service, for instance, or as far as I know any other medical service within the hospital.

Q. In your analysis of things your future needs are unpredictable, is that right?
A. Yes.

Q. So your analysis is that you will provide whatever treatment that the position seems to indicate in relation to the patient's needs or care?
A. I can't see the facts of life as regards specialists' surgical practice changing.

Q. Your position is that you will provide the requisite amount of care that you decide?
A. I will provide the appropriate care for each patient I am called to see.

Q. And the hospital will have no say in relation to that decision as to the amount of care that you decide to give, is that right?
A. The hospital has hired an expert in this area to decide what is necessary and that expert happens to be me.

Q. If you, in your wisdom, thought that a certain number of hours are required to treat a particular patient and someone else in a corresponding situation says double your half, that is the way the dice falls, is that right?
A. There is nobody else who can determine what I must do in a particular situation than me.

Q. Is what I put to you right?
A. That somebody might take a shorter time to do an appendectomy than I would, so twice as long, is that right? Is that what you are suggesting?

Q. Yes.
A. I suppose a hospital could have only those persons who do appendectomies routinely in three-quarters of an hour.

Q. Doctors may take a very different view as to the amount of after care that a particular operation requires within a professional judgment, is that right?
A. Doctors will give the appropriate care.

Q. The views about the amount of appropriate patient care may vary as between doctors, is that right?
A. Yes.

Q. The views of one particular doctor as to the appropriate circumstances in which he will decide to come back in and attend a patient might vary from the views of another doctor?
A. That is correct.

Q. The situation that you describe on your figures is an unpredictable one?
A. Yes.

Q. So as you say in paragraph 34 of your statement it is the patient care that dictates the amount of services I provide to the patient?
A. Yes.

Q. So that your analysis of the system is that really there isn't anything that can be done to avoid the situation in which the Hospital Administrator is faced with an unpredictable series of accounts rendered to him or her by the VMO, is that right?
A. I can't see how that would be altered commensurate with payment on an hourly basis.

Q. You invite continuation of the position in which a series of unpredictable accounts is going to be rendered through to hospital administrators throughout the State, do you?
A. That is impossible to change as long as you are paying hourly rates, yes, because the hours are indeterminate, unpredictable rather.

Q. You accept that there is an unwiliingness so far as doctors that you have spoken to about working for nothing in relation to clinical work?
A. I think there is a variety of opinions on that.

Q. Some people are of the view that they really are against the idea of working for nothing; other people have a more flexible view?
A. Other people wish to work in an honorary capacity only, yes.

I have quoted Dr. Burke's evidence at some little length because it represents, in an extreme way it seems to me, an attitude against the imposition on VMOs of many of the reforms already achieved in the public hospital system during the 1980s and further reforms sought by the Minister in his present claim. I formed the view that Dr. Burke was an example of the honorary in the former public hospital system who had carried attitudes through to the new system when VMOs were introduced and was continuing to persist in such attitudes notwithstanding, and what I perceived to be common ground between the parties, that efficiencies needed to be effected in the operation of the modern public hospital system. I therefore refer to Dr. Burke's evidence for the purpose of accepting it as demonstrating the need for a determination to be made consistent with structural efficiency measures and the cost effective operation of the public hospital system in accordance with available resources. Indeed, Phillip Anthony Trew, a nephrologist with VMO appointments to St. George Hospital and Sutherland Hospital, was heavily committed in administrative and budgetary tasks as Head of the Division of Medicine at St. George Hospital. He gave, in my view, impressive evidence as to his commitment to and co-operation with the public hospital system in what was very much a medical management role, and in which efficiency considerations were recognised. Dr. Trew made the point during cross-examination as follows:

Q. And certainly that devolution of responsibility within the Division of Medicine to clinicians, including yourself, is accepted?
A. It is a double-edged sword though. I believe this is the right way for me to get the best value for the public dollar.

Q. And I take it that in some situations it puts you in a difficult position of mediation between the administration and other VMOs in the hospital?

A. No, they don't have direct contact. I am responsible for what is going on in the division. If I don't deliver the goods then I get moved on. It is my responsibility to deliver the service or make sure the Division of Medicine delivers the service but VMOs don't have direct negotiations with the hospital administration.

Q. They deal with you?
A. Yes.

Q. And the system that you have given evidence about today, of working within the budget, I take it is premised very much upon co-operation with the VMOs and respect between the parties?
A. Yes.

Q. If they don't like a particular ruling or decision that you make about a matter --
A. I won't be in the job for long.

Q. They won't be?
A. No, I won't be. I think that you can see that everyone is about heading in the same direction. They want to deliver the service that the people using the hospital require. The people who deliver the service I think know best what the actual demands are and that is where we are sort of coming from. What we have ended up doing is, stripped firstly of the old administration, brought those resources back down to the patient level.

Q. All right, and I take it that the proper functioning of the Division of Medicine rests very much upon co-operation from all the VMO's?
A. I think the co-operation of everyone and everyone heading in that same direction.

And further Dr. Trew said in cross-examination:

Q. The situation that you face as the head of the Division of Medicine is that you have a budget that you must seek to adhere to in very difficult economic circumstances?
A. Yes.

Q. And it seems from your evidence that that at least provides one of the reasons for the monitoring process that you refer to in your evidence of the activities of the VMOs within your division?
A. Activities across the whole division, yes, we monitor activities of groups.

Q. And this is to guard against the prospect that, for whatever reason, the cost in a particular area may blow out and thereby completely undermine your capacity to stay on budget?
A. Yes. I think we keep on talking about dollars and cents and dollars are a common denominator in the way you do things, I guess. I agree, but our aim is to primarily deliver services; look at what resources we have got and look at the best way of using those resources to deliver those services and it is not all sort of centred around the dollar. The dollar is a component of it, agreed.

Our primary aim is to deliver services most effectively. You are trying to see how efficient you are delivering services. You have to

revise the way in which you are doing it and look at whether there are potential cost savings or potential cost losses and so forth and it is really the activities that we are about. Within the same sort of budget it has been possible to make savings across the board of something like 10% which means people are using those resources more effectively. In other words you are extending the services but the budget is a budget and that is a fixed amount of money whether you are at a bank or a hospital.

Q. Just on that point you have indicated you have managed to achieve an increased activity within the same budget but in general terms how did you achieve that in the last financial year, how were you able to increase activity by 10% and stay within budget?
A. We did it by looking at average length of stay before planning an admission and before planning a discharge. We looked at the utilisation of different groups of people, whether medical, nursing or allied health and then we looked at those areas where we could deliver services in a different way, and it was a combination of all those factors.

Q. Could you give us an example of delivery of services in a different way?
A. Yes. I think where in the past a patient came in and stayed overnight half of these now come in the morning and go home in the evening and that is a cost saving in lots of ways.

Q. But again co-operation of the staff within your division is critical in this regard?
A. Yes. They are the ones that run it day to day.

Q. You made reference in your evidence to peer pressure and you have indicated your experience has been if a doctor is made aware, following your discussions, that he is out of step and that the consensus is he does not have a fantastic explanation for it, in your experience he tends to, within his own revaluation, to bring himself back within the range?
A. Yes.

Q. Whilst this may not have been within your experience, if a doctor does not respond to that peer pressure, if you like, there is very little that you can directly do to control that activity, is there not?
A. Not entirely. I think that if a person practises outside of the norm and they just say "That's tough, that's the way I do it" then I think that any resources that you might distribute through his department may be allocated elsewhere. For instance, if you have an opportunity where a doctor has a fixation of keeping a particular illness in a hospital for three or four days longer than was common practice then maybe it is better to have those patients taken from him and put under someone who is more efficient.

Q. There are difficulties, are there not and limits on your capacity to do that?
A. It depends on what the concerns of the patient are. In our division there are certain groups of people who are elective admissions and they fit into certainly three or four large groups but across a number of departments the vast majority of patients are emergency determined admissions, unprogrammable, and it is up to

us to run rosters for each of the services so we can indicate whether it is efficient to run a particular person as his peer group.

Q. We have heard evidence of practices whereby a patient attends a hospital, that they will be admitted under the doctor that saw them - they were at that hospital regardless of whether that particular doctor is on call that particular night?
A. I agree, that has been the practice around a lot of hospitals. It is not always appropriate and with our system the way it happens, the person on call for that period takes care of that patient. They may transfer him back if it is a particularly complicated long illness to someone who has been caring for them previously but at the time of the admission they will be admitted under them and then there is an option of transferring back at a later stage.

Unless a patient is a private patient then in that case they have a choice.

Q. One of the clear themes in your evidence is your belief you do have to look at the relative efficiency of practitioners?
A. Yes.

Q. Because of the cost constraints that we have talked about and, indeed, your evidence has stressed what you believe is the essential need to be able to reward people who are more efficient consistently or limit those people who are less efficient?
A. Yes.

Q. With respect to the situation that you administer at St George you reward the VMO who appears to be working - I will stick to VMO, I know you have a wider responsibility - if a VMO has done a particularly good job and is responding to the needs of the department or the division in a particularly admirable way, your evidence contemplates the prospect of there being rewards for that efficiency. Could you indicate to his Honour the way in which you do reward that improved efficiency?
A. It is not up to the individual in our division, it is to their department, if a department runs efficiently and under budget the excess in their budget is retained within their department for the use of their department.

Q. I think you indicated at the bottom of page 4292, "Any improved efficiency in terms of the cost of running those activities are returned to that department to either increase or improve the quality of that particular activity or increase it if they have the facilities to do so."?
A. Yes.

Q. Say, for instance, the doctors in a particular department say "We now want to introduce a new procedure or have a different range of diagnostic services, and we produce the money on our own efficiency therefore can we do it?"?
A. One of our departments might be very efficient and they would like to increase the amount of, say, occupational therapy time then that was their option and their choice, in other words they have returned that to more patient care.

Q. I think you indicated a view that if a department was inefficient you could re-allocate resources away from that particular area if you so decided?
A. Yes. You decide what you need for a particular service, in other words what are the patient's needs for a particular service and you don't limit those because you have a few of the crew who are out of step. You make sure the people get the care even though the people who are delivering it are not the most efficient ones. As you have highlighted we get a lot of co-operation by people having information about what is happening.

Dr. Trew's evidence was an example of a VMO with a dedicated commitment to the public hospital system and with a recognition for present budgetary restraint, whilst at the same time ensuring the delivery of services consistent with patient need.

In a similar practical and realistic way, and achieving a balance to what I referred to earlier as the ethical dilemma, Michael John Jensen, a general surgeon specialising in cancer surgery with a VMO appointment at St. Vincent's Hospital, gave detailed evidence as to his and other VMOs' involvement in the area of structural reform. Dr. Jensen responded in cross-examination as follows:

Q. It involves co-operation between the visiting medical officers with a view to maximising facilities at the hospital?
A. Yes.

Q. You are certainly a member of the school which supports co-operation between the visiting medical staff and hospital administrators in relation to the utilisation of resources?
A. I believe most VMOs fall into the school if they are dealing with reasonable administrators.

Q. You certainly are not a member of the school which suggests that VMOs are only advocates for their patients and that there is such a conflict of interest between the role of the VMO as advocate for the patient and the process of allocation of resources, that it is really inappropriate for VMOs to become involved in the last mentioned issue, are you?
A. I actually gave evidence this morning I was an advocate for my cancer patients admitted into the hospital. That is the sort of role we mean by being advocates for our patients. This is not a union strike. It is a reasonable approach for us to get our patients into hospital. In my case the majority of my patients are cancer patients and if I am not their advocate, nobody in the system is. Perhaps on a fixed contract or on a staff specialist award I may not be an advocate in the same way.

> Q. So his Honour understands your position, you see no conflict of interest between your role as advocate for a patient in getting that patient into hospital and your role as a responsible member of the hospital community, medical community, in playing a role in relation to responsible use of hospital resources?
> A. No, none at all.

In his final address, Mr. *Sperling* shortly but comprehensively referred to efficiencies in the public hospital system and said:

> Your Honour has an enormous amount of evidence to show that the public hospital system has been improved very substantially in its efficiency, that it is delivering an accelerated level of volume and services for a non-expanding amount of money and that is the situation that is very much contributed to by visiting medical officers in their contribution to the efficiency of the system. Insofar as the spirit of the principle requires that the visiting medical officers themselves should have implemented measures to improve efficiency, they certainly have.

Whilst in general terms the position may well be, and I accept is, as Mr. *Sperling* stated, I think it to be clear from the evidence that sufficient numbers of VMOs are not participating with the majority of their colleagues in ensuring structural efficiencies consistent with available resources. The "dinosaur" syndrome has no modern relevance. It is necessary, therefore, for a determination to contain appropriate provisions to remedy the situation.

The evolving NSW health system

In a submission dated November 1988 by The Association of Medical Superintendents of New South Wales and the Australian Capital Territory, prepared for the inquiry at that time being conducted by the Public Accounts Committee into visiting medical officer costs and which submission was tendered in the proceedings before me, some of the problems experienced by country and district hospitals in New South Wales were noted. Directly as to VMOs the submission stated:

> The lack of real authority of Health Service Administrators in general and Medical Superintendents in particular, over the actions and behaviour of Visiting Medical Officers in public hospitals.

Such authority should be continued in the By Laws and contracts of employment. These should also lay down certain standards required of Visiting Medical Officers for accountability (as well as supervision and teaching of there Resident staff, evaluation and quality assurance, compliance with hospital admissions policy and so forth).

The old model By Laws and delineation of privileges were moving towards a more defined and detailed set of obligations, in consultation with medical organisations. the moderate majority of the profession recognised that doctors had responsibilities to public hospitals which did need more careful definition and it was freely admitted privately that there was a small but significant group of doctors who did not provide services in a professional manner. It was recognised that this group was, generally speaking, giving the profession an adverse reputation.

Many doctors in this small group were not really interested in public hospitals or their role, and tended to resent any regulations or attempts to limit their activities.

They would vigorously defend their right to extend operating lists for as long as they wanted to regardless of overtime costs to nursing, anaesthetic and resident staff. They would admit patients at any time of the day or night, do ward rounds when it suited them, provide little or no supervision to junior staff, let alone teaching, expect nursing staff to behave in the now out dated obsequious manner, invariably give priority to their rooms or private hospital sessions, frequently arriving at their public operating sessions late, wasting public hospital staff time, to say nothing of the inconvenience to the patient.

Such excesses of behaviour seem to have become more common in recent years.

Medical Superintendents whose authority has been significantly undermined over the years have to rely on the support of their Boards and Executive Officers, on their personal credibility and respect, and on the support of the more responsible members of the Medical Staff Council to exert Peer pressure.

Moreover, over recent years, with the health system constantly buffeted by changes, with Boards and administrative arrangements in upheaval, Visiting Medical contracts, if written at all, contain virtually no sanctions for this type of behaviour. Non-medical administrators frequently give little support to their Medical Superintendents and Board members are at best confused about the issues, and at worst either blindly pro or anti-doctor depending on their political perspective.

The ultimate sanction has to be failure to renew appointments. Yet hardly any hospital has been prepared to go this far despite deep dissatisfaction with some of its Visiting Medical Officers.

The reasons for this are first, that appeals by doctors against failure to appoint have been successful, second, in a country town or district metropolitan area, such action will cause major conflict in the community, third, as the concerns frequently relate to specific

> patients, much of the story cannot be publicly told, fourth, few doctors, when the crunch comes, are prepared to support sanctions aginst their colleagues, fifth, the majority of Executive Officers are accountants who come from a clerical/administrative background and are out of their depth in such circumstances.

The Association therefore recommended, *inter alia*, "(t)hat By Laws ensure contracts with Visiting Medical Officers clearly specify requirements for compliance with hospital policies and accountability for specific functions" and "(t)hat the provisions for reappointment be contingent on a careful and detailed report on such compliance." The significance of those submissions as part of the total context in which the present claims fall for consideration, particularly those as to structural efficiency measures and a more specific and detailed sessional contract, will be obvious.

At the Area Health Service Conference in February 1991 sponsored by the NSW Department of Health, the topic was "Area Health Services as a Planning and Management Tool for the Future." In the keynote address, the Hon. Brian Howe, federal Minister for Community Services and Health, observed that the Australian health system, common among developed countries, was currently experiencing organisational problems including the need to limit costs and to achieve greater equality in the share of resources and services across a multitude of geographical locations and between diverse groups of people. Of course, Mr. Howe dealt with many other issues. But I mention those two because of the clear relevance to the proceedings before me in terms of the already stated need for efficiencies and of the allocation of resources to the public hospital system as it might be affected by the ethical dilemma in the rendering of services by VMOs to public patients. Reference has been made to the evidence given by Dr. Horvath in that latter respect and there is no need to say more about it, except to emphasise what emerges as a clear national, indeed international, need for such issues to be recognised. The

Minister's claim, in the way it was presented, seeks to do that to the extent it can seek appropriate provisions in a determination as to the terms and conditions for the engagement of VMOs. Further, the then NSW Minister for Health, the Hon. Peter Collins, presented a paper in opening the Conference entitled "Improving Health Services: The Next Steps Forward". Relevantly, the Minister said in the paper:

> Managed Access: Involving Medical Practitioners in Management
>
> At the service delivery level, medical practitioners are a major influence on the health system. Governments have a poor record in communicating with the medical profession and in responding to their concerns. They have not been integrated into the management team.
>
> I have worked hard to restore better relations with the medical profession, with more doctors now on Area Health Boards and in the management of the Health Department. The return of the orthopaedic and ophthalmic surgeons is also evidence of this improved approach.
>
> Clinicians must have more involvement in the management process and take greater responsibility for service demand, adoption of new technology and access to hospital and specialist care. They need to be committed to the process of management. Their success and that of the organisation must be synonymous. This involvement should be professionally rewarding rather than merely a dull burden.
>
> In line with the Government's support for devolution I have asked the Area Chief Executive Officers to actively involve clinical staff in the management of public hospitals. This is an inevitable trend, which will increasingly bring those responsible for clinical services into the front line of resource allocation decisions.
>
> A number of hospitals in NSW have initiated such management reforms. An example is Royal Prince Alfred Hospital, where bed and resource management has been devolved to the clinicians themselves. They are responsible for making the best use of beds and for operating within their budgets.
>
> These additional responsibilities require management training for medical practitioners. University medical schools should be doing much more to ensure that doctors receive adequate management training. They focus too narrowly on diagnostic issues and not sufficiently on total health outcomes.
>
> Already some Area Health Services are organising short intense management training courses for medical practitioners. I would encourage an expansion of these.

> The acceptance of additional responsibilities by clinical staff places an obligation on hospitals to ensure improved flow of information. For example, the use of diagnosis related groups will allow clinicians to compare the costs and benefits of different treatment options.

The extent to which VMOs are sought to be involved in the management process in the public hospital system received clear recognition in the Minister's address. The nature and manner of implementing the structural efficiency measures discussed in the proceedings before me clearly are to be seen in light of the proposal so referred to at the Conference as directly affecting VMOs in the public hospital system. The details were dealt with extensively in the evidence before me, and I have earlier in these reasons attempted a summary by reference to the essential points.

Suffice it to say I am well satisfied the present context of the public hospital system, the way in which it has developed in the last decade or so and its needs in the foreseeable future, firmly make out the Minister's case for the implementation of structural efficiency measures and for a determination affecting VMOs under sessional contracts to recognise that by appropriate provisions. Of course, what those provisions should be will require consideration according to an assessment of the particular evidence in relation to each subject matter. But I accept it to be beyond doubt that an overwhelming case has been made out for a new determination, unlike those previously made where the circumstances were different, to contain quite specific and detailed provisions as to the terms and conditions under which a VMO renders services according to a sessional contract.

Public hospital system - present components

The *Public Hospitals Act*, pursuant to Pt.5C of which the present arbitration is being conducted, defines "Hospital" in s.3 as follows:

> "Hospital" means any institution or organisation established for the relief of persons to which any of the provisions of this Act have been applied by or under section 4, and subject to the provisions of this Act, includes any hospital under the control of an area health service, any separate institution, and any institution for the care of the aged or infirm, or of convalescent or incurable persons or persons suffering from a chronic ailment, any district nursing association, any bush nursing association and any organisation for providing aerial medical services.

It follows then, and as supplemented by the evidence of Ms. Crawshaw, that there are three categories of public hospitals as the principal components of the State's public hospital system and to which medical practitioner staff may be appointed to provide medical services, namely -

(1) Hospitals under the control of area health services. The *Area Health Services Act* 1986 constituted area health services, presently ten in number, according to local government areas in the major metropolitan centres of Sydney, the Hunter and the Illawarra: s.5 and Sch.2. The affairs of an area health service are controlled by the area health board for that service: s.13. An area health board is subject to the control and direction of the Minister: s.14. The primary objectives of an area health service are specified in a comprehensive way as to public health generally, and, relevantly for present purposes, "to achieve and maintain adequate standards of patient care and services" and "to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services": s.19. Specific functions are imposed on area health services, including the requirement "to manage hospitals or other health services under its control": s.20. An Area health service may, with the approval of the Minister, make by-laws as to various matters with respect to the affairs

of the service, including by-laws for the appointment, control and governance of visiting practitioners in hospitals under its control: s.32(1). Public Hospitals under the control of area health services cover the major teaching hospitals, and the metropolitan and district hospitals.

(2) Incorporated hospitals appearing in the Second Schedule to the *Public Hospitals Act*. Such a hospital is constituted as a body corporate: s.18. Each incorporated hospital is governed and managed by a board of directors subject to the control and direction of the Minister: ss.22 and 22A. The board has the duty to achieve and maintain adequate standards of patient care and services provided by the hospital, and to ensure the efficient and economic operation of the hospital: s.27A. By-laws may be made by the board, with the approval of the Minister, including by-laws providing for the appointment, management and government of visiting practitioners: s.28(1). Generally, incorporated hospitals are located in the country districts of the State, except The Royal Alexandra Hospital for Children at Camperdown, United Dental Hospital of Sydney at Surry Hills and The Sydney Home Nursing Service.

(3) Separate institutions appearing in the Third Schedule to the *Public Hospitals Act*. Those institutions are conducted by religious or charitable organisations and receive the greater proportion of their operating costs from government subsidies. Each such separate institution has its own governing authority which is required, like the board of an incorporated hospital, to achieve and maintain adequate standards of patient care and services provided, and to

ensure the efficient and economic operation of the institution: s.29AD. The governing body of a separate institution may, with the approval of the Minister, make by-laws, including by-laws providing for the appointment of visiting practitioners and generally for their management and government: s.29AE. Separate institutions are located throughout the State, examples being St. Vincent's Hospital (Bathurst, Darlinghurst and Lismore), Newcastle Mater Misericordiae Hospital, North Sydney Community Hospital, Sacred Heart Hospice at Darlinghurst, The Royal Hospital for Women at Paddington, St. John of God Hospital (Goulburn) and St. Margaret's Hospital at Darlinghurst.

It should be remarked that service planning and development, and the attendant need for rationalisation of hospital and other health services, now operate within both an administrative and statutory framework at a micro and macro level. For instance, the Department of Health has a State-wide service development, planning and monitoring responsibility in accordance with its functions under the *Health Administration Act* 1982, which Act established also the central administrative infra-structure of the State's health system. The Director-General of the Department is under a statutory duty imposed by the *Public Hospitals Act*, s.11 *inter alia* to facilitate the achievement and maintenance of adequate standards of patient care in hospitals and services provided by area health services and hospitals, and to facilitate the efficient and economic operation of area health services and hospitals. At an administrative level, the service planning and development functions of the Department in respect of individual hospitals are co-ordinated on a regional basis by officers of the Department in country centres, and by area health services in the major metropolitan areas.

Ms. Crawshaw, as part of her evidence in relation to the public hospital system, referred to the development of sound risk management policies as part of the statutory scheme for ensuring proper standards and sound clinical practices in hospitals. Her evidence in that respect was largely unchallenged and I have relied on it as further material forming part of the relevant context in which the present issues are to be decided. She mentioned the measures being adopted to ensure a clinically sound environment for patient care by reference to the NSW Treasury Managed Fund as the Government's self-insurance arrangement encompassing public hospitals and area health services. The Fund, the structural scheme of which was admitted into evidence, commenced on 1 July 1989. She said in that respect in her statement of evidence:

> Prior to 1989 the Department held Master Insurance Policies, including a Public Liability Policy, in respect of public hospitals and area health services, with the GIO.
>
> From 1 July 1989 these policies were replaced by the Treasury Managed Fund. This is, in effect a Government self-insurance arrangement which encompasses public hospitals and area health services. A direct consequence of the introduction of the Managed Fund has been the need to develop sound risk management policies in the health system. This, together with recent case law, has brought into sharper focus the duty of the system to ensure proper standards and sound clinical practices, particularly in its hospitals. Hospitals are directly accountable for all aspects of the care of hospital patients, commonly known as public patients, but none the less have a non-delegable duty of care in respect of all patients that attend, irrespective of their health insurance status. As indicated previously, this has been enshrined in legislation which requires hospitals and area health services to achieve and maintain an adequate standard of patient care.
>
> It is for these reasons that a number of measures have been or are being developed to ensure a clinically sound environment for patient care, including:
>
> (i) Appropriately delineating the role of hospitals consistent with the level of facilities, staff numbers, community requirements, etc. To this end a Guide to the Role Delineation of Health Services is being developed.
>
> (ii) Ensuring that the clinical privileges of all staff specialists and visiting practitioners are properly delineated on a clinically sound basis. To this end the Area Health Services

Model By-law, gazetted in August 1989, sets out appropriate procedures for the delineation of and subsequent review of clinical privileges by properly constituted Credential Committees comprising members of the medical profession.

(iii) Action by the Department to constantly review and update its administrative circulars which establish statewide policies for the health system on such issues as informed consent, patient confidentiality and various clinical issues.

That statement highlights, importantly it seems to me, the recognition of the direct accountability of hospitals for all aspects of the care of public patients and the non-delegable duty of care in that respect. That standard of patient care, as Ms. Crawshaw said, has been enshrined in recent legislation. This makes all the more critical, in the approach I take, the acceptance of a favourable view towards the Minister's structural efficiency claims in relation to the provisions in sessional contracts specifying important aspects in the relationship between a VMO and a public hospital as to matters such as clinical privileges, obligation to provide the services as specified, requirements as to compliance with all rules, by-laws and policies, maintenance of appropriate and necessary clinical records and other clinical documentation, requirements as to professional responsibility and adherence to accepted ethics, participation in various committees on quality assurance and peer review, participation in on-call rosters subject to call-back, and provisions for the suspension and termination of a sessional contract.

VMOs as part of the medical staff of public hospitals

The medical staff of a public hospital is comprised of both employees and non-employees of the hospital. However, I think it to be settled that a VMO even though an independent contractor is still very much part of the hospital staff: *Razzell v. Snowball* ([1954) 1 W.L.R. 1382;[1954] 3 All E.R. 429).

The employed medical staff is made up of interns, resident medical officers, registrars, senior registrars, career medical officers, specialists,

senior specialists and medical superintendents. Being employees, the terms and conditions of their employment are regulated by industrial awards made under the former *Industrial Arbitration Act* 1940 and now the *Industrial Relations Act* 1991. The term "resident medical officer" includes the categories of intern, resident and registrar and relates to those salaried medical officers in the first year after graduation (the intern) obtaining hospital experience in a supervised environment as a condition of registration as a medical practitioner to a medical officer seeking additional hospital experience (the resident) to the medical officer undertaking training in a medical specialty and obtaining higher medical qualification (the registrar). Those positions, by their very nature, are not long-term and are part of a practitioner's career development in obtaining either a salaried position as a career medical officer or a staff specialist in a public hospital or entering private practice. The Public Hospital (Medical Officers) Award (209 N.S.W. I.G. 2771) applies to resident medical officers, which, in addition to specifying conditions of employment, contains annual salaries and provisions for overtime and other penalty rates but no right of private practice. The Public Hospital (Career Medical Officers) (State) Award (unpublished, *Sweeney* J., 19 October 1989), as its name implies, applies to career medical officers as to salaries and employment conditions; it makes provisions for overtime and other penalty rates but no right of private practice. The staff specialists are covered by the Medical Officers - Hospital Specialists (State) Award (264 N.S.W. I.G. 1090) as to salaries and employment conditions but with no provision for overtime; private practice arrangements exist outside that award by agreement. The Public Hospitals (Medical Superintendents) Award (265 N.S.W. I.G. 1417) prescribes salaries and employment conditions for medical superintendents but there is no provision made for overtime nor for private practice arrangements.

Set out at Appendix "J" is a document prepared jointly by the parties explaining the nature of resident medical officers and career medical officers as part of medical services provided by public hospitals, and including a table of current annual rates of salary payable to the various categories of salaried medical officer. I would only add that the career medical officer, unlike the resident medical officer, is a category designed to cater for a career in the public hospital system for non-specialist medical officers and so would be expected to involve long-term appointment.

The relevance of the salaries and arrangements existing for the employed medical staff was the use to which they were put during the proceedings on a comparative basis to assess appropriate rates for VMOs. For the AMA's part, it concentrated on the salaries for staff specialists and their over-award entitlements to private practice in building an hourly sessional rate for a VMO specialist and then applying a proportionate increase to the hourly sessional rate for a VMO general practitioner. On the other hand, the Minister for the same purpose aligned the career medical officer classifications with the VMO general practitioner classifications and aligned the specialist classifications with the VMO specialist classifications. Whilst there was no express agreement between the parties on this aspect of comparison, indeed as will later appear the parties were wide apart even as to the items to be included in a proper comparative exercise, there was at least an acceptance that the actual work performed by a salaried staff specialist was generally the same as that performed by a VMO specialist and as requiring an equivalent level of qualifications, skill, knowledge and experience. I will of course deal later in these reasons with that aspect in more detail, but at this stage I am able to comment from an examination of the respective annual salary and hourly sessional rates that there is some comparative logic and

consistency in relating the career me
practitioner. However, existing relativities within the [illegible] VMO determination should not lightly be set aside in the absence of compelling evidence to the contrary.

For completeness, reference to which will be made later when dealing with the remuneration claims, reproduced as Appendix "K" to these reasons is circular No. 90/39 issued on 23 May 1990 by the Department of Health setting out changes made on 12 December 1989 to the private practice arrangements for salaried staff specialists and the resultant current arrangements in that respect for Schemes A, B, C and D.

Finally, the employed medical staff, and whilst precise figures were unavailable, would seem to number approximately 4,000 medical officers of whom about 1,000 are staff specialists; of those specialists, 900 are in Schemes A, B and C and about 100 in Scheme D. As to the private practice rights of staff specialists, those in Scheme A receive an allowance of 20% of award salary in lieu of private practice; those in schemes B, C and D have a right of private practice in addition to their employment duties; and those in Scheme D, known as "half-time specialists", receive 50% of the full-time award salary with the remaining available time spent by them in private practice outside the employing hospital. In the various comparative exercises conducted by the parties, the AMA relied on the arrangements applicable for the Schemes A, B and C staff specialists whereas the Minister concentrated on that for the Scheme D half-time specialists as most closely parallelling VMOs insofar as their private practice arrangements were concerned.

Apart from the employed staff, medical services are rendered by practitioners engaged otherwise than as an employee of the hospital or area health service concerned. Section 3 of the *Public Hospitals Act* defines "Visiting practitioner" as follows:

> "Visiting practitioner", in relation to a hospital, means a medical practitioner or dentist appointed to perform work as a medical practitioner or dentist, as the case may be, at that hospital otherwise than as an employee.

Section 29K of the *Public Hospitals Act* defines "visiting medical officer" as follows:

> "visiting medical officer", in relation to an area health service, incorporated hospital or separate institution, means a visiting practitioner appointed to perform work, as a medical practitioner, under a service contract with that area health service, incorporated hospital or separate institution or the governing body of that separate institution.

Thus, whilst a VMO must be appointed as a visiting practitioner, a visiting practitioner may not necessarily be a VMO. Appointment as a visiting practitioner to a public hospital entitles the practitioner to admit private patients to the hospital and to utilise its facilities and staff. Those visiting practitioners who have no VMO appointment to treat public patients are known as affiliates, and include practitioners retired from active service appointed as consultants *emeritus* largely on an honorary basis.

It will be seen from s.29K of the *Public Hospitals Act* that a VMO's appointment under a service contract is to be on an honorary, fee-for-service or sessional basis. Whilst precise numbers are not available, it would appear that there are currently in excess of 5,000 VMO appointments in the State's public hospital system of which there are approximately 3,442 on a sessional basis and 1,574 on a fee-for-service basis attracting remuneration. Because VMOs may have appointments to more than one public hospital, it was said by the parties to be difficult to determine the actual number holding the available 3,442 appointments, although it was generally agreed there would be approximately 2,750 practitioners under sessional contracts. It should be mentioned that whilst the present arbitration was concerned with VMOs it was only so

concerned with those under sessional contracts and not on a fee-for-service basis nor radiologists nor pathologists who, and whilst only small in number, were engaged under lump-sum contracts due to the nature of the services provided by them and the impracticability of using a sessional or fee-for-service basis. The relatively few honoraries remaining in the system were also excluded from present consideration. It may be remarked too that the mix of sessional and fee-for-service contracts altered as a result of the settlement reached in the 1985 doctors' dispute so that sessional contracts only were available in the teaching hospitals and modified fee-for-service contracts remained in the smaller country hospitals; VMOs were given the choice in the metropolitan district and country base hospitals to choose the preferred method of remuneration, either sessional or fee-for-service, each three years. The sessional basis of contract remains as the major means for remunerating VMOs in the State's public hospitals.

The participation of VMOs in the public hospital system will be seen to be most significant and important having in mind that of the total number of medical staff rendering services VMOs make-up about 55 percent. The degree of involvement of VMOs in the public health system will be more readily appreciated, again in terms of numbers of practitioners, from statistics provided by the Department of Health for the year 1990 in the "Profile of the Medical Workforce in NSW" which showed there were 13,161 active practitioners out of a total 19,877 medical practitioners registered with the New South Wales Medical Board - in excess of 20 percent of active medical practitioners were directly engaged as VMOs under sessional contracts in public hospitals.

Findings from the context

From my conclusions on the background as it has evolved to the present context of the public hospital system, I make the following findings -

- VMOs constitute a most significant and important part of the public hospital system as members of the medical staff.
- VMOs, from general practitioner to senior specialist level, include medical practitioners of the highest professional skills, standing and reputation, and with the undoubted commitment and co-operation of very many of them to the public hospital system as it has been evolving.
- That commitment and co-operation are by no means universal, and sufficient numbers of VMOs are not participating with the majority of their colleagues in ensuring structural efficiencies consistent with available resources.
- The modern practice of medicine and the proper functioning of the public hospital system require direct attention to resource allocation and management to an hitherto unprecedented degree.
- The various changes to the public hospital system, particularly in light of the cost of delivering health services, have been designed to ensure comprehensive control over the system, including by the participation of VMOs in a consultative capacity; the various structural efficiency measures sought by the Minister in a determination are intended to facilitate that process.

The present context of the public hospital system, and the way in which it has developed in the last decade or so and having in mind its needs in the foreseeable future, firmly make out the Minister's case for the implementation of structural efficiency measures and for a determination affecting VMOs under sessional contracts to recognise that by appropriate provisions.

CHAPTER 4 - BASIS OF APPROACH

The nature of the claims made by the principal parties requires attention be given to the scope of the arbitration. The AMA as a primary proposition put that the scope, and hence the jurisdictional limit, of any determination which I might make as Arbitrator was a determination of the terms and conditions of work in respect of medical services provided by VMOs under sessional contracts; the relevant obligation was limited to fixing the remuneration of a VMO for medical services (that is, the treatment of patients) performed over a specified period or specified periods. And, so the jurisdictional submission went, the Minister's claims in the following respects were beyond my power to make a determination -

(i) The promulgation of a sessional contract specifying agreed hours (referred to as an up-front hours contract) to be remunerated irrespective of the time spent by a VMO in treating patients.

(ii) Imposing an obligation on a VMO to participate in hospital administration, financial activity and budgeting.

(iii) Specifying the form of a sessional contract to be entered into by a VMO and a hospital or an area health service.

(iv) Directing that all of the terms and conditions of work should be incorporated in a written sessional contract.

(v) Granting to a hospital or an area health service the power to change or alter the clinical privileges of a VMO during the operation of a sessional contract.

(vi) Providing that there is no entitlement in a VMO to be re-appointed as such.

(vii) Inserting a provision of the type upheld in *Scott v. Avery* ([1856] 5 H.L.C. 811) prohibiting the commencement of proceedings at law or in equity in respect of a dispute arising

under a sessional contract or in connection with it unless and until an award had been made by an arbitrator appointed by the parties to resolve the issue.

Having identified the jurisdictional issues, I would propose to defer final consideration of them until the particular subject matters to which they relate are dealt with later in these reasons. However, the nature and scope of a determination which may be made under the *Public Hospitals Act*, and which are fundamental to the questions of jurisdiction, may conveniently be dealt with now. The manner of the exercise of my functions as Arbitrator, in terms of those matters to which the *Public Hospitals Act* requires me to have regard, is also fundamental to a consideration later of the merits of the respective claims. I intend, therefore, to deal here with those aspects as the basis on which the claims fall to be decided.

Statutory scheme

Part 5C (reproduced at Appendix "A") of the *Public Hospitals Act* provides the source and authority for the present arbitration, and therefore any determination made must comply with the scheme established by it. In presently relevant respects as to sessional contracts, the empowering provisions enable the arbitrator to determine the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable, in respect of medical services provided by VMOs: s.29M(1)(a). Any determination so made shall have effect on and from the date or dates, not being earlier than the date of the determination, fixed by the arbitrator: s.29M(1)(b). The arbitrator, having being duly appointed by the Attorney-General upon receipt of an application by the AMA or the Minister for a determination to be made (s.29L(1)), is required to hear the Minister and the AMA by their respective representatives who may be counsel or a solicitor:

s.29O(1) and (5). Intervention may be granted to any other person who has a special interest in the outcome of the proceedings: s.29O(2) and (3). Proceedings before the arbitrator are to be conducted in such manner as he may determine, either in public or in private, and in the exercise of that duty the arbitrator has the same protection and immunity as a judge of the Supreme Court: s.29P. Any determination made is to be notified, in writing, by the arbitrator to the AMA and to the Minister and such determination is to be final, otherwise than by appeal: s.29Q. An appeal is available from a determination to the Full Industrial Relations Commission by leave if the Full Commission is of the opinion that the matter raised on appeal is of such importance that an appeal should lie: s.29QA. On a determination being made, a sessional contract which is inconsistent therewith shall, to the extent of the inconsistency, be of no effect and the sessional contract shall be deemed to be varied so as to include the terms of the determination: s.29R.

It will be seen that the essential thrust of the legislation is to enable a determination to be made prescribing "the terms and conditions of work" in respect of medical services provided by VMOs, and including "the amounts or rates of remuneration and the bases on which those amounts or rates are applicable". Central to such a determination is that it be in respect of medical services rendered under "sessional contracts". The definition of a "sessional contract" in s.29K makes such a contract "a service contract under which a medical practitioner is remunerated on the basis of services performed over a specified period or specified periods, but not on a fee-for-service basis"; a "service contract" is defined by s.29K to mean an agreement between the parties "under which the practitioner agrees to provide (as a visiting practitioner) medical services specified in the contract, or medical services of a kind so specified," to patients at the specified public hospital or to a specified class of those patients. At the

time the 1985 determination was made, a sessional contract was not defined as it presently is nor by reference to a service contract. There was then no reference in the statute to a service contract and a "sessional contract" was defined as follows:

> "sessional contract" means a contract between an area health service, an incorporated hospital, a separate institution or the governing body of a separate institution and a medical practitioner under which the medical practitioner is required to provide medical services or medical services of any class or description specified in the contract, during periods or sessions specified in the contract, to all patients of hospitals under the control of that area health service or all patients that incorporated hospital or separate institution or to any class of patients of hospitals under the control of that area health service or any class of patients that incorporated hospital or separate institution specified in the contract

It was by the *Public Hospitals (Visiting Practitioners) Amendment Act*, No. 31 of 1988, which inserted the present definitions of "service contract" and "sessional contract" and "standard service contract" into Pt.5C of the *Public Hospitals Act* with effect as from 24 August 1988 (see Government Gazette No.137 of 24 August 1988 at p.4475). By that same 1988 Amendment Act, Pt.5C of the *Public Hospitals Act* was amended further to insert a new Div.3 - Service Contracts with Standardised Provisions comprising s.29RA requiring the terms and conditions applicable to a VMO to be in a written service contract between the parties and ss.29RB and 29RC providing a statutory mechanism for standard conditions to be included in service contracts by written order of the Minister on a recommendation by the AMA. The 1988 Amendment Act also amended Pt.5D - Visiting Practitioners by repealing s.29S as to certain conditions of appointment of visiting practitioners and inserted a new s.29T to provide for the terms of visiting practitioner agreements, and thus including VMO service contracts as affected by an arbitrator's determination, to prevail over inconsistent provisions of the *Public Hospitals Act*, other than Pt.5C, or of a regulation or by-law made

thereunder; cognate amendments were made to the *Area Health Services Act* by the *Area Health Services (Visiting Practitioners) Amendment Act* 1988 to the same effect as to hospitals under the control of area health services by a new s.33 in substantially the same terms as the new s.29T of the *Public Hospitals Act*.

The purpose of the 1988 amendments was stated by the then Minister for Health, the Hon. P.E.J. Collins M.P., in the second reading speech (*Hansard*, No.10 of 31 May 1988 at pp.875, 876) as follows:

> The main aims of the legislation before the house today are first, to remove the offensive and unnecessary provision known as the coercion clause, and, second, to require that all the conditions applying to a visiting medical officers' appointment to a hospital are included in a conclusive written contract which may not be unilaterally altered. The former New South Wales Government inserted the coercion clause, that is, section 29S of the Public Hospitals Act, shortly after Medicare was introduced by the federal Labor Government. The section states that a visiting practitioner shall not, to the detriment of any patient, discriminate as to the nature of treatment between private and public patients. The section also states that a visiting practitioner shall not coerce a patient to join a health insurance fund or elect to be treated as a private patient. This section is clearly highly offensive to the medial profession. The section was inserted at the height of the doctor-bashing rampage of the former Government. The bill provides for the immediate repeal of section 29S. The section is unnecessary because adequate provision is made under the Medical Practitioners Act to control any behaviour which may be deemed as constituting professional misconduct.
>
> The remaining provisions of the amending legislation relate to the establishment of standard contracts which will include all of the terms and conditions applying to a visiting medical officer's appointment to a hospital or area health service. At present, terms and conditions may be determined by an arbitrator under part 5C of the Public Hospitals Act. Visiting medical officers working in the public hospital system are at present working either on a fee for service or sessional basis under the determination handed down by Mr Justice Macken in December 1985. The orthopaedic surgeons have sought contracts which will allow them to return on an honorary basis.
>
> The legislation will allow the Minister for Health to agree, on the recommendation of the New South Wales branch of the Australian Medical Association, to new conditions of appointment which will be incorporated under standard service contracts. Once a doctor enters into one of these new standard service contracts, the Macken determination will cease to apply to his or her appointment. Other conditions, in addition to those approved by the Minister, may be

incorporated in a visiting medical officer's contract, provided that the other conditions do not conflict with the approved standard conditions, and provided it is with the mutual agreement of both the doctor and the hospital. The standard conditions included in the service contracts may be amended at any time with the agreement of the Minister and the Australian Medical Association.

The Government intends establishing a better record in reaching agreement with the medical profession than its predecessor. However, in line with usual industrial arrangements, provision is made in the legislation for an application to appoint an arbitrator to be made five years after the last standard service contract was approved. This provision will allow any stalemate on renegotiation of a contract to be resolved. The detail of the standard conditions to be included in visiting medical officers' contracts is still being developed in discussions with the AMA. However, it is anticipated that the new contracts will include regular adjustment to rates of remuneration, consistent with adjustments made for most other professional groups. Under the present section 29T of the Public Hospitals Act and section 33 of the Area Health Services Act, where a provision of a regulation or by-law under each Act is inconsistent with the rights and obligations of a visiting practitioner's agreement, the regulation or by-law has no effect, provided the agreement was in force at the time the regulation or by-law was made. The legislation amends both these sections in two ways. First, it extends the effect of the section to any provision of the Act, in addition to a regulation or by-law made under the Act. Second, an agreement will prevail over all regulations or by-laws under the Act regardless of whether they were made before or after the agreement.

The amendments to section 29T of the Public Hospitals Act and section 33 of the Area Health Services Act are consistent with the policy which has been accepted that all of the terms and conditions applying to a visiting medical officer's appointment should be written into a contract, and should not be able to be overturned by amendments to the principal Act or regulation or by-laws made under that Act. The legislation before the House today will facilitate the return to the public hospital system of doctors who had a conscientious objection to working under the discriminatory conditions imposed by the former Government. The legislation will also enable fairer conditions for those doctors who have continued to work in public hospitals. For the information of honourable members, I table a detailed explanation of the bills. I commend the Bills.

The evidence before me, particularly that of Mr. Clout, established that a series of discussions occurred between the AMA and the Department of Health concerning a wide range of terms and conditions to be applicable to VMOs, but no agreement was reached. There was too, of course, the inquiry conducted by the Public Accounts Committee, as referred to earlier herein, into payments to VMOs following the 1985

determination and which was the subject of report to the Parliament in June 1989. In the result, however, no agreement was reached between the Minister and the AMA so that a standard set of conditions for inclusion in service contracts was never settled pursuant to s.29RB. I should comment that the AMA tendered a document setting out the history of major events from January 1986 to the present arbitration, and, by reference to Mr. Clout's evidence, noted the negotiations between the Department of Health and the AMA covered various matters including modes of remuneration, payment of old or late VMO accounts, attempts to change on-call rosters, attempts to change VMO claim forms, application of *State Wage Case* increases, payment of the on-call allowance during normal sessional hours and call-back, payment of background practice costs during call-back, appropriate form of remuneration of VMOs in country hospitals, claim forms in relation to certain patients, disputes committees as to on-call payments and amendments to the *Public Hospitals Act*.

The legislative developments and the negotiations between the parties have importance in assessing the weight of a submission made by the AMA to the effect that the provisions of the 1985 determination were fair and reasonable in 1985 and nothing had occurred in the period since to show there were any problems; a powerful reason existed therefore to accept the 1985 determination as a proper basis for a new determination. I am unable to accept the AMA's argument in that respect. The legislative history and negotiations between the parties disclosed many differences on important terms and conditions for VMOs and I think it to be simply unrealistic to suggest that the provisions of the 1985 determination were, in effect, uncontroversial and as not involving persistent attempts by the Minister for changes in the period from January 1986 to February 1991 when the present arbitration was sought.

The amendments to the definition of "sessional contract" and the insertion of a new definition of "service contract" were relied upon by the AMA to support its jurisdictional arguments against a determination specifying a particular form of sessional contract and an up-front hours contract. The detail of that argument will be dealt with later, but at this point I simply mention the former "sessional contract" definition being referable to the provision of medical services "during periods or sessions specified in the contract" whereas the present "sessional contract" refers to remuneration being "on the basis of services performed over a specified period or specified periods" and a "service contract" talks about the practitioner agreeing "to provide ... medical services specified in the contract" to patients at the specified public hospital. The point made by Mr. *Sperling*, which will be developed later, was that the new definition of "sessional contract" contemplated services provided by a VMO to be remunerated on the basis of time spent and on no other basis; a basis of specified hours to be remunerated irrespective of the time spent treating patients, as the Minister claimed, was contrary to a sessional contract and so beyond power. The new definition of "service contract" precluded, on senior counsel's submission, a determination being made specifying a form of contract.

It only remains on the statutory scheme to deal with the aspect of clinical privileges. This is relevant in relation to the AMA's submission that the legislation makes provision for clinical privileges to be specified in the written service contract but it makes no provision for altering clinical privileges once they were so specified. It followed, as Mr. *Sperling* put, a determination which gave to a hospital or an area health service the power to change clinical privileges would not be a term or condition of work. Neither the *Public Hospitals Act* nor the *Area Health Services Act* make explicit reference to clinical privileges. However, the *Public*

Hospitals Act, s.42(1)(h1) enables regulations to be made for or with respect to "the appointment, management and government of visiting practitioners, including the conditions subject to which visiting practitioners may perform work at hospitals". The Public Hospitals Regulation 1991, cl.3(1) defines "clinical privileges" as follows:

> "clinical privileges", in relation to a visiting practitioner to a hospital means the kind and extent of work that the board of the hospital determines the visiting practitioner is to be allowed to perform at the hospital".

Clause 6 of that Regulation, in requiring the appointment of a visiting practitioner to be by written agreement between the person and the hospital, provides also that "the written agreement must specify the conditions to which the appointment is subject, including the clinical privileges of the visiting practitioner". The Public Hospitals Model By-law, Pt.7 enables a Medical Appointments Advisory Committee to be established to make recommendations to the hospital board concerning clinical privileges.

The *Area Health Services Act*, s.38 empowers the making of regulations, which, in conjunction with the by-law making power in s.32, enable the supervision of VMOs in hospitals under the control of area health services in a similar way to those hospitals regulated by the *Public Hospitals Act*. Clinical privileges are dealt with in a similar way by the Area Health Services (Visiting Practitioners) Regulation 1989, cl.5 and the Area Health Services Model By-law, Pt.7 requires an area health board to establish a Medical Appointments Advisory Committee to make recommendations concerning clinical privileges.

Nature of determination

The duty which I have as Arbitrator is to make a determination of the nature described in s.29M(1) of the *Public Hospitals Act*, namely the terms and conditions of work, the amounts or rates of remuneration and

the bases on which those amounts or rates are applicable in respect of medical services provided by VMOs under sessional contracts; and the date or dates from which any such determination shall have effect. The elements then of a determination are -

(i) terms and conditions of work;

(ii) amounts or rates of remuneration;

(iii) bases on which those amounts or rates are applicable;

(iv) medical services; and

(v) sessional contracts.

Terms and conditions of work, whilst undefined in the statute, is a much used and well understood expression in industrial jurisprudence. The AMA's jurisdictional submissions, as I have earlier intimated, challenged various provisions sought by the Minister as not being terms and conditions of work so that no determination could be made in relation to them. I refer in that respect to many of the claims made by the Minister as to structural efficiency measures, such as up-front hours and the incorporation in a determination of clinical privileges. Although any determination here will be in respect of VMOs as independent contractors and not employees under an industrial award, it seems to me that essentially one is concerned with the performance of work, and whether that be according to a contract of service or for services would be immaterial in giving a meaning to what the expression "terms and conditions of work" comprehend. In other words, the exercise inherently involves those matters pertaining to *work* regardless of the particular type of contract under which it may be performed. In an industrial setting, the words "terms" and "conditions" as constituting the expression "terms or conditions of service or employment" were considered by the High Court of Australia (*Gibbs*, *Stephen*, *Mason*, *Jacobs* and *Murphy* JJ.) in *Reg. v.*

Booth; Ex parte The Administrative and Clerical Officers' Association ((1978) 141 C.L.R. 257 at 262, 263), and their Honours said:

> The expression "conditions of employment" is defined in s.3(1) of the Act to mean "salaries, wages, rates of pay or other terms or conditions of service or employment". The expression as so defined is obviously intended to have a wide meaning. In *Australian Tramway Employees Association v. Prahan and Malvern Tramway Trust* ((1913) 17 C.L.R. 680 at p.693), in a passage cited by Dixon C.J. in *Reg. v. Findlay; Ex parte Commonwealth Steamship Owners' Association* ((1953) 90 C.L.R. 621 at p.630) *Isaacs* and *Rich* JJ. said:
>
> > "The 'terms' of employment are the stipulations agreed to or otherwise existing on both sides upon which the service is performed. The 'conditions' of employment include all the elements that constitute the necessary requisites, attributes, qualifications, environment or other circumstances affecting the employment."
>
> No doubt this extensive meaning should be attributed to the word "conditions" in the definition. The "other terms or conditions of service or employment" cannot be limited to those which are ejusdem generis with salaries, wages and rates of pay. A condition relating to seniority would come within the definition: cf. *Commissioner for Railways (N.S.W.) v. McCulloch* ((1946) 72 C.L.R. 141). The fact than an employee has, or has not, a right of appeal against the appointment of an outsider to a position the filling of which would affect his seniority is a circumstance affecting his employment. It is true of employment generally, including employment in the Public Service, that importance is attached by employees to the maintenance of their positions of seniority, with its influence on their prospects of promotion, and a natural enough way of preserving the existing seniority of an employee is to give him a right of appeal against the making of an appointment which would in a practical sense affect his seniority or his prospects... A right of appeal against the appointment of an outsider to a vacant office, whether granted by statute, award or agreement, might be made a term of the employment of an employee who might be affected by the appointment, and if granted would at least be a condition of the employment of such employee.

I would give to the expression "terms and conditions of work" in s.29M(1) a similarly wide meaning.

There was no issue concerning "amounts or rates of remuneration", and, seemingly, that expression permits a determination of remuneration for a VMO under a sessional contract to be either by a specified amount of money for services performed over a specified period or specified periods or

a rate to be used in calculating the remuneration for services performed over the specified period or specified periods.

The "bases on which those amounts or rates are applicable" is important. Not only may a determination fix the remuneration but it may also fix the *bases* thereof. Many matters are necessarily taken into account in determining remuneration, including the type of work performed, the qualifications, skills and experience needed to perform it and the conditions under which it is to be performed. But, in my view, and whilst perhaps those somewhat obvious types of matters may be included in a determination, I do not think the section is so limited. The *bases* which may be included in a determination are those on which the determined amounts or rates of remuneration *are applicable*. Put another way, the section, as I read it, envisages a determination being made which contains provisions as to the circumstances when and conditions under which remuneration for a VMO is to be applicable, that is, *paid*. Such a construction may, in any event, follow from the ability to make a determination of the "conditions" of work (see *Booth* (*supra*)), but statutory reinforcement has been given to the wide nature of a determination which may be made. However wide the section may be it cannot, of course, be limitless and it must be conceded, I think, that not every matter which arises as between a VMO and a hospital or an area health service would give rise to a competent determination being made; it has been so held in relation to demands made by employees on their employer as properly giving rise to an industrial dispute as to which an award may be made: *Reg. v. Portus; Ex parte Australia and New Zealand Banking Group Limited* ((1972) 127 C.L.R. 353 at 365). The test to be applied has been variously described: in *Findlay* (*supra* at 631), *Dixon* C.J. described a matter as being within an industrial matter if the connection between the employment and the purpose of the matter was "not remote or tenuous";

in *Re Manufacturing Grocers' Employees Federation of Australia; Ex parte Australian Chamber of Manufactures* ((1986) 160 C.L.R. 341 at 353) the High Court unanimously stated one test as being "that a matter must be connected with the relationship between an employer in his capacity as an employer and an employee in his capacity as an employee in a way which is direct and not merely consequential for it to be an industrial matter capable of being the subject of an industrial dispute"; and *Booth* (*supra* at 264) adopted what *Walsh* J. said in *Portus* (*supra* at 365) that "an industrial dispute will only arise if the employees demand a benefit or privilege of a kind which has a relevant connection with the relationship of employer and employee".

The test of "relevant connection" seems to me, conceptually, to be appropriate to apply in resolving whether a particular claim by the Minister may competently be made a provision of a determination as being so connected with the relationship of VMO and public hospital as a term or condition of work or as a basis on which remuneration is to be paid.

Whatever services a VMO may provide in the public hospital system, in order for there to be a valid determination under s.29M(1) in respect of those services it must be a determination in respect of "medical" services. There was much attention during the proceedings as to whether some of the structural efficiency claims made by the Minister to require VMOs to be engaged in administration, financial and budgetary matters were within the determination making power as not being in respect of "medical" services provided by a VMO, and notwithstanding that the performances of such services required the provider to be a medical practitioner. The particular services will be considered later in dealing with the total argument put on both jurisdiction and merit, and I turn at this time to a consideration of the true meaning of "medical services" in s.29M(1) as the foundation for resolving the issues. I might point out,

however, that the AMA's point in denying jurisdiction concerned the suggestion that the phrase "medical services" in its ordinary meaning meant the treatment of patients; engaging in administration, even in a hospital, was administrative and not medical activity even if performed by a medical practitioner.

The *Shorter Oxford English Dictionary* (3rd. ed., 1962 reprint) relevantly gives the adjective "medical" the meaning of "pertaining to the healing art or its professors; also, pertaining to 'medicine' ..." The noun "medicine" is defined by that dictionary relevantly as "the science and art concerned with the cure, alleviation, and prevention of disease, and with the restoration and preservation of health." The important observation may immediately be made as to the meaning ascribed that it is not so much referable to the clinical treatment of a patient but rather to the wider concept of relating to or concerning "the healing art" and "the restoration and preservation of health". True it may be that the treatment of a patient would be comprehended within that description, but as I understand the meaning stated there is the wider concern with "health". I must say I find it difficult to be conclusive on that material, and so I think it of assistance to have recourse to medical dictionaries and other learned works. *Blakiston's Gould Medical Dictionary* (3rd. ed., 1972) similarly describes "medical" as "pertaining to medicine", and "medicine" as "the science of treating disease; the healing art." Interestingly, that dictionary as to "hospital" states:

> Hospital ... A medical treatment facility intended, staffed, and equipped to provide diagnostic and therapeutic service in general medicine and surgery or in some circumscribed field or fields of restorative medical care, together with bed care, nursing, and dietetic service to patients requiring such care and treatment.

Butterworths Medical Dictionary (Rev. ed. 1965), not dissimilarly, defines "medical" as "belonging to the science of medicine" and "medicine"

as "the science and art of the treatment of disease and maintenance of health." A "hospital" is stated therein to be "an institution which is equipped and organised for the care of the sick, usually possessing facilities for the diagnosis, treatment, and cure of disease. Formerly, a place which provided hospitality for the sick and aged poor." *Stedman's Medical Dictionary* (4th. unabridged lawyers' edition, 1976) as to "medical" states "relating to medicine or the practice of medicine" and for "medicine" it states "the art of preventing or curing disease; the science that treats of disease in all its relations." A "hospital" is described as "an institution for the treatment, care and cure of the sick and wounded, for the study of disease, and for the training of physicians and nurses".

I think it correct to regard the phrase "medical services" as meaning services of a medical nature. In the context of the *Public Hospitals Act* in referring to services provided by a VMO, who as a visiting practitioner is appointed to perform work as a medical practitioner, must mean that the services in question are services which require for their proper performance the person to be a "medical" practitioner. Regrettably, the *Public Hospitals Act* does not define a medical practitioner, and even the *Medical Practitioners Act* 1938 refers to a medical practitioner registered as such but without further clarification. It would be reasonable, it seems to me, to regard a medical practitioner as a person who practices "medicine". And, so, one inevitably returns to the word "medicine", but, I would add, in the context of the *Public Hospitals Act* as relevantly concerned with a VMO's professional practice of medicine in a hospital; the meaning of "hospital" is, therefore, important to take into account.

I must say that none of the publications to which I have referred give any indication of limiting medicine to what may be described as the clinical treatment of patients. Indeed, they all extend the art to the treatment of disease and the maintenance of health. That same wider

context is apparent also from the way a hospital is referred to. Also of significance are the different branches of medicine; for instance, in *Butterworths Medical Dictionary* and *Stedman's Medical Dictionary* such branches range from air medicine, domestic medicine, environmental medicine, forensic medicine, group medicine, holistic medicine, physical medicine, preventive medicine, social medicine, state medicine, tropical medicine and war medicine. *Butterworths Medical Dictionary* as to "social medicine" and "state medicine" states:

> Social medicine, a comprehensive term including (a) research into social conditions which favour disease or affect health; (b) study of the social effects of disease, especially of the family unit; (c) health education and advice to those responsible for housing, employment and social policy; (d) provision of social services, and their co-ordination with public health and the medical treatment of disease.
>
> State medicine, the conservation and care of the health of the individuals comprising the community by a government. In Great Britain this is done through an administrative system based upon a number of Acts of Parliament and upon the machinery of the Civil Service and local government.

Stedman's Medical Dictionary refers to "state medicine" as:

> (1)public m.; the branch of medical science that deals with statistics, hygiene, the prevention and overcoming of epidemics, etc.; (2)the control of medical practice by an organisation of the government, the practitioners being an integral part of the organisation from which they draw their pay and to which the public contributes in some form or other.

It necessarily follows, in my view, that the professional practice of social medicine or state medicine by a medical practitioner represents the performance of medical services, and that is so even though the practitioner in so performing those services may be a neurologist or a cardiologist. A perusal of those branches of medicine will be seen to comprehend some at least of the services provided by VMOs in public hospitals, in whatever their specialty, quite apart from the particular treatment of their individual patient. In other words, it seems to me, the

clinical treatment of a patient is but part of the medical service which a practitioner is able to provide, and in an indirect sense patients are treated by the practitioner engaging in teaching, research, education and, I would add, even medical administration as the means by which patients are treated in the most effective and efficient manner consistent with the resources available.

It was common ground between the parties that the involvement of a VMO in education, teaching and research programmes at a public hospital fell within medical services, and I think that to be correct; it was not suggested in that respect that a medical practitioner would thereby be an educator , a teacher or a researcher, no doubt because the practitioner would be engaging in those types of functions essentially as a medical practitioner using his medical knowledge. Why then, one may ask, should it be any different where a practitioner, required to be medically qualified, is engaging in services of an administrative nature, including financial and budgetary considerations? *Prima facie* I find difficulty in seeing any distinction at all. Conceptually and logically, there seems to me to be no difference, rather it seems to stem from what I regard to be the narrow approach of a medical practitioner being limited to the clinical treatment of a particular patient and leaving it to others to provide the necessary administrative support. Reference has been made earlier to the evidence of some VMOs who regarded themselves as "dinosaurs", meaning thereby they were concerned with the clinical treatment of patients and left administration to administrators. I then commented that such an attitude was inappropriate for the practice of medicine, certainly in public hospitals, in the 1990s. In a similar ambulatory way the expression "medical services" should be construed as comprehending services the proper performance of which requires a person to be medically qualified. That conclusion may be tested by reference to the RACP Ethics Manual, to

which I have earlier referred, in dealing with the involvement of physicians in health policy, and which spoke of the relationship between the physician and society thus:

> 31. The Physician and Society
>
> Physicians have a particular place in society. The general trust and respect in which physicians are held emphasises their responsibility to society for their professional actions. This trust means that physicians should maintain their professional standards and should ensure that their knowledge is imparted to individuals and society as a whole.
>
> The physician has always had a role in advising society in general about medical matters and, in addition, has an obligation to draw to the attention of the public at large, the government and other bodies specific medical matters which may affect individuals or groups of people.
>
> Much of the responsibility of physicians is embodied in the Memorandum of Association of the Royal Australasian College of Physicians. The objects for which the College was established include "to promote the study of the science and art of medicine; to encourage research in clinical science and the institutes of medicine; to bring together physicians for their common benefit and for scientific discussions and clinical demonstrations; and to disseminate knowledge of the principles and practice of medicine by such means as may be thought fit".

In my view, that extract comprehensively gives practical meaning to what I understand to be the nature of medical services and medicine as set out in the dictionaries by recognising the special role of the medical practitioner in society as a whole. In particular, it emphasises the role in advising about medical matters with the obligation to draw to the attention of relevant bodies medical matters as they may affect individuals or groups of people. Where a VMO is required to utilise his medical knowledge for the better administration and allocation of resources in a public hospital then, I would conclude, that must involve the rendering of medical services.

A sessional contract, unlike other service contracts in Pt.5C of the *Public Hospitals Act*, is one under which a VMO is remunerated on the basis of services performed over a specified period or specified periods.

But, in common with other service contracts, it is one under which the VMO agrees to provide specified medical services; it is those services so specified which attract remuneration. I think that accurately summarises the combined effect of the definitions of "service contract" and "sessional contract" in s.29K. In denying jurisdiction as to the Minister's claim for up-front hours, Mr. *Sperling* relied on those definitions to submit that the statute contemplated remuneration under a sessional contract being on the basis of time spent in treating patients and not on the basis of time spent not treating patients. The former definition of "sessional contract", until it was amended in 1988, referred to a contract under which medical services were required to be provided "during periods or sessions specified in the contract, to all patients of hospitals" whereas the effect of the present definitions, as I have summarised it above, means that the specified services are to be "to all patients" and be "performed over a specified period or specified periods". Whilst I agree with Mr. *Sperling's* summary of the combined effect of the new definitions, I do not agree with the result for which he contended. A sessional contract, as a service contract, is for the provision of medical services to patients, but, and as I held above, that does not mean a VMO is required to directly treat a particular patient to satisfy the requirement for the services to be medical services. A patient will receive treatment in a public hospital as a result of activity by a VMO, albeit perhaps in an indirect sense, engaging in committee and conference work, such as peer review and quality assurance committees, where resource allocation and patients are discussed. Also, of course, it is to be borne in mind that a VMO is a visiting practitioner, as reinforced by the definition of "service contract", so that in considering the scope of the "medical services" covered by a sessional contract it seems to me clearly to envisage services beyond the mere treatment of a public patient to comprehend the role of the VMO as

part of the medical staff of the hospital; to the extent that that may involve a VMO in administrative, financial and budgetary activities, consistent with the concept of "state medicine" , I regard those activities as within "medical services" in 29M(1)) of the *Public Hospitals Act*.

The further point made by Mr. *Sperling* that the definition of sessional contract requires remuneration to be for services performed and not for services not performed might conveniently be deferred until the whole claim as to up-front hours is considered.

I mention, but without reasoning at this stage, the Minister's claim for the determination to contain the form and contents of the sessional contract to be used. Mr. *Kenzie* approached that matter on the basis that a determination which could properly lay down terms and conditions of work for inclusion in sessional contracts must include the power to decide the form of such contracts. Mr. *Sperling*, on the other hand, took the point that the nature of a determination made it separate and distinct from a sessional contract and that the *Public Hospitals Act*, s.29R deemed a sessional contract to be varied to include the terms of a determination so that each instrument was separate from the other. A resolution of that matter will be considered later in light of the statutory scheme as it has been outlined and according to the nature of a determination which may be made.

Manner of exercise of arbitrator's functions

The statutory scheme established by Pt.5C of the *Public Hospitals Act* allows to the arbitrator in making a determination very wide powers as to the conduct of proceedings and the matters which the arbitrator is to take into account in making a determination. As earlier noted, s.29P enables the arbitrator to conduct proceedings in such manner as he may determine and the proceedings may be conducted in public or in private as the arbitrator thinks fit; s.29Q, subject to a right of appeal by leave under

s.29QA, contains a privative provision making a determination final. By reason of the width of the discretions thereby given to an arbitrator, it follows, in my view, that an arbitrator has a special responsibility in conducting proceedings to ensure that the principles of natural justice are observed in affording the parties an opportunity to be heard and to address relevant matters as they see fit, including the opportunity to address matters which the arbitrator himself may see as relevant. I would wish to record that in the conduct of the present arbitration I have endeavoured to follow that approach, and, indeed, the whole of the proceedings were conducted in public; the only limitation imposed was, with the concurrence of the parties, that the financial details of the private practices of the VMO witnesses were admitted into evidence on a confidential basis. There was no objection to the general disclosure of such material, if otherwise thought appropriate, but not so as to disclose the identity of the individual concerned.

The principal provision in Pt.5C concerning the way in which the arbitrator's functions are to be exercised is s.29N. That section in sub-s.(1) enables the arbitrator to inform himself on any matter as he sees fit and not to be bound by the rules of evidence: par.(a). The sub-section imposes a duty on the arbitrator to act judicially and be governed by equity and good conscience without regard to technicalities and legal forms: par.(b). Although not bound by the rules of evidence, I took the view in conducting the arbitration that those rules were based on fairness and the prevention of prejudice, and, accordingly, the rules of evidence generally were applied. Further, in moving towards the making of a determination I have only informed myself on those matters which the parties dealt with and as to which they had an opportunity to address. Insofar as s.29N(1) grants a discretion, I refer to and adopt what the

Industrial Commission in Court Session said in *PDS Rural Products Ltd. v. Corthorn*([1987] 19 I.R. 153 at 155) as follows:

> First, it is correct to say, as the commissioner did, that he was not bound to observe the rules of law governing the admissibility of evidence (s.83). It should be borne in mind that those rules are founded in experience, logic, and above all, common sense. Not to be bound by the rules of evidence does not mean that the acceptance of evidence is thereby unrestrained. What s83 does do in appropriate cases is to relieve the Commission of the need to observe the technicalities of the law of evidence. Common sense, as well as the rules of evidence, dictates that only evidence relevant to an issue which requires determination in order to decide the case should be received. This means that issues must be correctly identified and defined.

Those observations were followed by the Industrial Commission in Court Session in *Amalgamated Metal Workers' Union v. Electricity Commission (NSW)* ([1989] 28 I.R. 155 at 161).

Both Mr. *Kenzie* and Mr. *Sperling* addressed at some length those matters which s.29N(2) says the arbitrator "shall have regard to" in making a determination, namely the economic consequences of the proposed determination: par.(a); the most recent determination of the Industrial Relations Commission under s.14 of the *Industrial Relations Act* 1991 of the amount or the method by which an amount may be determined by which rates of wages in awards made under that Act shall be varied: par.(b); and the principles of wage fixation for the time being adopted as a general ruling or declaration of principle in connection with awards made under that Act: par.(c). The debate centred around the meaning to be given to the expression "shall have *regard* to" in assessing the weight which the relevant matters should have in the making of a determination, particularly having in mind that s.29N(1)(b) requires the arbitrator in making a determination to be governed by equity and good conscience.

Mr. *Kenzie* submitted that the effect of s.29N(2) was that the arbitrator was required to take the matters set out, and each of them, into

account and to give weight to them as fundamental elements in making the determination. Reliance was placed on what was said by *Mason* J., with whom *Gibbs* J. agreed, in *Reg. v. Hunt; Ex parte Sean Investments Pty. Ltd.* ((1979) 25 A.L.R. 497 at 504) as follows:

> When sub-s(7) directs the Permanent Head to "have regard to" the costs, it requires him to take those costs into account and to give weight to them as a fundamental element in making his determination. There are two reasons for saying that the costs are a fundamental element in the making of the determination. First, they are the only matter explicitly mentioned as a matter to be taken into account. Secondly, the scheme of the provisions is that, once the premises of the proprietor are approved as a nursing home, he is bound by the conditions of approval not to exceed the scale of fees fixed by the Permanent Head in relation to the nursing home. In many cases it is to be expected that the scale of fees will be fixed by ascertaining the costs necessarily incurred and adding to them a profit factor. In the very nature of things, the costs necessarily incurred by the proprietor in providing nursing home care in the nursing home are a fundamental matter for consideration.
>
> However, the sub-section does not direct the Permanent Head to fix the scale of fees exclusively by reference to costs necessarily incurred and profit. The sub-section is so generally expressed that it is not possible to say that he is confined to these two considerations. The Permanent Head is entitled to have regard to other considerations which show, or tend to show, that a scale of fees arrived at by reference to costs necessarily incurred, with or without a profit factor, is excessive or unreasonable. It may be that the rent paid by the proprietor of a nursing home, though a cost necessarily incurred, exceeds the prevailing rental which is paid for comparable premises and that the determination of a scale of fees by reference to that rent would result in a scale of fees which is unreasonably high. The Permanent Head would be entitled to take this factor into account in making his determination.

As support for treating the matters concerned as fundamental elements senior counsel made the following points -

. There is an obvious relationship between the process of wage fixation for employees under awards made under the *Industrial Relations Act* and the process of arbitration contained in the *Public Hospitals Act* in that the arbitrator is to be a member of the Industrial Relations Commission and an appeal is provided to the Full Industrial Relations Commission against a determination made by the arbitrator -

it may be expected that the wage fixation principles would be applied in the same way as in any industrial award case.

- Following the finding by *Macken* J. in the reasons supporting the 1985 determination that the wage fixation principles were "quite impossible" of application (see 1985 reasons at p.9) and that in making a determination he should not "attempt to squeeze into the confines of the guidelines a situation with which they were never designed to deal" (see reasons at p.12), the *Public Hospitals (Amendment) Act* 1986, as earlier referred to, inserted s.29N(2) into the *Public Hospitals Act* and at the same time enacted s.29QA to provide for an appeal. The legislative history supported, therefore, the Minister's approach.
- The expression "shall have regard to" was to be considered in light of the Parliamentary debate by reference to the then Minister's second reading speech when he said that "the bill contains provisions that will require the arbitrator to consider the economic consequences of any proposed determination, and have regard to the prevailing principles of wage fixation. These provisions reflect the major implications that such determinations have for the provisions of medical services in public hospitals" (*Hansard*, Legislative Assembly 30 April 1986 at p.3495)
- There is an obvious relationship between VMOs and award-covered medical officers in public hospitals so that there should be equality of treatment in considering those matters to take into account.

Mr. *Sperling* submitted that the function of the arbitrator was to make a determination which was just and reasonable, based essentially on

the concept of what was fair, and the terms of s.29N(1) supported that approach. As to those matters in s.29N(2) to which regard was to be had, Mr. *Sperling* succinctly put the AMA's position thus:

> The upshot of all that is it is our case that under this section the arbitrator is obliged to consider the wage fixation principles; he is obliged to examine them for their relevance to the present proceedings; he is obliged to recognise that his primary obligation is to be governed by equity and good conscience, that is fairness and reasonableness, and that he is to give to the wage fixation principles such weight as he thinks they should have in the circumstances of the case, that he would certainly not permit them to have an effect which was inconsistent with the view that he might form on the ground of reasonableness and fairness, that it would be open to him, having considered them, not to be influenced by them in the sense that the decision he would have come to without them may be exactly the same decision as he comes to having had regard to them

In distinguishing what was said in *Sean Investments* (*supra*), senior counsel put that the decision-maker there, unlike my duty here as arbitrator, had no statutory injunction to be governed by equity and good conscience, and, secondly, the statute imposed only one explicit requirement to which regard was to be had; it was, therefore, inescapable that the requirement was found to be fundamental. Reference was made to what was said by *Fox* and *Franki* JJ. in the Federal Court of Australia in *Howells v. Nagrad Nominees Pty. Limited* ((1982) 66 F.L.R.169 at 194), but prime reliance was placed upon the observations of *Barwick* C.J. in *Rathborne v. Abel* ((1964) 38 A.L.J.R. 293 at 295) as follows:

> Roper J. pointed out in *Davey v. Murfin* (1956), 73 W.N. (N.S.W.) 222, that the direction in s.21(1) of the Act "to have regard to" did not necessarily mean that "the Board" was bound to make a specific finding as to each of the matters, nor was it bound to give any particular weight to any of them. This view is in line with other judicial interpretations of like expressions: see *R. v. The Vestry of St. Pancras* (1980), 24 Q.B.D. 371, at p.376, overruling *R. v. The Vestry of St. George's, Southwark* (1887), 56 L.J. Q.B. 652; *Perry v. Wright*, [1908] 1 K.B. 441, at p. 458, where a not dissimilar expression was said to be "a guide but not a fetter". Whilst, of course, it may not be universally true that a direction "to have regard to" certain facts or circumstances does no more than require the tribunal to which the direction is given to consider whether it should give any and, if so, what weight to the particular fact or

circumstance when performing the duty or exercising the right which is given to it, it can, I think, be said that in general a direction in such terms does not do more than that. In my opinion, the direction in the Act "to have regard to" the list of matters set out in s.21(1) is no more than a direction to the Fair Rents Board, when determining the fair rent of premises, to consider each of these matters and determine for itself whether any, or any particular weight should be given to them when arriving at its conclusion.

To a similar effect, reliance was placed by Mr. *Sperling* on the decision of the High Court of New Zealand (per *Wylie* J.) in *New Zealand Co-operative Dairy Co. Ltd. v. Commerce Commission* ([1992] 1 N.Z.L.R. 601 at 612, 613) where his Honour said:

> The statutory injunction of s26 is no greater than that the commission "shall have regard to" the Government's policy. The commission itself discussed the impact of s26 in its decision in *Re New Zealand Kiwifruit Exporters Association (Inc)- New Zealand Kiwifruit Coolstores Association (Inc)* (1989) 2 NZBLC (Com) 104,485, At p 104, 494 after setting out the terms of s26 the commission said this:
>
> > "The scheme of the Act is for the Commission to advance the stated Government policy of promoting competition [as outlined in the preamble of the Act] but to allow, in matters within its jurisdiction, lessening of competition in circumstances where, on the facts of a particular case, some public benefit is judged by the Commission to have precedence. 'Public benefits' could and is likely to involve some other valid and proper Government policy. By way of possible example only, such a policy could include the promotion of employment, the promotion of exports, the furtherance of CER, and so on.... In such circumstances, having regard to the general policy discretion in the Act to promote competition sec 26 may be used to advise the Commission of Government policy or policies or to be more specific in relation thereto. It is not to influence or determine the decisions which the Commission must make. Thus, fully preserving the discretions given to the Commission in the Act, the Commission is required only 'to have regard to' such statements in reaching its decisions. The *Oxford Dictionary* defines the word 'regard' as meaning 'attention, heed and care.' The criteria in the Act, eg 'dominance', 'substantial lessening of competition', 'detriment' therefrom and 'public benefit' must continue to be assessed and balanced by the Commission paying of course due attention, heed and care to any policy transmitted to the Commission by the Government."
>
> ...
>
> As with any other evidence it is for the tribunal to assess the weight to be given to each item of evidence and in the case of a statement of this kind, which in our view is simply an evidentiary statement of

> Government policy - it is certainly not a direction - it remains for the tribunal to assess the weight to be given to it as an expression of official perception of, in this case, public benefit. We do not think there is any magic in the words "have regard to". They mean no more than they say. The tribunal may not ignore the statement. It must be given genuine attention and thought, and such weight as the tribunal considers appropriate. But having done that the tribunal is entitled to conclude it is not of sufficient significance either alone or together with other matters to outweigh other contrary considerations which it must take into account in accordance with its statutory function: *New Zealand Fishing Industry Association Inc v Minister of Agriculture and Fisheries* [1988] NZLR 544, 566 and *Ishak v Thowfeek* [1968] 1 WLR 1718, 1725. In the end, however weighty the statement may be as an expression of considered Government policy, it does not have any legislative effect to vary the nature of the duties which the tribunal must carry out.

On the basis of authority and the ordinary approach to statutory construction, I would construe the words "shall have regard to" in s.29N(2) as meaning the arbitrator is required in making a determination to consider the matters specified and to accord them such weight, if any, as should be given in light of all the circumstances but consistent with the overall function to be governed by equity and good conscience. Specifically, I agree with Mr. *Sperling* that *Sean Investments* (*supra*) is distinguishable for the reasons stated by senior counsel, but, in any event, I point out that even in *Sean Investments*, *Mason* J. (*supra* at p.504) remarked that the decision-maker was entitled to have regard to other considerations in making a decision. What relevant weight then should the matters specified have?

The answer to the question so posed will have to await consideration of the matters concerned, but it is convenient to refer to the relevance given to economic factors and to the principles of wage fixation by former Medical Fees Enquiries conducted to determine the level of fees to apply for Medicare benefit purposes under the *Health Insurance Act* 1973 (Cth). I consider that process to be directly analogous to the arbitration I am conducting in that VMOs in New South Wales under fee-for-service contracts are remunerated on a modified fee-for-service

basis according to a variable percentage of the Medicare schedule fee depending on the availability of resident medical officers and registrars in the hospital concerned. It should be pointed out that those enquiries were concerned with fixing fees for medical benefit purposes only and not with the fees to be charged or the incomes of medical practitioners, although the close relationship between fees charged and the levels of schedule benefits will be perhaps obvious. Such enquiries were conducted for some years with the last such enquiry being conducted by Mr. Deputy President *McKenzie* of the then Australian Conciliation and Arbitration Commission in 1985, following which the Australian Medical Association discontinued its participation; schedule fees were then fixed by the Commonwealth Government administratively. The pattern developed in those enquiries whereby the schedule fees were adjusted by a medical fees index for the various categories of medical practitioner comprising components for net income and practice costs (salaries and wages, motor vehicle and other). On 20 May 1985, *McKenzie* D.P. in his report to the federal Minister for Health following the 1985 Medical Fees Enquiry as to the net income component said (at p.15):

> Net Income Component
>
> 4.21 The major parties agree that, at least at this Enquiry, the Net Income component of the Index should be adjusted consistent with the principles and decisions of the Australian Conciliation and Arbitration Commission. This practice has been adopted by previous Enquiries and in addition the Terms of Reference specifically require that the decisions of the Enquiry have regard to National Wage Case (NWC) decisions.

Specifically as to the wage fixation principles, *McKenzie* D.P. said (at p.27) in the same report:

> 5.8 In the present economic climate of continued restraint, with the Commission's Wage Fixing Principles, the Prices and Incomes Accord and the like, equity demands as far as possible a consistent policy approach to movements in incomes generally. I have considered carefully the detailed AMA submissions. I repeat what I said in the 1984 Enquiry, that there can be no question of a mandatory requirement being imposed on medical practitioners.

> However, I am not persuaded that the general tenor of the Commonwealth proposal is unreasonable. While there may be unusual circumstances in individual cases which could be said to provide justification to the contrary, I consider that medical practitioners generally should increase their fees by a not higher percentage than the relevant increases determined for the period of my Determination, which applies till 30 April 1986. I expect both the AMA and the Surgeons to advise their members of this. I note the Commonwealth conclusion that the medical profession has generally complied with the 1984 Determination.

It will be seen that the wage fixation principles were then applied for Medicare benefit purposes very much on the basis that "equity demands as far as possible a consistent policy approach to movements in incomes generally". That consistency, it seems to me, might otherwise be called "industrial fairness" or "industrial equity", and indeed the AMA then accepted adjustment of the net income component of the medical fees index in accordance with the wage fixation principles. It might be emphasised that the Terms of Reference for that 1985 Enquiry required it "to have regard to" *inter alia* "changes in the economy since 31 March 1984 affecting medical practitioners and the community generally ... including the Salaries and Wages Pause, National Wage Case decisions and the Government's prices and incomes policy".

I place considerable weight on the approach adopted in the determination of the net income component as part of the medical fees index for Medicare benefit purposes. Therefore, in my view, careful and specific attention must be given to the economic consequences and to the wage fixation principles in the making of a determination. Supportive of that approach are the findings made already by me in relation to the background and context in which the arbitration was conducted as to the need to attend in the proper functioning of the public hospital system to resource allocation and management, including the implementation of structural efficiency measures.

Economic consequences

This arbitration has proceeded during a period of severe national economic recession. New South Wales cannot be excluded from that context in terms of consequences, and neither can the present issues be considered other than in a setting which fully recognises economic reality. The viability of the public hospital system and the public interest require as much.

In the decision of the Industrial Commission in Court Session in the *State Wage Case - May 1991* ([1991] 36 I.R. 362) the economic setting was examined. The Court Session said (*ibid* at 401, 402):

> The current condition of the Australian economy must impact upon our decision, especially where it is proposed further increases be built into the future with respect to wages and superannuation at intervals during 1991, 1992 and 1993. To assist in resolution of problems of wage fixation related to the economy, we have reviewed the approach of the Australian Commission and noted the parties' submissions. Secondly, we have attempted to assess the circumstances of the New South Wales economy, particularly in the context of unemployment.
>
> The Australian Commission concluded that its hearing of the *National Wage Case* coincided with a severe recession. Among the indicators of recession it noted the following:
>
> * the national accounts show that gross national expenditure (seasonally adjusted and measured at constant prices) in the last quarter of 1990 was three per cent less than in the corresponding quarter of 1989 and 1.3 per cent less than the previous quarter. (Because of an increase in export volumes and a reduction in import volumes, the gross domestic product was 0.6 per cent higher in both the yearly and quarterly comparisons, despite the fall in gross national expenditure);
>
> * full-time employment (trend estimate) reached a peak in July 1990 and March 1991 was 179,600 (2.9 per cent) fewer. Total employment fell by 140,900 (1.8 per cent);
>
> * the unemployment rate, which was 6.2 per cent (trend estimate) in March 1990, had risen by March 1991 to 8.9 per cent;
>
> * the number of job vacancies (seasonally adjusted) fell from 65,200 in November 1989 to 35,400 in November 1990;

* average weekly overtime fell from 1.49 hours in November 1989 to 1.25 hours in November 1990;

* the turnover of retail and selected service establishments in nominal terms (trend estimate), was 2.6 per cent higher in January 1991 than a year earlier. This increase was below the rate of inflation;

* registrations of new motor vehicles fell from a peak of 53,944 (trend estimate) in April 1990 to 43,553 in February 1991 - a reduction of 19.6 per cent;

* private new capital expenditure (constant prices) in the December quarter of 1990 was nine per cent less than in the corresponding quarter of 1989. Expenditure in the December quarter of 1990 (seasonally adjusted) was 11 per cent less than in the September quarter. In the December quarter, business reported expectations of new capital expenditure in the financial year 1991-92 which were 14 per cent less (in nominal terms) than corresponding estimates for 1990-91 reported in the December quarter of 1989;

* trend estimates of the value of buildings approved show a decline throughout 1990, but some increase in the first two months. The number of houses approved appears to have recovered slightly between September 1990 and February 1991, but approvals of all dwelling units have continued to fall.

Specifically as to the position in NSW, the Court Session observed (*ibid* at 403, 404):

> We turn to discuss data and submissions concentrating particularly upon unemployment in the New South Wales economy.
>
> The New South Wales Treasury, April 1991, records a monthly fall in employment in March 1991 of 82,400. The publication notes that had the New South Wales unemployment rates been as high as the national average, an additional 25,000 people would be unemployed in New South Wales.
>
> In three areas the conclusions need serious review and consideration:
>
> 1. Under the heading "*The Labour Market*" the New South Wales Treasury said:
>
> > "The only good news to be found in the appalling labour market figures for March was that NSW continues to out perform both the national average and the 5-State average in terms of employment growth, unemployment, job vacancies, average overtime hours worked and working days lost as a result of industrial disputes. The continued decline in the forward indicator of the labour market, the ANZ job advertisements series, suggests that there will be several more months of bad news in this area."

2. Under "*Average Weekly Earnings*":

> "Despite the recession, the annual growth in average weekly earnings accelerated to 7.3 per cent in the December quarter from 6.3 per cent in the September quarter. Increases ranged from 10.2 per cent in Queensland to a low of 4.6 per cent in Victoria. The increase in NSW matched the 5-State average of 8.0 per cent."

3. A comparison of indicators relating to the Labour Force shows that with respect to days lost per 1,000 employees in *Disputes*, the New South Wales result was clearly the best of all States, and well below the 5-State and Australian average.

The State Bank - Australian Chamber of Manufactures, March Quarter Survey noted that New South Wales manufacturers reported the eighth consecutive (and most significant yet) deterioration in business this (March 1991) quarter. Some 51 per cent of firms on balance recorded deteriorating conditions.

> In all, more than one in three firms cut staff in the March quarter as they returned from Christmas to empty order books ... The pain of the recession has not been restricted to those without jobs. A record 20 per cent of firms reported that they did no overtime at all and an additional net 31 per cent of firms drastically cut overtime levels.
>
> That survey states the increased job losses, combined with few wage rises and lower overtime will ensure that consumer confidence will not pick up for some time yet and this will reduce the confidence of manufacturers when it comes time to invest in new plant and equipment.
>
> Already we have experienced the second consecutive quarter of virtually no new investment. While this policy induced recession has made manufacturers drop investment plans, our international competitors have continued to invest, resulting in a further deterioration in our competitive position.

We have been strongly influenced in our decision by this material. Our conclusion is that the New South Wales economy, although performing significantly better than other areas in relation to employment, nevertheless is in serious recession with high unemployment more likely than not to deteriorate still further. Great social hardship, not falling short of suffering in individual cases, is being felt by those who have been displaced from employment or are certainly facing unemployment. We believe that those with employment have a special responsibility in these circumstances not only to themselves and their families, but to others less fortunate. The low figures in this State relating to time lost in industrial stoppages, if maintained, is consistent with a widespread acknowledgment of this position.

The economic date (New South Wales Treasury Economic Indicators) show an accelerated wage growth in the December quarter of 73 per cent (Australia), in New South Wales, 8 per cent.

As to the immediate future, the Court Session found (*ibid* at 404) - "We are at or beyond the position where one person's wage rise can be another person's job."

In the *State Wage Case - March 1992* ([1992] 41 I.R. 239) the Industrial Commission in Court Session again considered the economic setting in NSW as it had developed from the previous case in May 1991 and concluded (*ibid* at 294-297):

> All these factors reveal that New South Wales has largely caught up with the rest of Australia in contrast to what was stated on the last occasion that New South Wales appeared to be faring better. New South Wales is no longer immune from the effects of the general economic conditions throughout Australia.
>
> ....
>
> The view was expressed that the New South Wales economy was in a real if not technical recession in January 1992 but probably had reached its lowest point. If the costs of employment labour were held down, interest rates did not rise and governments made appropriate decisions, the recovery might slowly take place over the next twelve months.
>
> Important factors in economic recovery would also be the real successes of generating genuine cultural and structural reform and increases in productivity at the enterprise level.
>
> The general conclusion reached by the Chamber as to the economic outlook was that there were some positive signs of recovery but it would be weak and patchy at best. The outlook for the New South Wales economy was more uncertain than for any period over the last decade.
>
> ...
>
> Although there was some difference in the parties' assessment of the economic indicators, the relatively more favourable position of New South Wales, particularly concerning unemployment as assessed in May 1991, has now dissipated. The NSW economy is currently subject to the full impact of the recession. It is not possible to predict with any confidence the prospects of recovery in the foreseeable future due to the State's economic dependence upon international as well as local influences. The acceptance of all parties of economic instability places the role of industrial relations very much to the fore. The impact of industrial relations on economic welfare is well recognised. It places the utmost importance on nurturing the slowly emerging conviction of all parties of the need for greater productivity and efficiency and this, in our view, is the driving force which will be needed to give effect to increasing growth in the economy and reducing unemployment.

> Improved productivity and efficiency provide the essential catalyst fo the opportunity for the workers to obtain real gains in their standard of living. Increases in money wages, whether based on the consumer price index or some other statistical factor are illusory.
>
> ...
>
> The Commission considers that, in view of the lack of expectation of any significant recovery in the near future, any increase in wages will necessarily be dependent upon a more than equivalent contribution by the workforce in regard to productivity and efficiency.

I would only add by way of up-dating the unemployment rate as quoted in that judgment of 10.3 percent for New South Wales in December 1991 that it had increased to 11.5 percent in September 1992.

The economic evidence for the Minister was presented through Mr. Barker. He said that the thrust of the Department of Health's approach was in terms of health outcomes, and the particular reforms being introduced to meet the situation have been detailed earlier in these reasons. The objective of the task was to evaluate the best available allocation of scarce health resources. Mr. Barker examined the financial impact on the State's health budget of the AMA's claims and summarised that as follows:

> FINANCIAL SUMMARY
>
> The proposal will cost around $76-80 million additional in the year of implementation and thereafter plus $11.1 million in Year 2 and thereafter in respect of cost escalation for a total of say $87-90 million per annum or around a 55% increase on the existing base.
>
> Whilst not costed, sight should not be lost of shifts from the fee for service arrangement to Sessions which is not defined in the proposal. Therefore, I am unsure on how we maintain the FFS base at around $53 million.
>
> FINANCIAL IMPACT ON HEALTH BUDGET
>
> For 1990/91 the Health Total Payments budget was $4,294 million or around 28% of the State budget.

All of this budget is committed to deliver health services throughout the State and no internal scope exists to provide $87-90 million to fund the AMA claim without seriously impacting services.

The Premier and Treasurer, on 2 July, 1991, delivered a "Financial Statement" to the Parliament identified that a State revenue gap of $1.5 billion existed which must be addressed by structural solutions.

The Department of Health will be required to make a contribution due to its substantial proportion of the State budget.

In these circumstances it would appear that any approval by the Arbitrator of all or part of the AMA's claim will require internal funding by the Health system.

If this eventuates, the following savings or combination thereof are provided to illustrate the difficulties that will be required to internally fund $87 million per annum.

- Reduce the extent of VMO work (standard hours, on-call and fee-for-service) so that the existing budget base of $219 million absorbs the increase. Effectively, this is a 40% reduction in inputs and outputs for the same amount of funds. Will result in underutilised hospitals and an estimated increase of 10,000 patients on the waiting lists (presently around 21,000) per annum.

- Apply a 2.5% cut to all hospital programs. This will result in an across the board reduction in service availability. Will increase waiting lists as VMO's and direct care services will bear part of cut. Is on top of 1.5% productivity savings applied in Health over last 4 years which have centred on administration and hotel type services.

- Reduce general health workforce by some 2,500 employees (average salary $35,000 (including oncosts). This again will involve reductions in direct care services.

- Close a number of hospitals to give required yield, for example:

  - Hornsby and Manly or Mona Vale

    or

  - St. George or Sutherland and Canterbury

    or

  - Blacktown and Mount Druitt

    or

  - Liverpool and Bankstown

    or

- the majority of services on the Central Coast

or

- at least 20% of rural hospitals

The Deputy Secretary of the NSW Treasury, Michael Lambert, provided a statement as to the financial assessment undertaken by the Department of Health and expressed the view that the Department's approach in estimating the cost of the AMA's claims at $76 to $80 million per annum, and cost escalation of $11.1 million per annum, was reasonable. Mr. Lambert dealt also with the financial impact and implications of the AMA's claims in terms of the Government's strategies, as set out in the Financial Statement delivered on 2 July 1991 by the then Premier and Treasurer, the Hon. N.F. Greiner M.P., and concluded:

> In the event that additional budget expenditure is incurred, such as the additional cost of the VMO claim by the AMA, the options are to:-
>
> (i) require the agency incurring the additional cost to meet the cost by reducing other expenditures;
>
> (ii) seek offsetting savings in other portfolios;
>
> (iii) increase taxes;
>
> (iv) increase borrowings.
>
> The Department of Health has identified the broad financial impact of having to absorb the additional cost of the VMO award. It should also be noted that this impact would be in addition to the requirement already imposed on the Department to meet the operating costs of all new health facilities and increased demand within its budget allocation.
>
> The second option, offsetting savings in other portfolios, would have to be carefully evaluated. However, it needs to be appreciated that of the $950 million per annum in expenditure savings to be achieved by 1993-94, $650 million is to be achieved by cuts in agency expenditures. All Ministers and agencies have already been provided with required savings targets to be achieved in each of the next three years.
>
> The third option, increased taxation, has been rejected by the Government in its Financial Statement. All heads of Government at the 1991 Premiers' Conference agreed to avoid, to the maximum possible extent, increases in taxes and charges. Increased taxes and charges feed into inflation and could thus undermine the

Commonwealth's objective of moving Australia to a lower inflation rate, on a level with our major trading partners.

Finally, resort to increased borrowings is contrary to the Government's overall financial strategy and would have two undesirable effects:

- first, it would increase the financial exposure of the State such that adverse movements in revenue would place State finances under greater pressure. The greater the proportion of debt cost to expenditure, the less the flexibility to respond to adverse financial developments; and

- second, increased borrowings will reduce the level of funding available to high priority Government programs by increasing debt costs.

In conclusion, in view of the Government's financial strategy and commitment on taxes, the only option to absorb increased VMO costs would be to either require the Department of Health to absorb the costs at the expense of other areas or to make equivalent expenditure reductions in other portfolios.

In a sense, one might think Mr. Barker and Mr. Lambert were saying that because provision had not been made in budgets for increases in VMO expenditure that therefore the AMA's claims should not be granted. That aspect was tested by Mr. *Sperling* in the cross-examination of Mr. Barker and the following emerged:

Q. You would know the Government makes provision in its financial arrangements for further increases in salaries to Government public servants?
A. Yes, that is right.

Q. Including increases in salary for employed doctors in the public hospital system?
A. That is correct.

Q. The Government, I take it, has made no provision for increases in the rate to be paid for visiting medical officers, is that right?
A. That is correct. Of course, as I explained some time earlier, the visiting medical officers have not been, do not wish to be part of the various structural efficiency or superannuation components of the National Award decisions.

Q. And do you say that because Government has not made any provision for an increase in visiting medical officer payments his Honour determining this matter ought not to award an increase?
A. I am not saying that and I don't think the treasury people are saying that either. They are saying that if an increase is granted which is over and above what we envisage budgetting for it will be the responsibility primarily of the Minister for the area to work out how that is going to be funded.

Q. Mr Barker, every increase in expenditure of any kind almost certainly results in less services being provided to the public than would otherwise be the case, doesn't it?
A. Every increase in expenditure results in less services - I would not say that is occurring.

Q. One example: if you don't pay any increase to staff specialists you can employ more staff specialists and provide more services, can't you?
A. Yes, you could do that.

Q. Yes, so, I mean, is it seriously considered that a good way of maintaining an increase in through-put in the public hospital system is to preclude increases, any increases in staff specialists' remuneration?
A. Well, that has not been something that has been contemplated.

Q. But that is the very thing that is contemplated in the case of visiting medical officers, isn't it? You say if an increase is granted to visiting medical officers that will result in less services being provided than would otherwise be the case, therefore, there should be no increase. Isn't that the whole thrust of this argument that is being put in relation to the financial implications of an increase?
A. Well, I think the argument that is being put is in the context of the claim that is being made and the quantum amount of fees that the claim would amount to.

Q. But that is a question of degree, the same argument would apply irrespective of how much it was?
A. I think the thing that we are trying to indicate is that to find that amount of money in the very tight financial position that the State is in and the Department is in is not a very easy thing to do and the money does not exist to cover that quantum amount of money and I think also, I have had a look, I think it is exhibit 9, which is the revised claim, and my estimation there of private practice background costs is another $50 million over and above the initial claim that is being lodged.

Q. You say the money is there to pay a lesser increase?
A. The money is not there to pay any increase in the sense that if there is this money over and above what the budget now provides there is going to have to be some tough decisions made internally on how that is to be funded.

Q. So that I am right when I suggest to you that the argument that is advanced operates irrespective of the degree of the increase - the argument that is advanced is that there is no provision made for an increase, therefore, there should not be one because it would be necessary to reduce the services that would otherwise be provided in order to find the money for any increase that might be made, isn't that the key argument?
A. No, we are not saying there should be an increase. What we are saying is that if there is an increase there are going to have to be some tough decisions made on how it will be funded.

Q. And they will be made?
A. They will have to be made.

Q. And it will have to be funded?
A. It will have to be funded out of the existing funds budget.

Q. And as in the case of any increase in expenditure in any area health service, that will have its repercussions in relation to the amount of services that can be provided?
A. That would be correct, yes.

The AMA's economic evidence was given by David Ross Chapman, Senior Lecturer in Economics at the University of New South Wales. Mr. Chapman was Research Associate at the Centre for Applied Economic Research of the University and Associate Commissioner of the Industry Commission. His previous experience included acting as a consultant to the NSW Minister of Finance in 1984 and a secondment as Visiting Economist to the Industries Assistance Commission during 1987. He had studied Mr. Barker's evidence, including the assessment by Mr. Barker of the impact and implications of the AMA's claims, and he had studied too Mr. Lambert's statement. Mr. Chapman presented a detailed paper setting out his comments and formed the following conclusions:

i)The need to reduce the State's debt as a constraint on such public sector expenditures may have been exaggerated.

ii)There is a strong case for Commonwealth augmentation of funding for the state of NSW and of health funding in particular. Such arguments should bear fruit over the next few years, with favourable effects on the health budget.

iii)The cost of the claim has been exaggerated.

As to the cost of debt servicing being overstated, Mr. Chapman observed there had been recent significant falls in both official and commercial interest rates with the result that lower interest charges on debt being rolled over would occur; also, the rate of inflation for 1991-92 was running at less than 2 percent with business forecasts expecting an increase over the next few years to 3.8 percent. Although it was difficult to estimate, Mr. Chapman had the view that those two aspects meant the current level of debt as a constraint on public expenditure had been

exaggerated. On Commonwealth funding, he adopted the view that, overall, the State had legitimate grounds for complaint against the current funding arrangements for public hospitals under the Medicare programme so that in the renegotiation of Medicare funding arrangements due in 1993 NSW could benefit by a reformulation of Commonwealth grants for health. In saying the estimated costs of the AMA's claims had been exaggerated, Mr. Chapman made the point that reductions in the utilisation of VMO services would result in a corresponding reduction in other related expenditure, such as nurses and facilities, and that an increase in VMOs' incomes would generate additional government revenue in the form of income tax; as those two factors had been ignored then the estimated cost of the AMA's claims was flawed.

Mr. Chapman conceded in cross-examination he had no particular expertise in relation to the process of formulating a government budget nor a health budget nor in relation to the operations of the Commonwealth Grants Commission. From his answers, he appeared to me to be at some disadvantage in expressing a firm and concluded view of the issues raised by reason of a lack of access to detail. Overall, Mr. Chapman's conclusions were somewhat tenuous and did not really qualify to any extent the thrust of the evidence given by Mr. Barker and confirmed by Mr. Lambert. I prefer Mr. Barker's evidence as to the cost of the AMA's claims and the implications on the health budget.

The economic context as found in the most recent *State Wage Cases* is one of seriously depressed activity and in which an expectation of recovery in the near future was most guarded. It is irresistibly clear, it seems to me, that money resources, certainly in the public sector although one would not doubt also in the private sector, are extremely scarce in meeting the very many competing demands. The cost of meeting the AMA's claims in whole amounts to $87-90 million per annum, and funding

that amount would necessarily be either from within the existing health budget or by re-allocation from another area. In the opinion I have formed, the consequence of those findings is that for the AMA's claims to be granted in whole or in substantial part would require a most decisive and compelling case to be made out. In the balance, of course, would be the benefits of the implementation of the Minister's various structural efficiency measures, non-costed as they were, but which were admitted as being a significant contribution to the containment of VMOs' costs in practice and as directly improving productivity and efficiency overall in the public hospital system.

State Wage Cases and principles of wage fixation

Mr. *Sperling* submitted that the principles of wage fixation as formulated in *State Wage Cases* were largely inapplicable to the present case, but to the extent they were applicable, even in spirit, they had been complied with by VMOs. He identified the primary principle relied upon by the Minister as that relating to structural efficiency. Senior counsel based his submissions on the proposition that the relevant principles were those contained in the *State Wage Case August 1989* ([1989] 30 I.R. 107 at 116) and not those principles in the *State Wage Case - May 1991* ([1991] 36 I.R. 362 at 422), because, as the decision in that latter case ruled (*ibid* at 422), where cases were part-heard as at 29 May 1991 then they "may be processed to finality in accordance with the previous wage fixation principles and independently of requirements which flow from this decision." The significance of that approach here, whilst not affecting the concept of structural efficiency, would be to render inoperative the variations made to the work value changes principle by the latter case concerning increases for all classifications and the time from which work value changes were to be measured as being, unless extraordinary circumstances permitted, not earlier than 4 October 1989 in lieu of the

earlier date of 1 January 1978 under the August 1989 principles; also, the 1991 principles omitted the previous anomalies and inequities principle contained in the 1989 principles. In any event, Mr. *Sperling* submitted it had been demonstrated that as VMO rates of remuneration had been effectively frozen since February 1988 when they were last adjusted in accordance with the *State Wage Case February 1988* ([1988] 23 I.R. 340) the present claims could be processed as a special case.

I am of the opinion that the present case was not part-heard on 29 May 1991. True it is there were proceedings before me as the Arbitrator as early as 6 March 1991, but those proceedings concerned preliminary matters in order to prepare the arbitration for hearing, and the exhibits tendered by the parties on 20 May 1991 were really in the nature of pleadings. The hearing proper commenced on 12 August 1991, and, therefore, the relevant principles of wage fixation are those contained in the *State Wage Case-May 1991* as affected by the *State Wage Case-March 1992* in relation to structural efficiency considerations.

In his final address, Mr. *Sperling* summarised the AMA's position as to the principles of wage fixation and structural efficiency as follows:

- The structural efficiency principle in concept was inapplicable to visiting medical officers.
- The various structural efficiency measures laid down in the *State Wage Cases* focus on skill-related career paths and multi-skilling which were inapplicable to visiting medical officers for whom sub-specialisation was the appropriate development and for whom progression to higher grades with the acquisition of new skills was not regarded as an appropriate basis for remuneration.
- The emphasis on employer-sponsored training as part of structural efficiency was not apposite in the case of visiting

medical officers who have their own training and their own updating in skills very much in their own hands.

- The "no extra claims" commitment was inapplicable to visiting medical officers who would not be free to enter into enterprise agreements or arrangements inconsistent with a determination.
- Fundamentally, and in any event, the arbitrator is only bound to have regard to the principles rather than a mandate to apply them; accordingly, considerations of applicability, relevance and common sense operate to determine what weight, if any, should appropriately be given to the principles.

On the basis of applying the *State Wage Case August 1989*, Mr. *Sperling* relied upon the work value changes principle and the anomalies principle, particularly having in mind that VMOs' rates of remuneration had not been increased since February 1988, with the result that the special case requirements were made out. If the claims were to be processed in accordance with the *State Wage Case - May 1991* then the circumstances satisfied the special case test, including the ability to measure work value changes back to the previous assessment in 1985.

Mr. *Kenzie* dealt at some length with the application of the principles of wage fixation to the present matter and traced the development of the principles from the *National Wage Case March 1987* ([1987] 17 I.R. 65), and the corresponding *State Wage Case March 1987* ([1987] 17 I.R. 105), to the *National Wage Case April 1991* ([1991] 36 I.R. 120) and the *State Wage Case-May 1991* ([1991] 36 I.R. 362). Senior counsel summarised the primary concern of those cases since 1987 as being related to measures taken to improve productivity and efficiency, and, apart from basic wage increases, wage increases could only be

obtained if certain criteria were met. Additionally, he particularly noted the expressed view of both the federal and State industrial tribunals that wage increases available pursuant to the principles, other than the structural efficiency principle, would be very limited as structural efficiency was seen to be the centre of wage fixation. Reference was made to the superannuation principle in view of the provision in VMOs' rates of a superannuation component; reference was made to the decision of the Industrial Commission in Court Session in the *State Wage Case-May 1991* (*supra* at 413) in which it rejected a claim for increases in the superannuation contribution level on the basis that superannuation and retirement policies were subject matters properly for national consideration, and noted the expressed intention of the Australian Government to convene a national conference on superannuation.

As to the applicability of the principles of wage fixation, Mr. *Sperling* in his final address submitted:

> In 1989 the principle also included that the parties implement measures to improve efficiency, that being the next phraseology in the clause.
>
> I should mention the reference to "parties" in the principle would, so far as the workforce is concerned, be a reference to registered unions of employees.
>
> There is something more than a technical point to be made about the role of the AMA in these proceedings. Under the legislative code the AMA has a right of appearance at an arbitration such as this. The AMA also has a role in relation to any promulgation of a standard form of contract. That exhausts the statutory role of the AMA. It is not, at the end of the day, a party to the determination in the way that a registered union of employees is party to an award.
>
> Furthermore, upon a determination being made, such as in 1985, the statutory function of the AMA in relation to such a determination is exhausted and it has no statutory role or authority to treat in relation to such a determination, save only in this promulgation of a standard form of contract, which is a different matter and a different aspect of the code altogether.
>
> When the structural efficiency principle, in effect, imposes an obligation on the parties to implement measures to improve efficiency, that is not a principle that is really capable of applying in

the circumstances of this case, there being no relevant party, but apart from such a view, one can look at the matter in terms of spirit and inquire whether the visiting medical officers themselves have implemented measures to improve efficiency and as to that we stand on our record, or at least the AMA stands on the record of the visiting medical officers on their behalf.

...

In 1991 the structural efficiency principle is as recorded in the State Wage Case in 36 IR, 362 at 427. There a general statement is made, with particular matters referred to in pars (a) to (f). There again we would say there has been compliance in principle with provisions that cannot apply strictly because of the nature of the relationship between the parties and the absence of a registered union of employees which is party to an award and which has an obligation to do anything in relation to the determination once the determination has been promulgated. We say in spirit these paragraphs have certainly been complied with.

...

Lastly, we would say that the core concept is that the workforce in question should have applied itself to improvements in efficiency. On the evidence the visiting medical officers have done that. They update their skills in their own time and at their own expense. They undertake self-discipline by way of rigourous peer review to maintain their standards. They participate in management, organization, clinical units, as heads, as committee members and department members; they serve on committees designed to improve efficiency and on special purpose committees designed to develop more efficient methods. They participate in the changes which have brought about shorter length of stay, day only surgery and early discharge. They carry the tensions and stresses of those arrangements in the interests of efficiency. Without their cooperation the public hospital system would not be able to boast, as it does, that services are going up without an increase in overall costs. We say the results speak for themselves.

The question is not whether there is room for improvement, there is always room for improvement, the question is whether what has been done has sufficiently satisfied the principle and we say that it does.

In those circumstances, we would say your Honour was satisfied that the VMOs pass through the necessary gate, if it be a necessary gate, to enable this claim for review to be entertained.

Mr. *Kenzie* presented, and spoke to, a most comprehensive written submission on the relevance of the wage fixation principles. A significant part of that submission concerned the application of the principles to the present case, and, in view of its importance, I reproduce that part as Appendix "L" hereto. As a general finding, I accept the thrust of the

submissions there made by Mr. *Kenzie*. In doing so I recognise that VMOs are independent contractors and not employees, but it seems to me where rates of remuneration are to be fixed, including the bases therefor and together with the terms and conditions of work, principles applied to employees under industrial awards performing work under contracts of service are most apt to apply to independent contractors performing work under contracts for services. I mention in support of that approach the adoption by the various Commonwealth Medical Fees Enquiries of the principles of wage fixation in determining the net income component of fees for Medicare benefit purposes.

The result is that the appropriate principles to take into account are those formulated in the *State Wage Case-May 1991*, and, specifically, those principles relating to structural efficiency, work value changes, existing allowances and superannuation. The nature of the claims made here and the circumstances in which they arise require processing in accordance with the wage adjustments principle as a special case. Consistent also with the purpose and intent of the principles, I propose to follow a policy of restraint, particularly having in mind the economic consequences as earlier referred to, thereby enabling the monitoring of costs in an environment to achieve increased efficiency and productivity.

In order to move from this point to a consideration of the merits of the respective claims, it is necessary to settle an appropriate base as the reference point. On that there was considerable division between the parties as to what the base should be. The AMA relied upon the 1985 determination whereas the Minister said the appropriate reference point was the 1982 determination as the last work value assessment. It is necessary then to consider the previous determinations.

Arbitral approach

The importance of the 1985 determination as the immediately prior fixation of the terms and conditions of work for VMOs was supported by Mr. *Sperling* with the proposition that the ordinary nature of an industrial arbitration was for the arbitrator on an application for a new determination to re-enact the terms of the previous determination but making such variations thereto as were necessary to meet changes or special circumstances which had arisen in the meantime and which were shown to require attention. He relied upon the approach so stated by the former Court of Industrial Arbitration (per *Curlewis* J.) in *In re Brickmakers, &c. (Cumberland and Country) Board* ([1923] A.R.(N.S.W.) 67 at 67, 68) as follows:

> In this case the conditions of the industry were first fixed, so far as the matter has been brought to my attention, ten years ago. Mr. Croft suggests that after ten years the rule of the Court, that unless a change of conditions or special circumstances are shown the award will not be altered except to give effect to the fluctuations of the living wage, should be altered.
>
> I am not prepared to say that there is not something in the suggestion. I am not prepared to say that care should not be taken that the awards of the Court do not become absolutely rigid, and that no reconsideration of awards on a change of public opinion, at any rate as expressed in legislative enactments, should be made. But, whatever the merits of such a proposition may be, I feel quite certain that it is not one that ought to be laid down by a single Judge. It is an absolutely novel proposition, and in my opinion the very lowest tribunal that should lay down such a rule should be the Full Court. But I may further say that I think it is for the Legislature to bring about that change if it thinks fit to do so.
>
> As it stands, however, it has got to be remembered that, to give effect to such an application as Mr. Croft is making, would certainly disturb the relations of these particular employees and the whole industrial world. They have gone on for ten years to a certain position with regard to others. ... The consequence would be a general opening of the floodgates of all industry.
>
> ...
>
> In my opinion, therefore, at any rate, sitting as a single judge it is my duty to follow the rule of the Court, and wait until the Full Court or the Legislature lays down a different rule.

The ordinary rule thus stated was put by Mr. *Sperling* to be presently applicable because there was nothing in the *Public Hospitals Act*, and specifically s.29N thereof, which would require the arbitrator to review rates of remuneration and the conditions under which work was performed in any other way. Senior counsel contrasted the position here with that obtaining in industrial arbitration after the decision in *Brickmakers* (*supra*) when the *Industrial Arbitration Act*, 1912 was amended by Act No. 14 of 1926 by inserting s.11 which directed a review to be made of the conditions of an industry, together with the wages payable, notwithstanding any previous enquiry if either party so applied. The statutory successor to s.11 in the *Industrial Arbitration Act* 1940 was s.32(1) and in the I*ndustrial Relations Act* 1991 it is s.10. The effect of the insertion of s.11 was stated by *Street* and *Cantor* JJ. in *In re Government Railways and Tramways (Moulders) Award* ([1928] A.R. (N.S.W.) 566 at 603) "to abrogate the self-imposed general rule of the Court, by placing upon the Committee the duty of reviewing all the terms and conditions set out in an expired award upon any application for another award covering the industry if either party so apply." The resulting position was stated by *Cantor* J. in *In re Gas Meter Makers (State) Conciliation Committee* ([1932] A.R. (N.S.W.) 341 at 346) thus:

> Since the passing of this section it is accordingly the duty of a conciliation committee, and of this Commission also, in the event of the committee failing to make an award upon the application before it if requested, to inquire itself into the nature of the work done by employees in the industry covered by the application, the conditions under which the work is done, and all other relevant circumstances, and notwithstanding that no special circumstances exist, or that no change in the industry has taken place since the last award was made (whether it was made after inquiry under the Principal Act or the Act of 1926), to make such award as the Commission itself or the Committee itself, as the case may be, according to its own judgment is satisfied is a proper award to be promulgated in the industry. But when exercising this jurisdiction the tribunal is not bound to disregard the provisions of previous awards or industrial agreements that have been made from time to time covering the industry. Those awards and industrial agreements, together with

> the provisions of such other awards and agreements as the tribunal thinks are relevant and will guide or aid it in arriving at a proper determination, may be taken into account. Indeed, it is open to the tribunal, as a result of its own examination and consideration of all the material before it, to come to the conclusion that the provisions of the existing award are proper to be re-adopted and to make a new award embodying the same terms. Nothing in the section prevents such a course being followed. Or the tribunal may think that in all or some respects the existing terms and conditions should be altered; the section directs that, if applied for, the conditions of the industry shall be reconsidered, but the result of the reconsideration is entirely a matter for the Commission, and, in the case of a hearing by a conciliation committee, a matter in the first instance for the committee, subject to appeal to the Commission.

That approach has been consistently followed: see *In re Crown Employees (Professional) Conciliation Committee* ([1937] A.R. (N.S.W.) 603 at 612, 613) and *In re Crown Employees (Scientific Officers - Division of Science Services, Department of Agriculture) Award* ([1962] A.R. (N.S.W.) 250 at 273). It should be added that s.23A of the *Industrial Arbitration Act* 1940, following its insertion in 1959 by Act No. 29 of 1959, aided that approach to arbitration as may be seen from the decision of the Industrial Commission in Court Session in *In re Dispute - Broken Hill Pty. Co. Ltd. Re Bonus Payments (No.2)* ([1971] A.R. (N.S.W.) 754 at 776) thus:

> We are unable to understand the notion that, upon the making of the Steel Works Award in 1968, s. 23A had the effect of exhausting the Commission's jurisdiction in relation to the fixation of the remuneration of employees in the industry. In our opinion the mandate imposed on the tribunal by s. 23A is one that is to be complied with on each and every successive occasion when the tribunal comes to exercise its powers, being powers relating to the fixation of prices for work done and rates of wages. It is a mandate which, as the Commission in Court Session said in the *Scientific Officers Case* ([1962] A.R. (N.S.W.) 250 at 273), deals with the processes of the mind which are to be adopted by the tribunal in exercising its powers under the Act. The fact that one judge in 1968 deemed certain rates to be just and reasonable to award did not make those rates just and reasonable for the term of his award or any other period of time in the sense that it would not be open either to the same judge or another judge, when asked to exercise his powers under the Act, to deem other and different rates to be just and reasonable. Were it necessary to rule on the argument based on s. 23A we would reject it.

Section 23A as there referred to provided that in exercising its powers an industrial tribunal was to "fix such prices for work done and

rates of wages as (were deemed) just and reasonable to meet the circumstances of the case."

In my view, the approach urged by Mr. *Sperling* was overly narrow and too restrictive, and, in any event, failed to give proper regard to the nature of the determination which I am required to make. In accordance with s.29M(1) of the *Public Hospitals Act*, it shall be a determination as to "the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable ... and the date or dates, not being a date or dates earlier than the date of the determination, on and from which any determination made ... shall have effect." Further, s.29N(1) enjoins me in making a determination to "act judicially and be governed by equity and good conscience." That I am to make a determination which, as Mr. *Sperling* conceded, was to be just and reasonable and based on fairness, but in respect of which I was bound to re-enact the previous determination other than by recognising changes since it was made, seems to me to be somewhat incongruous and inconsistent with the nature of a determination and the manner in which I am to exercise my functions under the *Public Hospitals Act*.

Accordingly, the approach which I propose to follow, having conducted appropriate inquiry, is to make such determination as I am satisfied is proper in accordance with all relevant circumstances, including those matters to which I am required to have regard, and notwithstanding that no special circumstances may exist or that no changes may have taken place since the last determination was made. As to previous determinations for VMOs, I do not propose to disregard the provisions of them but will take them into account to the extent thought relevant and as a guide or aid in arriving at a proper determination as a just and reasonable settlement of the present claims.

CHAPTER 5 - PREVIOUS DETERMINATIONS

The 1976 private arbitration and recommendations

Following the agreement in 1975 between the then Commonwealth and New South Wales Governments to abolish the honorary system for the treatment of public patients and its replacement by a system in which VMOs would render medical services to public patients in return for a sessional payment, Mr. *Rogers* was appointed as arbitrator to make recommendations as to -

(a) The basis and amount of remuneration to be made to VMOs.

(b) The nature and extent of leave to which VMOs may be entitled.

(c) The conditions and other benefits included in contracts for services provided by VMOs.

On 8 September 1976 Mr. *Rogers* delivered his recommendations and reasons therefor. They were duly accepted by the Minister and the AMA, and eventually incorporated into an agreement which represented the initial provisions for the terms and conditions of work, including rates of remuneration, on a sessional basis for VMOs in the State's public hospital system.

In the reasons accompanying the recommendations, Mr. *Rogers* recorded the evidence as showing that at that time there were approximately 3,000 honorary medical officers occupying some 6,000 posts in public hospitals in the State; full-time salaried staff specialists numbered somewhere between 300 and 400 and there were approximately 1,500 resident medical officers. The honorary medical officers in the larger cities were mainly specialists, but at hospitals in the country the honorary staff comprised mainly the local general practitioners.

After observing that the evolution of medical fees had been haphazard in the extreme, Mr. *Rogers* recorded in his reasons (Pt.2 at

pp.7-9) the basis on which medical practitioners set their private fees, having in mind the honorary work, as follows:

> The fees that were charged by these Consultants were those which they individually considered appropriate for the work that they were doing. In setting their fees, they sought to cover themselves for the honorary work that they carried out in public hospitals for public patients and also the low rate of remuneration they received from lodge members and some of the other indigent members of the community.
>
> The evidence suggested that they tended to charge relatively more than was justified for procedures and relatively less than was justified for consultations, being concerned only with their own income. In the result, when the notion of the "common fee" was introduced in the 1960's, the charges which were "common" had not been determined on any scientific basis but had built in the compensatory factor for free or subsidised services tendered to public patients and lodge members. This has not been eliminated by any of the subsequent inquiries carried out for the Federal Government, first by Mr. Justice Mason, then Mr. Justice Ludeke and more lately by Mr. McIntosh of Peat, Marwick & Mitchell. The evidence on this point was given by Dr. Guyot, the Treasurer of the New South Wales Branch of the A.M.A. In Exhibit 56 Dr. Guyot said this:-
>
> > "8. The 1970 variations in the Health Scheme meant that many services previously carried out in an honorary capacity were now performed for a fee on private patients and this had meant an increased income to doctors without any increase in the work done.
> >
> > 9. This unfortunately is a perfectly valid concept as medical fees have evolved in the following manner.
> >
> > 10. Looking at the evolution of medical fees it becomes clear that doctors accepted that they would be working a certain number of hours per week, some of these hours being occupied in an honorary capacity in hospitals, some spent in treating the indigent in their private practices (those people not being able to pay part or any of their fees) and for the remaining private patients whom they would be charging, there would be a residual bad debt rate.
> >
> > 11. Added to the above the doctor realised that there would be costs necessary to the running of the practice and the supply of service to patients.
> >
> > 12. Private medical fees were set at a level which would cover these expenses and leave a reasonable net average hourly earning rate taken over the entire hours that the doctor works (i.e. the total of that time spent in seeing private patients, public patients and the indigent in his private practice).

13. The above has been referred to as the 'Robin Hood' principle."

In oral evidence at page 411, he said:-

"Rogers: So that this inbuilt compensation factor for sterilised time has continued to remain in the system as she is and over the evolution of the fee adjusted by Mr. Justice Ludeke and by Mr. McIntosh from time to time.

Guyot: Yes sir.

Rogers: So that ultimately, when a contract is produced it is going to produce a situation where the initial compensatory factor is still in the system in a sense, but will now also be augmented by remuneration for the particular item for which that compensatory factor was consciously or unconsciously designed by the doctor in setting his initial fee.

Guyot: Correct."

The adjustment to the fees that took place from time to time catered for rising costs and general inflationary pressures but no attempt was made at any time to determine fees purely as reward for service tendered to private or intermediate patients and to exclude therefrom any element of remuneration or reward for time spent on service to public patients.

Concern was expressed by Mr. *Rogers* that future remuneration of a medical practitioner by a sessional payment for services previously rendered to public patients without charge on an honorary basis, but with fees payable to them by private patients continuing to reflect the element of loading pursuant to the "Robin Hood principle", would result in VMOs being remunerated twice for the time spent treating public patients. That problem of double-counting was drawn to the attention of the parties during the proceedings but they jointly asked it to be disregarded in the making of recommendations: the parties sought, and as a private arbitrator Mr. *Rogers* felt bound to accept, the fixation of fair remuneration for the services rendered on a sessional basis to public patients and the question of the element of free work previously considered in fixing "common fees" be best resolved by bringing the

problem to the notice of the appropriate Commonwealth authorities when medical fees schedules were being determined. However, and this was common ground between the parties in the present proceedings, no action has since been taken to adjust the medical fees schedules to remove any element for that double-counting nor have medical practitioners been known to reduce the level of fees which they charge private patients. Apart from the effect on remuneration, Mr. *Rogers* noted also the double-counting impact with private practice costs and said in his reasons (Pt.2 at pp.12,13):

> The crying need for a fresh approach being made to the whole field of determination of medical fees is compounded when one has regard to the claim by the A.M.A. for contribution to Private Practice costs by the hospitals as part of the remuneration package sought. It is claimed that a Practitioner's private practice structure is integrated with and of such assistance to the Hospital part of the practice that a portion of its cost should be reimbursed. I will consider this claim in detail later in this Award, but it is sufficient for present purposes to note the double compensation aspect that this claim bears. The fees charged to private patients are self evidently, calculated with a view to full recovery of practice costs but a further partial recovery is now sought. In relation to this aspect of the claim also, the Commission agreed with the A.M.A. that I should disregard the private fee structure and its component elements and thus in effect, if thought fit, to award any part of private practice costs providing double compensation for part of this outlay.

In the result, in assessing a proper sessional rate, including a factor for private practice costs, Mr. *Rogers* must be taken to have excluded any consideration for the "Robin Hood principle", thereby fixing rates of remuneration which he considered fair. The aspect of double-counting therefore continued in respect of the fees received by VMOs from private patients. The dilemma, apparently still unresolved, was illustrated by Mr. *Rogers* in the reasons (Pt.2 at p.14) by reference to the evidence given by Dr. Guyot, then Treasurer of the AMA, in this way:

> It would be unfair if I failed to mention that the A.M.A. recognised the need for a fresh approach, although the emphasis may have been directed in another direction. Dr. Guyot said:-

> "One reason why one sector should not be subsidised by the other, is that doctors are going to do varying amounts of work in the private and public sector. All doctors are not going to be spending 50 per cent of their time in each. Unless we get each side right, if we sought to subsidise the public sector by charging more in the private sector, this would relatively advantage those doctors who are spending a higher proportion of their time in the private sector less than the public sector, and disadvantage those doctors who are doing the reverse."

Perhaps one might now only echo the plea made in 1976 by Mr. *Rogers* - "I am left with no choice but to urge with all the emphasis at my command, the introduction of a system that bears more of the hallmark of fairness, both to the tax-payer, to the fee paying patient and to the medical profession, than the scheme based as it is on a substantially incorrect series of assumptions" (see decision Pt.2 at p.13). Notwithstanding what the position may be insofar as a VMO's private patients are concerned, the "Robin Hood principle" formed no part of the 1976 assessment of sessional remuneration for VMOs.

Base rate: Remuneration in 1976 was fixed as an annual base rate on the basis of a VMO rendering services for one session, that is a period of 3.5 hours, per week as a result of either one or two visits to the public hospital. A "split session", that is a period of 3.5 hours' service as a result of three or more visits to the public hospital, attracted a loading of 10 percent. The arrangement was for a VMO under a sessional contract to render services to the public hospital by sessions and/or split sessions of not less than one nor more than ten per fortnight, a greater number requiring agreement between the parties. For work performed during a session or sessions the VMO was to be remunerated at the normal sessional hourly rate, such rate being calculated by converting the annual base rate to a weekly rate (annual base rate divided by 365 and multiplied by 7) and then converting the result to an hourly rate (weekly rate divided by 3.5).

In assessing appropriate annual base rates of remuneration, Mr. *Rogers* acknowledged the parties joint reliance on then existing award rates for salaried staff specialists determined in an initial fixation by the Industrial Commission in Court Session in 1966 in *In re Medical Officers - Hospital Specialists (State) Award* ([1966] A.R. (N.S.W.) 144) and by regular "work value" reviews by *Richards* J. in 1968 ([1968] A.R. (N.S.W.) 469) and by *Cahill* J. in 1972 ([1972] A.R. (N.S.W.) 675), through to the then current award made by *Kelleher* J. in 1975 ([1975] A.R. (N.S.W.) 78). Having regard to the importance placed on the award for staff specialists in the proceedings, Mr. *Rogers* examined in some detail the work performed by them and the value placed on it by the Industrial Commission in determining salary rates. I have had in mind Mr. *Rogers* reasoning in that respect and I have taken the opportunity also of reading the judgments of the Industrial Commission in the various staff specialist cases. It seems to me the following relevant conclusions were made by Mr. *Rogers* in his assessment of appropriate annual base rates of remuneration for VMOs -

- The qualifications, skill and devotion of both categories of medical practitioner were commensurate.
- VMOs included practitioners whose reputation and skill ranked them as the most pre-eminent in the field, not only in Australia but in the world.
- Staff specialists included practitioners in the very first rank of practitioners in the State in their particular discipline.
- Staff specialists worked and were remunerated on the basis of an average of 55 hours per week.
- Staff specialists were subject to on-call and to call-back for which no additional remuneration of any kind beyond the base salary was provided.

- Each of the judgments of the Industrial Commission as to staff specialists recognised the high quality of the practitioners, their professional skill and ability, the exceptional stresses and strains involved in decisions affecting the very life of patients, the great strides made in medical and general scientific knowledge and the burden imposed on the practitioner in keeping abreast of all new techniques and developments.
- Staff specialists had award salaries fixed excluding any consideration that at least some full-time specialists had the right of private practice which they exercised in hospital hours; a staff specialist was paid an allowance of 16 percent of base salary for private work, and assistance was given in connection with financing conference and study leave.
- A staff specialist who did not exercise a right of private practice received an over-award payment of 16 percent of base salary.
- In making a comparison between VMOs and staff specialists, it was realistic to make the comparison on the basis that in addition to the award salary a full-time staff specialist received an allowance of 16 percent, either from private practice carried on during hospital hours or directly from the hospital in lieu of private practice.
- The award salary rate for a senior registrar, as a resident medical officer, was of some significance in determining the commencing point for the scale of salaries for staff specialists, bearing in mind that the ultimate responsibility for the care of the patient was that of the staff specialist into whose care the patient was entrusted.

Mr. *Rogers* thereupon recommended for a VMO specialist (by five annual increments) and a senior specialist annual base rates which converted to normal sessional hourly rates as follows -

Classification	Annual Base Rate $	Normal Sessional Hourly Rate $
Specialist -		
1st year	2,184	11.97
2nd year	2,293	12.56
3rd year	2,407	13.19
4th year	2,527	13.85
5th year and thereafter	2,653	14.54
Senior specialist	2,918	15.99

Mr. *Rogers* then recommended annual base rates for VMO general practitioners, which converted to the following normal sessional hourly rates -

Classification	Annual Base Rate $	Normal Sessional Hourly Rate $
General practitioner with less than 5 years experience	1,747	9.58
General practitioner with less than 10 years experience	1,965	10.76
General practitioner with 10 or more years experience	2,293	12.56

For completeness, and a better understanding, the annual salary rates for a staff specialist (5th year and thereafter) and a senior staff specialist, with the corresponding hourly salary rates calculated on a working week of 55 hours, current at the time Mr. *Rogers* made his recommendations were -

Classification	Annual Salary (as at 8.9.76) $	Calculated Hourly Rate (as at 8.9.76) $
Staff Specialist (5th year and thereafter)	27,636	9.66
Senior specialist	30,374	10.62

Superannuation: In addition to the base rate, the parties jointly were of the view that a superannuation loading should be allowed, although there was disagreement as to the quantum. The AMA sought a loading of 15 percent, whereas the Health Commission proposed 5.25 percent being the percentage of salary contributed to the Local Government Superannuation Fund for a full-time staff specialist. Mr. *Rogers* recommended a loading at the rate of 5.25 percent of the base sessional rate.

Private practice costs: The AMA sought the payment of a further loading to compensate for background private practice costs in an amount roughly equivalent to the annual base rate. It relied on the results of a survey conducted by it amongst both general practitioner and specialists in city and country areas to enable the practice costs of a fair average practice to be assessed for various matters such as furniture and equipment, motor car, entertainment, library, etc. In his reasons (Pt.5 at pp.2-4), Mr. *Rogers* concluded:

> It is self evident that some practice costs can be readily ascribed to that part of a practitioner's practice devoted to hospital patients e.g. if a practitioner utilises the services of his secretary in order to type a report concerning a hospital patient, or a postage stamp is obtained in order to mail such report. On the face of it, it would seem to be fair that reimbursement for this service should be obtained otherwise than from private patients. Unfortunately, nobody is in a position to segregate costs on this basis and the evidence simply does not enable me to make any accurate estimate of the costs involved. In this regard, there is no typical practice which can be structured merely by a survey. Dr. A. may have 5 sessions a week. Dr. B. may have only 2. On the other hand, Dr. B. may make a practice of writing a report in relation to each hospital patient he has, utilising his own secretarial facilities, Dr. A. may use hospital staff or may not send any reports. ... Finally, take the case of a surgeon, who spends most of his time in the operating

theatre and contrast that with a physician who spends 70% of his time in his rooms. One surgeon who gave evidence sees patients for one half day a week and that generates enough work in the surgery to keep him busy during the ensuing week. How is the cost of rental to be taken into account? To try and divide costs on a time basis as the A.M.A. has done, is entirely too simplistic.

On the other hand, I think that the approach of the Commission is also in error. It is hardly to the point to say that a practitioner would engage a secretary in any event or that he would incur the rental of a surgery even if he had no hospital patients to attend to. If, in fact, the secretary is using the telephone in the surgery in furthering the interests of a hospital patient, then why should the public sector not bear an appropriate portion of the cost of the facility?

My problem, as I have said, is that the evidence fails to disclose even a rough and ready means of calculation which would be fair to the practitioners as a whole, as well as to the Commission. The patient mix between private and hospital patient varies tremendously. The extent to which a practitioner may utilize his facilities for the purpose of hospital patients also varies greatly.

The problem is not alleviated by the fact that as I have shown in the evolution of the fee structure to which I have already referred, the total amount of the practice costs has been covered in calculating the fees to be paid by private patients.

Mr. *Rogers* found on the evidence he was unable to make any recommendation as to a specific allowance for practice costs, but that factor had been borne in mind in the making of other recommendations. Like his earlier recommendation in relation to the base rate on the double-counting aspect, Mr. *Rogers* recommended further that the question of private practice costs and the apportionment between private patients and public patients should be made the subject of an enquiry by the Commonwealth and State Governments. No such enquiry has since been held.

Sessions: A provision was sought by the AMA for a split-session loading of 25 percent of the base sessional rate where a VMO had to make more than two visits to a public hospital to aggregate 3.5 hours for a session. The loading was claimed on the basis of the additional travelling time involved, although it was recognised such time would vary greatly according to the VMO concerned. Mr. *Rogers*, "and erring on the side of

generosity", recommended a loading of 10 percent in respect of split-sessions (Pt.6 at p.2).

Extension of sessions: Where a VMO was required to extend a scheduled session, payment was sought at the normal sessional hourly rate between the hours of 8.00 a.m. and 6.00 p.m. Monday to Friday and payment at the rate of twice the normal sessional hourly rate outside those hours. In finding as "entirely reasonable that a practitioner should be paid for time actually worked", Mr. *Rogers* recommended payment for any time worked by way of extended session at the normal sessional hourly rate with no loading. He stated in the reasons (Pt.7 at pp.3,4):

> However, what the A.M.A. has failed to recognise is that the Judgment is impregnated with references to "ordinary industrial standards" in relation to "conditions of employment". Now, if there is one matter that unites the A.M.A. and the Commission in the instant Arbitration, it is that V.M.Os. are not to be treated or considered as employees. Indeed, both draft contracts propounded by the A.M.A. and the Commission respectively, contain an express recital to the effect that the V.M.Os. are not employees but independent contractors. Furthermore, there is no question but that V.M.Os. will not be working 40 hours a week in the performance of their duties much less over 40 hours per week. Indeed, I am told that there will be an upper limit of 5 sessions per week. In those circumstances, I completely fail to understand the validity of an approach which seeks to pray in aid judgments which determine the industrial conditions of employees and in particular, employees such as Resident Medical Officers who were working in some instances, 100 or more hours per week. Similarly, the principles enshrined in the Industrial Arbitration Act for the protection of employees, can hardly be invoked by those whose manifest purpose it is to repel the embrace of that description.

On-call: The AMA sought a payment of 25 percent of the normal sessional hourly rate for each hour a VMO was rostered on-call, whereas the Health Commission sought compensation by payment for one additional session. It was a question for determining quantum. The following view was expressed (Pt.8 at pp.2-4) by Mr. *Rogers*:

> The burden which is imposed on a practitioner by the fact that he is rostered on call, is in my view, alleviated somewhat by the fact that, according to the evidence, a practitioner is on call for his private patients and to such hospital patients as have been admitted under

his care. He is, it is said, on call to such patients 24 hours a day, 7 days a week, except when he is out of town. Thus, the practitioner's ability to conduct his life as he pleases, is substantially restricted, regardless of any question of being rostered on call for hospital patients. In other words, the additional burden of being on call on roster, seems to me to be more reasonable than would be the case did the other obligations not exist.

On the other hand, I think that the evidence does justify the conclusion, that being rostered on call does increase the number of telephone calls which a doctor receives. In the case of at least one Physician, the number of phone calls received was quite burdensome. Unfortunately, it was not possible to determine how many of the phone calls referred to private patients and how many to hospital patients. The evidence does seem to indicate that Physicians do receive considerably more telephone calls whilst rostered on call, than their procedural colleagues. I mention this aspect again as one which requires to be borne in mind when one has regard to the competing demands that are made on Physicians and those performing procedural work.

Mr. *Rogers* then recommended:

I recommend that an on call allowance at the rate of one tenth of the normal sessional hourly rate should be paid for each hour that a practitioner is rostered on call, provided that where a practitioner is rostered on call to more than one hospital, he shall receive not more than one on call allowance. If there is a call back to the contracting hospital during the period he is rostered on call, he shall not receive the on call allowance for the period occupied by the travelling time and call back.

Call-back: There was no dispute that remuneration should be paid for a call-back, the issue was as to quantum. Mr. *Rogers* reasoned (Pt.9 at pp.2-4) the problem in the following way:

There are a number of difficulties in determining what is a fair and proper way to treat time spent on call back. Firstly, there is question as to whether or not there should be a minimum period. A call back may range from a doctor being called across the road from his rooms to the hospital for a few minutes to travelling through heavy traffic, in order to reach the hospital and then having to spend some hours there. Yet again, as another alternative, he may be called in the middle of the night and sometimes more than once. At the same time, particularly in relation to a practitioner who is called from home, the question arises as to why the Commission should pay for the time occupied by a practitioner travelling from say, Palm Beach to Prince Henry Hospital.

...

In relation to call backs, I think it is unreasonable, even in relation to someone who is not an employee, and who does not work in the employment of the Commission for 40 hours per week, to expect

> service to be given without prior warning at some hour of the night or on the weekend, without additional remuneration being provided for this service over and above that payable at other times.

In the result, it was recommended (Pt.9 at pp.3,4):

> I recommend that payment for a call back should be made to include travelling time with a maximum of 20 minutes travel each way and with a minimum payment for one hour at the rate applicable to normal sessional hourly work, together with a loading of 10% for call backs commencing within the hours of 8 a.m. and 6 p.m. Mondays to Fridays and a loading of 25% for call backs commencing outside those hours.

Public holidays: The issue was whether payment should be made to a VMO who was not required to perform normal sessional work on a public holiday. Mr. *Rogers* recommended, even though VMOs were working on a part-time basis only and as independent contractors, an entitlement to be absent from agreed sessional commitments on public holidays without loss of remuneration. Where a VMO was required to render services on a public holiday he was to be remunerated at twice the normal sessional hourly rate.

Long service leave: As to long service leave, Mr. *Rogers* said (Pt.11 at pp.1,2):

> In the end, what it comes to in my view, is this. Long service leave is granted by a particular employer so as to obtain the services of an employee for a lengthy period of time. This consideration cannot exist once the entitlement is made portable. Then the long service leave is granted so as to reward the worker with a lengthier period of sojourn than that provided by annual leave. To obtain long service leave, the V.M.O. will be required to serve at least ten years. The ten years he serves will be with the one deemed employer. I think that the purposes behind the grant of long service leave will be fully satisfied if the requirement be that the V.M.O. should complete at least three years continuous service from the end of the last break of his service.

The parties agreed a VMO should be compensated on account of long service leave, and also that the period should be 2 months after 10 years service and thereafter 5 months for each 10 years service. The only issue concerned provision for broken service, and Mr. *Rogers'* recommendation dealt with that.

Annual leave: The parties agreed a VMO should receive 5 calendar weeks annual leave in respect of each 12 months service plus one day in respect of each public holiday occurring during the period of leave. The point at issue was the payment of an annual leave loading based on the loading payable to full-time staff specialists. In noting that a staff specialist received no on-call or call-back allowance, Mr. *Rogers* found such a provision had no application to VMOs and therefore the claim was disallowed.

Conference and study leave: A period of 4 weeks leave per annum was sought by the AMA to enable a VMO to attend medical conferences and have a period for study, with provision for such leave to be accumulated to a maximum of 20 weeks. The Health Commission was prepared to allow 1 weeks leave per annum with an accumulation to a maximum of 2 weeks. Mr. *Rogers* found the evidence established a requirement for a VMO to maintain an up-to-date knowledge of his specialty and to attend conferences in Australia and overseas from time-to-time. Of course, the frequency of overseas visits varied considerably with the individual VMO and the specialty concerned. Recognising the claim was more generous than the benefits available to staff specialists, Mr. *Rogers* recommended that conference and study leave should be allowed in an amount of 3 weeks leave per annum, with an accumulation of 2 weeks each year to a maximum of 6 weeks.

Membership of the Royal Australian College of General Practitioners: The AMA sought a provision that membership by examination of the Royal Australian College of General Practitioners should be recognised as a "higher medical qualification" to permit specialist recognition. Mr. *Rogers* declined the claim on the basis it was properly a matter between the learned college concerned and the National

Specialist Qualification Advisory Committee; he was not prepared to intrude into what was substantially a medical issue.

Other matters: Mr. *Rogers* dealt with various other matters, but as they do not appear to me to be presently relevant I do not propose to refer to them. However, in the agreement which followed the recommendations the parties included a provision for the payment of travelling expenses where a VMO was required to attend a hospital, other than the hospital at which he ordinarily rendered services, at the motor vehicle rates prescribed for use in the public service. I note that that provision was agreed at a time when no specific allowance was fixed for practice costs.

Sessional hours: Finally, in relation to the 1976 proceedings, reference should be made to the arrangements settled between the parties for the determination of the sessional time to be worked by each VMO. Apparently, that was not a matter which Mr. *Rogers* considered, no doubt because there was no issue about it. However, it is relevant having in mind the Minister's present claim for a specified number of hours to be inserted in a sessional contract (known as an up-front hours contract) and in respect of which there was strenuous opposition by the AMA. In the circular from the Health Commission of New South Wales No. 76/264 issued on 24 September 1976 advising Mr. *Rogers*' recommendations and those matters on which the AMA and the Health Commission had reached agreement, the following paragraphs appear:

> 10. A sessional arrangement shall be offered only where the assessed needs for "routine service" (see Clause 2, Definitions) amounts to at least three and one half hours per fortnight (i.e., equivalent of one session or one split session per fortnight).
>
> 11. Apart from those visiting medical officers mentioned in paragraph 7 an agreement to render services by sessional arrangement is NOT to be entered into by those hospitals to which the modified fee-for-service arrangement applies.

12. The sessional allocation for each visiting medical officer shall be assessed on his present routine service to "hospital patients", e.g. ward rounds, clinics, operating theatre time.

13. It is to be noted that under the NEW form of agreement, the time spent on call-backs and the on-call allowance are no longer to be included in the sessional allocation but are to be remunerated separately, (see Clauses 9 and 10). However, the maximum number of sessions (including split sessions) remains at ten per fortnight.

14. The sessional time to be allocated to each visiting medical officer shall be determined by the Regional Director after discussion with each hospital; provided that in respect of the Teaching Hospitals and Royal Newcastle, the Regional Director might confine his approval to the overall number of sessions available in each specialty, and the hospital may determine the individual allocation.

15. The sessional time allocated to each visiting medical officer shall be reviewed by the Hospital in consultation with the Regional Director as and when the need arises.

The settled agreement for services by sessional arrangement contained the following in the recitals:

(B) the Visiting Medical Officer has agreed with the Contracting Hospital to provide medical services to hospital patients of the Contracting Hospital for (insert number of sessions) per week/fortnight (delete period which is not appropriate) and for (insert number of split sessions) per week/fortnight (delete period which is not appropriate) upon the terms and conditions hereinafter appearing.

The agreement itself in cl.5, Sessions stated:

5. SESSIONS

(a) The routine services of the Visiting Medical Officer under this Agreement shall be expressed in sessions and/or split sessions.

(b) Work performed during a session or sessions shall be remunerated at the normal sessional hourly rate.

(c) Work performed during a split session or split sessions shall be remunerated at the normal sessional hourly rate plus a loading of ten percentum.

(d) The routine services to be rendered to the Contracting Hospital by the Visiting Medical Officer shall be rendered by sessions and/or split sessions of not less than one nor more than ten per fortnight or by such greater number of sessions and/or split sessions as agreed between the Visiting Medical Officer and the Health Commission.

(e) At any time after commencement of the Agreement the Visiting Medical Officer or the Contracting Hospital may seek an alteration in the number of sessions or split sessions which the Visiting Medical Officer renders to the Contracting Hospital.

Clause 7, Remuneration contained the rates recommended by Mr. *Rogers*, as earlier detailed, "as a remuneration for the professional service to be rendered by (the VMO) under this Agreement." I might remark at this stage that such provisions in relation to the period during which a VMO was to render services and to be paid are not, in my view, conceptually dissimilar from the Minister's present claims before me.

The 1976 proceedings were truly foundational in nature, and I have found them and the recommendations of particular assistance in this arbitration.

The three determinations in 1978, 1980 and 1981

The first arbitration under the *Public Hospitals Act* pursuant to s.29M(1) thereof after Pt.5C was inserted on 31 March 1978 was conducted by *Macken* J. as arbitrator commencing on 14 August 1978. His Honour acknowledged the foundational nature of the recommendations made by Mr. *Rogers* in 1976, and attempts were then made to bring the AMA and the Health Commission to an agreement as to the terms of a new determination. In the result, agreement was reached on quite a number of issues leaving but a few, although significant, for determination. The major issues ruled upon by his Honour in making the determination on 8 December 1978, effective as from 1 January 1979, concerned ordinary remuneration, superannuation loading and background private practice costs. Generally, I think it to be the case that the 1978 arbitration adopted the framework of the 1976 agreement in accordance with the recommendations made by Mr. *Rogers*, and the differences related to matters of the quantum of remuneration and allowances.

Similarly, the determination by *Macken* J. on 29 February 1980, effective as from 1 March 1980, reflected substantial agreement between the parties with his Honour being required to decide issues as to maximum duration and the mode of performance of sessional contracts, sessional contracts for salaried employees, the form of the determination and the role of the Health Commission. Included in the issue of the performance of sessional contracts was those contracts which, in terms, provided for on-call service only so that an appropriate on-call allowance had to be determined. Otherwise as to remuneration, the 1980 determination provided for rates as previously adjusted by basic wage increases. Essentially, then, the 1980 determination by comparison with that made in 1978 was concerned with disagreements as to the implementation and interpretation of the first determination made in 1978.

On 18 September 1981, *Macken* J. made a new determination, effective as from 1 October 1981, which provided a radical departure in concept from previous determinations. The AMA and the Health Commission were unable to reach agreement on the respective claims, and his Honour had to resolve major issues relating to the concept of sessions, the times during which sessions were to be worked, ordinary remuneration and its basis, leave of absence, extended sessions, and on-call and call-back allowances. Most of the changes made by the 1981 determination have direct relevance to the issues confronting me, and, in summary, they were -

. Although the title "sessional contract" continued, being the phrase referred to in the *Public Hospitals Act*, the determination changed the period during which a VMO was to render services from a "session" or a "split session" of 3.5 hours for a minimum of one session and a maximum of ten

sessions per fortnight to an agreed set number of hours in each four-weekly period.

- The minimum contracted hours in each four-weekly period was one and a maximum of seventy.
- The ordinary remuneration per hour of service rendered by a VMO was expressed in the determination as a "rolled-up" sum comprising a base rate, superannuation loading, private practice loading, split session loading and a leave loading. The amount thus obtained was known as the normal hourly rate.
- The normal hourly rate was payable in respect of time actually spent in the rendering of services by a VMO to public patients, so that, and unlike the previous determinations, no payment was made when a VMO was absent on any form of leave nor when services were not provided on a public holiday.
- Periods spent on-call were paid at the rate of $10.00 per period which period was not to exceed 24 hours. The previous on-call allowance was 10 percent of the normal sessional hourly rate for each hour rostered on-call.
- A classification structure was formulated by abolishing the five annual increments for a specialist and setting a single specialist rate at the fifth year of service level.
- Remuneration for public holiday work was fixed at the normal hourly rate plus a loading of 50 percent.
- Extended sessions attracted payment at the normal hourly rate.
- A travelling expense provision was continued in terms of that agreed initially in 1976 to reimburse a VMO for the

additional cost of travelling to a hospital other than the hospital to which he was contracted under his sessional contract.

In view of what I perceive to be the importance of the changes made in 1981, I propose to set out below the basis for the principal matters by reference to his Honour's reasons.

Sessions: The Health Commission sought to have the concept of sessions abolished altogether and for remuneration to be for "service provided by a VMO pursuant to the provisions of this Determination"; the AMA sought to have "routine service" defined to mean "service provided by a VMO between 8.00 a.m. and 6.00 p.m. Monday to Friday inclusive, or at such other times as the VMO in his absolute discretion might agree, but does not include service beyond his agreed sessional commitment to the contracting hospital or service provided by reason of call-back". The AMA effectively sought retention of the concept of a session being for a period of 3.5 hours. The change was, therefore, quite fundamental and, in deciding the issue in favour of the Health Commission by providing for a notional 1-hour minimum session, his Honour in the reasons said (at pp.3,4):

> Thus, the AMA envisages a continuation of the practice by which work performed during a session is remunerated at the normal sessional hourly rate while work performed during a split session is to be remunerated at the normal sessional hourly rate plus a loading of 10 percentum. The Commission challenged the whole concept of three and one half hour sessions on this occasion. It seeks to have sessions and split sessions abolished as a concept to be replaced by a base hourly rate which will include a split session loading built into it at 5 percent. The concept that a session shall be three and one half hours has been a feature of the two Determinations made under the Public Hospitals Act since 1978. It appears to have its origin in the length of service originally estimated to be taken to deal with out-patients and ward rounds. The evidence of a number of Commission witnesses indicated that hospital work is not organised into that type of span any longer, even in the larger hospitals. The abolition of out-patient service and the changes in hospital practice appear to make a sessional period of three and one half hours anachronistic in the current medical world.

...

> The greater flexibility in having sessions able to be calculated on the basis of each hour has much to recommend it and, if it does enable some practitioners to be offered contracts who would otherwise be excluded, it would seem to be a change of advantage to VMOs. If hardship is worked by the change I have no doubt it will be revealed in the operation of this new Determination over the six-monthly minimum period of its life. I propose therefore to make such a change in this Determination.

Ordinary remuneration: The Health Commission sought a change to the "rolled-up" rate concept against AMA opposition based on the fear that if loadings such as superannuation and private practice costs were incorporated into an hourly rate it may prejudice future arbitrations in a review of such loadings. His Honour set out in quite some detail precisely how he arrived at the normal hourly rate so that the fear was "more ephemeral than real." As to the base rate, the AMA sought it be fixed by reference to the award rate for staff specialists but not so as to include any "work value" component because a separate work value review was intended in the near future; his Honour, therefore, adjusted the base hourly rates strictly in accordance with community wage movements, leaving any tie with staff specialists' award rates to a later arbitration. To the base rates so fixed, and after replacing the five year incremental scale for specialists with a single rate at the previous fifth year rate, his Honour determined the following loadings as additions to the base rate to give a total hourly rate -

- A superannuation loading of 7.5 percent of the base rate.
- A private practice loading, adjusted by *State Wage Case* increases, of $1.90 per hour for a general practitioner and $2.50 per hour for a specialist.
- A split session loading of 5 percent of the base rate.
- A leave loading of 36.8 percent of the base rate; that loading took into account five weeks annual leave, two weeks sick leave, two weeks long service leave, three weeks conference

leave and two weeks public holidays giving a total of fourteen weeks per annum.

Leave of absence: With the inclusion of a leave loading in the normal hourly rate, leave of absence in the future was unpaid at the time it was taken, having, of course, been paid in advance when each hour of service was rendered.

Public holidays: The loading of 50 percent to be paid in addition to the normal hourly rate for services rendered on a public holiday followed the industrial standard; payment for public holidays not worked was included by way of the leave loading in the normal hourly rate.

Extended sessions: The AMA's claim for payment of extended sessions at overtime rates was rejected in favour of retaining the then existing provision for payment at the normal hourly rate.

On-call and call-back: The Health Commission sought the omission of any payment whilst a VMO was on-call, although it conceded payment for a call-back at the request of the hospital should attract a loading of 10 percent of the normal hourly rate between 8.00 a.m. and 6.00 p.m. and 25 percent between 6.00 p.m. and 8.00 a.m. The AMA sought payment for a call-back when a VMO was rostered on-call to be by a loading of 50 percent of the normal hourly rate for the first two hours and 100 percent thereafter, and, when a VMO was not rostered on-call, a loading of 200 percent of the normal hourly rate. His Honour concluded that issue by saying (at p.13):

> I have already indicated that on this occasion I do not propose to abolish the on-call roster and I have not embraced an overall on-call payment within the base hourly rate. The present position provides for payment of an on-call allowance equivalent to one tenth of the normal sessional rate for each hour during which a VMO is on-call for hospital patients. The fixation of an on-call payment by such an administratively difficult method does not strike me as appropriate any longer. I have adopted the original proposition of the Commission and I have provided for an allowance to be paid to a VMO on-call at the rate of $10.00 per each on-call period. (an on-

> call period was provided to mean a period not longer than twenty-four hours)
>
> The existing level of payment and penalties for call-backs (10 percent and 25 percent) seems to me to be fair in all the circumstances.

It will be apparent then that the 1981 determination was indeed a radical departure in concept, and represented a structural framework on which later determinations were built. Even so, there was no suggestion that the bases for the remuneration fixed involved any departure from the approach adopted by Mr. *Rogers* in 1976, which, as urged by the parties, was assessed at levels considered fair. In other words, as I would conclude, by excluding any consideration for the "Robin Hood principle".

The 1982 determination

Proceedings for a new determination were initiated by the AMA nearly six months into the life of the previous determination, and the hearing of the claims commenced before *Macken* J. on 13 September 1982. His Honour made a new determination on 15 December 1982, effective as from that date, describing in the accompanying reasons (at p.3) that "most hearing days were spent considering in detail evidence of work value changes which have affected the practice of specialist medicine since 1976". Agreement was reached between the parties on a number of matters, but, and despite some agreement in principle, the principal claims remained in issue. The claims on which his Honour had to rule concerned hourly rates of remuneration (involving work value changes, economic adjustment, and wage and salary restraint), sessional periods, on-call and call-back provisions, variation of a sessional contract and payment for public holidays.

The setting in which the claims fell for consideration was stated by his Honour as follows at (at pp.2,3):

> Mr. Gyles stated that the application by the A.M.A. on this occasion was qualitatively different to earlier applications which had in

substance been confined to seeking the updating of the Determination then existing. On this occasion a full-blooded challenge to many of the underlying concepts which go to determine the hourly rate and sessional period for V.M.Os was to be mounted. Mr. Gyles claimed that the existing hourly rates for V.M.Os were inadequate either on the basis of work value considerations or on a comparison with movements in the basic wage or average weekly earnings, or with hourly rates for related disciplines.

Generally, the 1982 determination followed the concept of that established in 1981 of having a "rolled-up" rate of remuneration and without payment for periods of leave when actually taken, but it refined the previous determination as to the method of calculating the number of paid sessional hours each month. In summary, the main alterations made by the 1982 determination, having in mind their relevance to the present issues, were -

. A sessional contract was expressed in hours per calendar month rather than hours per four-weekly period.

. The previous provision whereby a VMO who worked fewer hours than those specified in his sessional contract received no reduction in monthly remuneration continued, but there was no additional payment where a VMO worked a greater number of hours (other than on-call and during a call-back) in any month; that is, an "under and over" system was introduced.

. The number of the contract hours per calendar month specified in a sessional contract was to be the average number of hours per calendar month during which the VMO rendered services, other than those during on-call and call-back, in the six calendar months immediately prior to the operative date of the determination; unpaid leave was added to the number of hours for calculation purposes.

. Where a sessional contract had not been in force for a period of six calendar months immediately prior to the operative

date of the determination, the number of contract hours per calendar month specified was one; the VMO was remunerated also at the normal hourly rate in respect of all services rendered in excess of that one hour.

- Contract hours were adjusted each six months on the basis of the average hours during which services were rendered in the immediately preceding six calendar months, so that the number of contract hours per calendar month thus calculated formed the basis of the sessional contract hours for the ensuing six months.
- The normal hourly rates of remuneration were increased by 14 percent, with an additional 6 percent increase deferred.
- The on-call allowance was increased from $10.00 to $20.00 and the on-call period attracting that allowance was reduced from a maximum of twenty-four hours to a maximum of twelve hours.
- A VMO, to facilitate the calculation of the contract hours per calendar month, was required to maintain a record of the date upon which services were rendered and indicating the commencing and finishing times and the number of hours involved.
- The settlement of disputes procedure could be initiated only by the AMA or the Health Commission, and not, as previously, by an individual VMO or hospital.

It is necessary to refer to his Honour's reasons in order to appreciate the basis for the various changes made.

Ordinary remuneration: His Honour referred to various passages in the reasons given by Mr. *Rogers* in 1976 as to the nature of visiting medical officers and the work performed by them, and said (at p.15):

> These comments drawn from the Rogers Report, together with other of the bases for the Recommendations in it, are important because the A.M.A. accepts the findings of fact with respect to professional skills as foundational for the claim now made for a considerably higher hourly rate. The work value evidence led from all witnesses predicated a firm and sound datum point for a consideration of those changes in the 1976 Rogers Report.
>
> The acknowledged characteristic of the V.M.O. at the time of the Rogers Report in 1976 remains true today. V.M.Os in the State of New South Wales are in the front rank of practitioners in their various disciplines in the State of New South Wales and the Commonwealth of Australia. Many of them enjoy enviable international reputations. Like their professional counterparts who are medical specialists employed by the public hospitals, they carry out their professional skills under great stress and strain; strains which are involved in decisions affecting the very life of the patient. The great strides made in medical knowledge impose on them a further burden of keeping abreast of new techniques and developments.

His Honour noted the need to keep abreast of changes in the conduct of one's profession was a recognised and normal obligation of every profession, so that some of the evidence given by the specialists of work value changes since 1976 had been discounted on industrial principle. Nevertheless, his Honour accepted the changes since 1976 on a work value basis were beyond those to be expected as part of the normal progress of a profession, and, whilst not true of every specialty, it was sufficiently true enough to require the hourly rate to be increased by reason of such changes. Whilst his Honour did not specify the particular changes, nor was any attempt made to identify the more spectacular of them, the range of specialties and some of the changes which had taken place were identified by reference to the particular VMOs who gave evidence. His Honour acknowledged (at p.17) that "on each occasion adjustments to the hourly rate have been made without regard to work value changes".

His Honour referred to the claim made by the AMA as to hourly rates of pay; it ranged from an increase of 104 percent for a senior

specialist to 160 percent for a general practitioner with less than five years experience. His Honour observed (at pp.18, 19):

> If at first sight this claim appears to represent a selfish and uncharacteristic raid on the public purse by the leading medical practitioners of the State, it should be understood that it reflects approximately the schedule fee established for medical benefit purposes taken as a rough average. The common fee, of course, varies with the nature and extent of the consultation or treatment. Over the wide range of specialties from which evidence was led, however, the lowest return for the treatment of private patients was about $77.00 per hour whilst most witnesses earned in private practice approximately $110.00 per hour as an average. This earning rate is achieved by charging private patients approximately the common fee allowed for such work. It can be seen, therefore, that the claim of the A.M.A. represents a return to V.M.Os for hospital work below that earned by them for work performed on private patients. The A.M.A. argued that, as no unfairness can be suggested against the common fee, it is appropriate that the same return should be allowed for work on public patients in hospitals as is allowed for treating private patients for the same illnesses.

However, his Honour saw a number of conceptual difficulties with the AMA's argument in terms of the basis on which Mr. *Rogers* fixed rates in 1976 and in light of the "Robin Hood principle". His Honour concluded (at pp.19-21):

> The agreement made in 1975 transmuted most honoraries into paid V.M.Os but this change plainly did not entitle the V.M.O. to receive for the treatment of public patients the same remuneration as they were entitled to receive for the treatment of private patients with no account being taken of the tradition of honorary service. Nor the advantages of the appointment itself for the V.M.O. with respect to the treatment of private patients. This question was canvassed before Mr. Andrew Rogers Q.C. in 1976. He referred to the "Robin Hood" principle which envisaged private medical fees being set at a level such as to cover overhead expenses and leave a reasonable net hourly earning rate averaged over all the hours the specialist worked. Thus, the "Robin Hood" principle was one pursuant to which public patients were treated free of charge because honorary doctors were recouped by fees paid by private patients.
>
> ...
>
> Thereafter, Rogers Q.C. fixed a sessional rate for V.M.Os which has provided the foundation for all determinations made since 1976, and which has been adjusted on economic grounds ever since.
>
> Having regard to these facts I reject as an appropriate method by which V.M.Os should have their sessional payments fixed the adoption of a level of remuneration equivalent to that fixed for the

> treatment of private patients. It is not only too late to reverse the course of industrial history established over the past 10 years, but, if it was a practical exercise to undertake, it would require, as Rogers Q.C. found, that the rate paid for the treatment of private patients should first be unloaded by an amount to take into account the "Robin Hood" element which he found to be present at the time of the original fixation; an anomaly which Rogers Q.C. was debarred from correcting by consensus of the Health Commission and the A.M.A. This is impossible.
>
> The A.M.A. has adopted the Rogers Determination as foundational for purposes of his findings on work skills and responsibilities. Work value changes have been measured since that date for this reason. I consider it equally appropriate that the rate fixed then should remain foundational. It remains for me now to fix a rate of remuneration, appropriate in the 1982 context, predicated on a correct fixation having been made in 1976.

In my view, and as I would understand his Honour's reasoning, the 1976 approach by Mr. *Rogers* was regarded as foundational for the purposes of assessing the work skills and responsibilities of VMOs; using 1976 as a datum point, his Honour saw his task as accepting as correct the 1976 fixation and up-dating it to 1982 in light of the changes which had occurred. Rejecting the fixation of remuneration at a level equivalent to that fixed for the treatment of private patients, because private fees contained an amount to cover the previous honorary work in treating public patients, his Honour clearly accepted the 1976 rates as proper rates at the time and as appropriate to base an assessment in 1982. Accordingly, it logically follows in my view, his Honour must be taken as having accepted in 1982 that Mr. *Rogers* in 1976 fixed fair rates but excluded any discounting for the "Robin Hood principle". That that must be so is clear, in the view I take, from what Mr. *Rogers* said in his reasons (Pt.2 at pp.10, 11):

> ...the fees payable to Doctors by private and intermediate patients will continue to reflect the element of loading which Doctors had incorporated in their charges to recompense them for what had formerly been unpaid work. Doctors will be remunerated twice for their time devoted to hospital patients ... I drew attention to this serious and to my mind, wholly unacceptable, anomaly a number of times, but I was asked by both parties to disregard it for the purposes of my recommendations.

After acknowledging remuneration fixed in each determination since 1976 had largely accorded with the principles of wage fixation, his Honour as to economic considerations said (at p.23):

> On such figures it seems plain that, apart from work value considerations, V.M.Os are entitled to a salary increase based on their loss of relativity with the industrial community generally, and with staff specialists in particular. Such an increase is the equivalent of the amount which they would have received by reason of the general wages round (in 1981-82) comprised of the three increases (4.3, 7-10 percent and 4 percent) recently awarded.
>
> Because the loadings are calculated as a percentage of the base rate, no reason exists for not applying the percentage determined herein to the "rolled-up" rate.
>
> It remains to be considered as to whether an hourly rate should be fixed by applying this mathematical calculation, together with some addition to represent work value changes, or whether such an approach should be qualified because of our economic exigencies.

And so his Honour considered the question of wage and salary restraint. After identifying two elements to which regard had to be had in the assessment of hourly rates, namely economic considerations and work value, his Honour settled on an increase of 14 percent, with a further increase of 6 percent deferred, on the basis as set out in his reasons (at pp.26,27) as follows:

> In order to fix an hourly rate for V.M.Os in current money values which would reflect general wage movements which have occurred since 1976, the rates in the current Determination should have to be increased by 14 percent. To the extent that comparisons should be made with staff specialists an addition of 14 percent would also have to be added to the hourly rates of V.M.Os. Taking into account the work value changes as well, a fair fixation would require an adjustment of 20 percent to current rates. Such a percentage would not reflect any economic movement occurring during the life of the Determination, which must, by reason of the Statute, be at least the first half of 1983.
>
> I have had the greatest difficulty in determining to what extent the calls for restraint should be heeded because V.M.Os have enjoyed limited variations since 1976 and the continually deferred work value hearings should have entitled them to some salary adjustments long before the need for the present economic constraints became apparent.

> I am satisfied as to their entitlement to a 20 percent hourly salary adjustment to bring them into line with the rest of the community and with the medical community with whom they are most closely related, viz: staff specialists in public hospitals. Of this percentage they should be awarded the minimum of 10 percent referred to by the Statutory Remuneration Tribunal and the Industrial Commission in Court Session with respect to senior salaried public servants. The question is whether some additional sum between the 10 and the 20 percent should be awarded having regard to the long deferred work value adjustments. This question has to be argued against the background of staff specialists being considered for some further movement based on economic considerations and work value.
>
> In the current economic circumstances and in particular because public health has come under such great pressure by way of bed reductions, staff cut-backs and the like, I consider that the public interest requires the deferment of part of the entitlement to 20 percent. I propose to make this deferment in such a way that the component deferred is clearly identified and capable, therefore, of being contended for in the future. Although there is more logic in awarding the work value component together with part of the economic component, the interests of the V.M.O. would be better served by my deferring altogether the work value component but to adjust the hourly rates so that at December 1982 it can be said that they reflect all economic movements to that date. This involves the need to adjust hourly rates of pay by 14 percent at this time and to defer the 6 percent for the moment.

Sessional periods: The issue here concerned a claim by the AMA to return to a sessional minimum of 3.5 hours per fortnight. The Health Commission argued for sessional contracts to be based upon the average number of hours per calendar month, with the "average" being calculated according to the hours in the immediately prior 6 months; the concept of a 1-hour minimum should apply where a sessional contract had not been in effect for 6 months. In adopting the Health Commission's approach, his Honour said (at pp.30, 31):

> I have no doubt that the adoption of an average hourly concept will result in minimum sessions of 3 1/2 hours or more attaching to the great majority of sessional contracts offered to V.M.Os. In this regard it will relieve V.M.Os of the problems feared by the establishment of a 1 hour minimum. I can foresee some difficulties arising in establishing the average hours to be worked by V.M.Os. The Health Commission seeks variations to cl.10 of the Determination which require the V.M.O. to maintain records indicating the date upon which he has rendered services pursuant to the Determination; including recording the commencing and finishing times during which services are rendered, and the number of hours to the nearest 1/4 hour of such elapsed time as is

> attributable to services which are to be remunerated in accordance with the Determination. It also requires each V.M.O. to keep a record showing particulars of such service including the date, time of day, name of patient and nature of services rendered. These records have to be submitted to the contracting hospital by the 15th of each month.
>
> Such a provision (however necessary it may be at least in the beginning of a sessional arrangement) may well become a galling imposition on V.M.Os unless it is administered with understanding and a reasonable degree of latitude by the hospitals.
>
> I propose to treat the change in this Determination as a trial period for the concept of "average hours". I hope mutual goodwill can make the system work.

On- call and call-back: The 1981 determination varied the on-call allowance from 10 percent of the normal sessional rate for each hour during which a VMO was rostered on-call for public patients to an allowance of $10.00 for each on-call period of twenty-four hours. His Honour in reviewing the provision in 1982 remarked that the 1981 change was to overcome administrative difficulties, but that "the $10.00 flat rate which was fixed in the Determination in 1981 was too low a fixation for the period to which it was applied" (at p.32). In determining the new amount of $20.00 for a reduced on-call period of twelve hours, his Honour concluded (at p.32):

> A great deal of evidence was called in the 1982 proceedings as to the social imposition occasioned to V.M.Os and their families by being required to be on-call. They distinguished being on-call as a V.M.O. from being on-call with respect to their private patients, partly because they know in advance the degree of urgency likely to attach to being required by a private patient, while being on a roster for a hospital provides an absolute requirement to be available. It cannot be qualified by the professional judgment of the V.M.O. because he cannot know at any given time what a public patient in the hospital (or yet to be admitted) may require of him. The V.M.Os complained bitterly that the sum of $10 for a 24-hour on-call period is totally inadequate to remunerate them for the imposition which the duty requires.

Variation of sessional contract: The AMA sought a provision to enable the parties by mutual agreement to amend a sessional contract during its currency; the Health Commission considered the change unnecessary. His Honour, in declining the AMA claim (at p.33), expressed "some

concern that variations by mutual agreement which may be widespread and have a common cause could be frustrated by the need to vary each individual document".

Public holiday payment: The AMA sought a return to the position where a VMO received payment when he was absent on a public holiday. His Honour found no unfairness in the existing position and continued it.

It seems to me the 1982 determination may properly be categorised as a work value case, but the increases in the normal hourly rate were based upon economic movements only with the deferral of the work value components because of the need to adopt a policy of restraint. The determination may be categorised as well as one adopting the average hourly concept in the rendering of services and payment therefor, a concept which has direct similarity with the Minister's present claim for an up-front hours contract.

The 1983 determination

The period from December 1982 to September 1983 was a period of wage restraint for economic reasons and known as the "wages pause". Nevertheless, on 8 June 1983 the AMA sought a new determination re-making the provisions of the 1982 determination but with changes in respect of ordinary remuneration, definition of "specialist", record of attendance, computation of payments and contracted hours, and on-call allowance. On 14 December 1983 *Macken* J. made a new determination, effective as from that date, the elements of which are set out below.

Ordinary remuneration: This matter was the major contested issue, with the Health Administration Corporation opposing any increase. There were two aspects argued, namely the remuneration adjustment provision to reflect increases in the basic wage following a *State Wage Case* and an increase in the normal hourly rates to the order of 15.6 percent.

As to the basic wage provision, his Honour decided to continue it and said (at pp.4, 5):

> In origin the basic wage clause was a consent provision which the parties included when Determinations first came to be made. It has had the effect of reducing the number of applications for new Determinations as hourly rates have kept in line with variations arising from State Wage Case Decisions from time to time.
>
> ...
>
> It has its origin in the wish of the parties; it has been maintained in Determinations over the years by consent of the parties and it has been given effect to by both parties. Its convenience as a mechanism for avoiding the need for constant applications for new Determinations justifies its continuation. I expect it to have the same fruitful future existence as has justified its inclusion in past Determinations.

As to the hourly rates claimed by the AMA, there were three components involved in the increases sought - first, 4.3 percent from the then most recent *State Wage Case*; second, 6 percent work value increase deferred from the 1982 determination; and, third, 5.3 percent on account of economic adjustments on a catch-up basis. His Honour considered it appropriate to allow the 6 percent deferred increase and found "no sound reason" against allowing the 4.3 percent increase emanating from the *State Wage Case - 1983* ([1983] 5 I.R. 1). His Honour observed in his reasons (at p.6) that a refusal to grant the 4.3. percent increase "would be the first occasion on which an important judgment emanating from the Industrial Commission in Court Session pursuant to s.57 of the Act has not been so translated". Rates were thus increased by 10.3 percent.

Definition of "specialist": The Health Administration Corporation sought to limit a VMO specialist to a medical practitioner who was "engaged in specialist practice" to overcome an apparent problem in which the existing definition of "specialist" was said to permit, particularly in country areas, a general practitioner being paid as a specialist rather than as a general practitioner because he possessed a higher medical

qualification or was otherwise recognised as a specialist. The change was resisted by the AMA. His Honour noted in the reasons (at p.8) that the Health Administration Corporation did not see it as "a big problem" and "there would seem to be very little incidence of any difficulty"; the matter was therefore left to the parties to continue discussions.

Record of attendance: The Health Administration Corporation claimed a provision to require a VMO to maintain records "on stationery supplied by the contracting hospital". The claim was resisted by the AMA and his Honour found (at p.9) that the existing clause "has operated effectively and I suspect that the fears of the Corporation are groundless". No change was made.

Computation of payments and contracted hours: The issue here concerned the significant changes made to the definition of a sessional period in the 1982 determination which introduced the concept of "average hours". At that time, his Honour introduced the concept for a trial period with the hope that "mutual goodwill could make the arrangement work"; it will be recalled that in the 1982 proceedings it was the Health Administration Corporation which had sought the adoption of the averaging concept and the AMA sought a return to the 3.5 hours sessional period. However, in the 1983 proceedings the AMA sought the preservation of the concept of "average hours" whilst the Corporation sought its abolition in favour of payment for hours actually worked in each calendar month.

In the result, his Honour adopted the alternative suggestion by the Corporation which was to enable VMOs to elect between payment for the actual time worked each month or on the basis of the average hours worked during the previous six months. It was to be a matter for the choice of a VMO, but once an election was made it could not be altered during the six month period. This provision as to the hours for which a

VMO received remuneration in the rendering of services under a sessional contract was continued in the 1985 determination and is therefore the current prescription.

On-call allowance: In view of the different rostering practices in use at hospitals, the Health Administration Corporation sought a change to the method of payment for on-call to an hourly rate instead of an amount for a period of twelve hours. The AMA sought retention of the on-call period. His Honour fixed a new allowance of $20.86 for the first twelve hours and $1.75 per hour thereafter.

The 1983 determination is important in that it put into effect what was found in the 1982 proceedings as being a proper level of ordinary remuneration according to work value considerations; at the same time, in conjunction with the 1982 determination, it adjusted the remuneration for VMOs in economic terms and in light of general community movements, and, in particular, by reference to award rates for staff specialists. The 1983 determination also has particular significance in that it set the method for determining the hours during which VMOs were to be remunerated for services according to the individual choice of a VMO as between the average hours concept and actual hours.

The 1985 determination

I have earlier in these reasons referred to the circumstances in which the 1985 proceedings were conducted. Following the introduction of Medicare in February 1984 and the amendments made to the *Health Insurance Act* 1973 (Cth.), a serious dispute arose in New South Wales in which very many VMOs withdrew from the treatment of public patients in public hospitals in protest against the alleged intrusion by government in the conduct of their private practices and the adverse impact on their incomes by reason of a change in the mix of public and private patients in public hospitals in favour of more public patients. The particular details

giving rise to the dispute are not themselves relevant for present purposes and there is little point in reciting them. However, it was during the course of the doctors' dispute that on 19 October 1984 the then Minister for Health made application for the appointment of an arbitrator for the purposes of making a determination under s.29M(1) of the *Public Hospitals Act* as to "the present sessional rate, and any increase in the rate which is attributable to or resulting from the introduction of Medicare as it applies to New South Wales". The arbitrator appointed on 23 October 1984 was *Macken* J., who thereupon attempted to commence a hearing on 30 October 1984 but experienced some difficulty in exercising his functions both as to conciliation and arbitration; the AMA entered a conditional appearance by reason of objections to the application proceeding because it was alleged to be defective and including the claim that the arbitrator's appointment was invalid. The context of course was the continuing and serious disputation the subject of the doctors' dispute. It appears his Honour took steps to facilitate the processing of the application and private discussions occurred between the parties. Eventually, on 2 April 1985 a joint statement was made by the then Prime Minister and the then Premier of New South Wales announcing a package aimed at settling the doctors' dispute, and the joint statement with the settlement package is set out at Appendix "M" to these reasons. It will be seen that the implementation of the package was dependent upon a return to normal levels of service in the public hospital system and was "subject to the New South Wales Branch of the AMA proceeding to arbitration on the level of the hourly sessional rate". It may be noted as well that the joint statement commented:

> It is quite clear that the additional remuneration contained in the package compensates doctors for any reduction in their incomes due to the reduced number of private patients under Medicare.

The settlement package in relation to the sessional rate to be arbitrated provided:

> The New South Wales Government has already offered a $12.50 interim increase in the sessional rate to $62.50 an hour. Any further increase in the level of the sessional fee can only be made through the established arbitration procedures. However, the New South Wales Government has a considerable level of funds available, to provide an increased number of sessions for medical staff in recognition of the increased number of public patients.
>
> The total package provides the New South Wales Government with an additional $16 million per annum from the Commonwealth for paying doctors, on top of the estimated $27 million per annum provided for doctor remuneration under the Medicare agreement.
>
> ...
>
> The additional State and Commonwealth funding brings the total amount of remuneration available for the treatment of public patients in New South Wales to $105 million per annum. This is a 150 % increase on the $32.9 million paid for the treatment of public patients in 1982/83. Currently, less than half the amount available has been taken up by doctors in New South Wales due to the dispute.

I interpose at this point to mention that from the evidence of Mr. Barker the additional cost of remunerating VMOs under the settlement package was estimated at some $40 million per annum, but, as a result of the determination finally made, an additional cost was incurred giving a total annual cost of implementing the 1985 determination of approximately $150 million per annum. Having in mind the total VMO cost for the year 1984/5 was around $50 million, the impact of a further $150 million per annum in payments will be obvious. In terms then of cost, the 1985 determination may reasonably call for strict examination as to the reasonableness of its provisions in the circumstances, particularly having in mind also that the AMA in the present proceedings maintained its correctness in order to provide a base for an up-dated determination from the present arbitration.

The arbitration duly commenced before his Honour on 20 September 1985 and on 19 December 1985 a determination was made effective on and from 1 January 1986.

Major changes: The 1985 determination made a number of changes to the then existing determination, and a summary of those with present relevance follows:

- The definition of "specialist" was varied to provide that the higher medical qualification was that recognised by the National Specialist Qualification Advisory Committee of Australia.
- A provision for the payment of cancelled sessional time was inserted whereby if a hospital cancelled a session without giving twenty-eight days' notice for anaesthetists and surgeons for operating theatre time and fourteen days' notice for all other VMOs then there was an entitlement to be paid for that cancelled time.
- The on-call provision was amended to delete reference to payment for an on-call period and in lieu to prescribe an on-call payment of 10 percent of the normal hourly rate for each hour spent on an on-call roster.
- Where a VMO returned to a hospital, other than as a consequence of being on-call or where the hospital initiated a call-back, payment had to be authorised by the Chief Executive Officer of the hospital, which authority was to be presumed unless otherwise indicated.
- The minimum payment for a call-back was to be one hour plus the actual travelling time to a maximum of twenty minutes each way.

- A call-back was deemed to commence when the VMO left his residence or place of contact to commence the call-back.
- The base rates were increased for all classifications to take into account the "Medicare effect" by amounts ranging from $17.00 per hour for a general practitioner with less than five years experience to $30.00 per hour for a senior specialist; that resulted in new base rates of respectively $36.00 per hour and $63.00 per hour, which, after adding the 49.3 percent loading gave normal hourly rates of respectively $54.00 and $94.00. Thus, the respective total hourly increases in ordinary remuneration ranged from $26.00 to $44.00.
- The amount for private practice costs, which was previously a loading within the "rolled-up" normal hourly rate, was removed and placed in a separate clause in the new determination. The amount for background practice costs was increased from $2.67 per hour to $20.00 per hour for a general practitioner and from $3.49 per hour to $25.00 per hour for a specialist.
- Hospitals undertook to pay VMOs' accounts for remuneration within one month of receipt.
- The determination contained a new clause relating to payment for attendances by a VMO at committee meetings, such as clinical planning, departmental administration, peer review and public patient management. Attendance at meetings of the medical staff council or board of directors were unpaid. Payment was to be in the same proportion as the individual VMO's private to public patient ratio.

Although not required by the new determination, the AMA and the Government agreed that the new rates of remuneration should be applied from 1 December 1984. There was no retrospectivity as to background practice costs.

Notwithstanding the significant increases in ordinary remuneration granted directly by the determination, as will later appear further increases occurred by operation of the automatic remuneration adjustment provision. That provision made the normal hourly rates by reference and in relation to the basic wage for adult males and where the Industrial Commission in Court Session made a determination or specification in a *State Wage Case* then the normal hourly rates prescribed by the determination were to be varied to the extent necessary to give effect to the change in the basic wage. I have referred earlier to the effect in that respect of the judgment of the Court of Appeal in *Hyslop (No.2)* (*supra*) which resulted in the normal hourly rate for a senior specialist being further increased by a total of $14.50 per hour following two basic wage increases in 1987 and 1988 in the total sum of $16.00 per week. The significance of this will be considered later.

The sessional rate: Clearly the most important issue dealt with in the 1985 proceedings concerned the hourly rate at which the various classifications of VMO were to be paid. In the accompanying reasons, his Honour dealt in some detail with the factors leading to the assessment made and opened that discussion by observing (at p.6):

> The A.M.A. sought considerable increases in the sessional rates paid to V.M.Os because the introduction of Medicare in 1984 had depressed the incomes of V.M.Os in public hospital practice. The reason Medicare had this effect has its origins in the principles that have been applied to V.M.Os salaries in the Rogers' Determination of 1976 and in all the determinations made since that time.
>
> The changes to public hospital medical practice which have come about as a result of the Medicare scheme have been of such a character that very little of the previous wage-fixation history is

> relevant for purposes of this Determination. Furthermore, it has made the application of wage-fixation principles stemming from *Stage Wage Cases* all but impossible to apply, other than in accord with their general philosophy of restraint.

It is apparent, it seems to me, that his Honour recognised the way in which the AMA's case was then put was as compensation for the reduction in VMOs' incomes by reason of the introduction of Medicare, the so-called "Medicare effect". The clear implication found by his Honour was that that change to public hospital medical practice was to almost negative the relevance of previous determinations as to the fixation of remuneration for then present purposes, and, significantly, to make all but impossible to apply the principles of wage fixation. The approach so stated by his Honour is important, in my view, in understanding the rates which were finally determined, because they must necessarily be seen in light of his Honour's approach against the history of previous fixations and very much in accordance with then current events, namely the settlement of the 1984-85 doctors' dispute. Indeed, after referring to the settlement package negotiated in April 1985 to resolve that dispute (see Appendix "M"), his Honour contrasted the more advantageous position of VMOs in hospitals other than the large teaching hospitals to be able to elect to be remunerated on a modified fee-for-service basis of 85 percent of the Medicare schedule fee where there were no resident medical officers or registrars, 70 percent of the schedule fee where a hospital had resident medical officers but no registrars, and 60 percent of the schedule fee where there were registrars at the hospital in the same discipline. The result, as his Honour remarked, "was to markedly increase the incomes of VMOs in all but the teaching hospitals", and that concession as to a fee-for-service contract was noted as "a central issue in the debate as to the level of the sessional rate" in the proceedings. His Honour then noted the concession made by government to VMOs at the teaching hospitals for the sessional rates to be increased by a flat amount of $12.50 per hour with

any higher increase to be subject to arbitration. In further explaining the way in which the AMA put its case for substantial increases in remuneration, his Honour said (at pp.8, 9):

> Sessional rates of pay for V.M.Os have always been based upon an assumption that there was a reasonably consistent mix of public and private patients so that the remuneration per hour for attending upon public patients could be subsidised by a number of factors including the right of the V.M.O. to have his private patients admitted to the hospital and charged on a fee for service basis. Ever since the time of the Rogers' Recommendations this anomalous basis for the salary fixation of V.M.Os has been known as the "Robin Hood" principle. In the ten years since the Rogers Recommendations were made the "Robin Hood" principle has provided the background for all salary arbitrations.
>
> The introduction of Medicare had a dramatic impact on the incomes of V.M.Os because it increased the proportion of public as against private patients. The "Robin Hood" principle fell to pieces under the strain as there was now no means by which private patients could subsidise public patients. A galling side-effect of Medicare was the fact that public patients now included the very wealthy as well as the indigent. It was upsetting to V.M.Os to know that they were treating on a reduced sessional rate a patient who could buy and sell them many times over.

I should immediately comment, apart from his Honour's finding that the "Medicare effect" itself had a dramatic impact on VMOs' incomes by changing the patient mix, that I find strange his Honour's reference to the "Robin Hood principle" as providing the background for all salary arbitrations since the 1976 recommendations by Mr. *Rogers*. I have referred in some detail to all of the earlier fixations of VMO remuneration, and, from the initial 1976 proceedings through each and every arbitration by *Macken* J. it seems abundantly clear, at least to me, that the "Robin Hood principle" played no part. Indeed, Mr. *Rogers* was at some pains to say he proposed to fix remuneration at fair and proper levels because the parties asked him to do so and regardless of his concern that by so doing there would be a double-counting effect in VMOs' incomes by reason of that component in their private fee structure to compensate for the honorary work previously performed by them. Therefore, whilst the

"Robin Hood principle" during the period from 1976 may have continued to inflate the level of fees received from private patients, it was no part of the assessment of sessional rates for VMOs in the treatment of public patients; that extended also to the assessment of private practice costs. In each determination made by *Macken* J. prior to 1985, his Honour assessed increases, as I would understand it, by reference to the previous fixation and to the foundational assessment made by Mr. *Rogers* in 1976. I am unable to see any element in that fixation of the "Robin Hood principle" as causing lower rates for VMOs than what otherwise might be said to be fair and proper rates.

Accordingly, on the basis of the approach stated by his Honour, it is my respectful view his Honour in 1985 misconstrued the basis of previous fixations in terms of the "Robin Hood principle", with the necessary result his Honour wrongly perceived VMO rates of sessional remuneration as being artificially low and as therefore requiring a considerable increase to compensate for the demise of the "Robin Hood principle" as a result of the "Medicare effect". Specifically, it seems to me on the history, the "Robin Hood principle" never had any impact on remuneration levels for VMOs, rather its continuing impact was the double-counting in the levels of private fees charged. To the extent that private income levels may have reduced as a result of the "Medicare effect", that does not seem to me to be a relevant consideration to take into account in determining remuneration because his Honour was only, and could only be, concerned with remuneration in respect of medical services provided to public patients. In any case, it must be axiomatic that a reduction in private patients meant a corresponding increase in public patients for whom a VMO received a sessional fee. At worst, therefore, a VMO received a reduced income from private fees but an increased income from public payments, albeit at a

lower rate due to the double-counting aspect in private fees from the "Robin Hood principle".

The $12.50 per hour interim increase in the sessional rate, offered pending an arbitration in the level of the hourly sessional rate, had about it compensation for a reduction in incomes of VMOs due to the reduced number of private patients under Medicare, and in fact the joint statement by the Prime Minister and the Premier on 2 April 1985 said as much. However, that is not to say that in a subsequent arbitration of an appropriate sessional rate ordinary principle ought to be replaced by some concept of acknowledged "income maintenance". Rather, in the view I take, it was a recognition of the need for some interim arrangement to be put in place pending an arbitration of an appropriate sessional rate. In that respect, it is to be borne in mind it was just on two years since VMOs had received an increase in their sessional rates so that it seems to me, properly viewed, the $12.50 payment was a true dispute settlement payment on an interim basis pending an arbitration. But, I would emphasise, that in no way represents recognition for remuneration henceforth to be assessed on an income maintenance basis nor according to anything other than proper and ordinary principle. Regrettably, as I have concluded, his Honour saw it differently and proceeded to assess VMO sessional rates, against the background of the doctors' dispute and the "Medicare effect", by the erroneous application of the "Robin Hood principle". From the outset then, the whole basis of approach to remuneration in the 1985 arbitration was flawed.

The further conclusion by his Honour that the circumstances made application of the principles of wage fixation quite impossible represents, in my view, an additional reason for finding the 1985 assessment was flawed. I have earlier dealt with the applicability of wage fixation principles to the assessment of VMO remuneration following the approach

in successive Medical Fees Enquiries into the level of Medicare schedule benefits, and I am quite unable for those reasons to accept the "Medicare effect" as being an abnormal difficulty justifying the non-application of those principles. The amendments made to the *Public Hospitals Act*, s.29N(2) in 1986 requiring the arbitrator to "have regard to" the principles of wage fixation seems to emphasise the correctness of that view. In any case, it may be mentioned that the replacement of established and firm principle by a concept as transient as the level of incomes at any particular time is fraught with difficulty, and, it must be recognised, could only have meaning, if at all, in relation to those VMOs affected at that point of time and not those entering practice later nor those whose practice consisted mainly of public patients.

One aspect which has caused me some concern has been the "Robin Hood principle" in its wider meaning, as I have earlier stated, namely the benefits received by a VMO in having his private patients treated in a public hospital with access to the special facilities of that hospital as a *quid pro quo* for the treatment of public patients at a lower rate. However, the evidence in this case established that VMOs generally regard a hospital appointment as of considerable value in their private practice and some would be unable to practice effectively without it. Therefore, I regard the wider nature of the "Robin Hood principle" as being neutral.

Another aspect which to me confirms the appropriateness of my conclusion that the 1985 approach by *Macken* J. was erroneous, is the fact his Honour found a significant reduction in VMO earnings; but there was no evidence before me that the total earnings of VMOs from both their private and public work had been adversely affected. Indeed, although no more than a suggestion, there was some evidence that VMOs' incomes in total have continued to increase over the years.

The history of VMO remuneration has established the relevance of the award salaries for staff specialists. In his 1985 reasons, *Macken* J. referred to that and to the changes which had then just occurred by agreement whereby staff specialists received improvements in their private practice arrangements. His Honour said (at pp.11, 12):

> The fact that Medicare reduced the proportion of private patients in public hospitals equally affected salaried staff specialists in that it reduced their private practice earnings. Negotiations between the Public Medical Officers' Association and the Corporation resulted in a new method of remuneration for staff specialists to cater for this problem. This involved conceding a lift to a normal upper limit for private practice earnings of 25% of salary, an expense allowance of 10%, a further 10% for call-back and 10% for on-call allowances. Together these lifted the maximum take home pay for staff specialists to 155% of salary.
>
> Certain other advantages attached to staff specialists by this agreement including allowing conference leave and the payment of air fares within Australia (Doctor E. H. Morgan estimated these as having a value of $1,000 per year). This travel option is part of a package in which a more limited private practice salary addition of 16% was agreed. Without canvassing all of the schemes with their differing levels of remuneration their significance can be gauged from the fact that the fourth level of scheme B provides a staff specialist with a salary of over $100,000 per annum, while the award rate is $60,738 per annum.
>
> Predictably the A.M.A. points to this agreement, made by the government with their staff specialists in teaching hospitals, as further justification both for an increase, and for quantification of that increase, for V.M.O.'s who are required to remain on sessional rates of pay in those hospitals.
>
> It will no doubt be asked as to how these adjustments could be made within the framework of the State Wage judgments given the rigid guidelines which have flowed from those decisions and the underlying doctrine of restraint applicable to wage levels throughout the community. The answer to this question is to be found in the fact that the rate paid to V.M.O's in the New South Wales hospital system has never been accepted by the parties, nor by tribunals, as truly reflecting the income of the V.M.O.'s receiving it. To apply Wage Fixation Guidelines to such incomes is to attempt to preserve a fiction.
>
> From as far back as the first application for an award for staff specialists the Industrial Commission has recognised that the award rate of pay is supplemented by private practice earnings of various kinds. It has always refused to enter into the arena so far as private practice earnings are concerned. V.M.O.s have similarly looked on their hospital payments as a small part of a private practice income. Indeed many V.M.O.s refused to accept any

> payment at all. V.M.O.s were concerned with their total incomes, not with the components that went to make it up. It was only when their total incomes fell so dramatically as the result of the introduction of Medicare that they felt it necessary to press for the fixation of a more realistic rate per hour for public hospital service.
>
> Certainly, since the Rogers' Recommendations were implemented and the first arbitration of rates took place in 1981, variations flowing from *State Wage Case* decisions have been applied to them, but that is not to say that, in making a Determination under such different conditions, I should attempt to squeeze into the confines of the guidelines a situation with which they were never designed to deal.

I will deal later with the salary rates for staff specialists as part of a comparative exercise in determining sessional remuneration for VMOs, but at this point I think it may be mentioned that the reasoning of *Macken* J. provides only part of the equation by leaving out the earnings of VMOs from their private practices. His Honour in assessing an hourly sessional rate for a VMO seems clearly to have looked at the total benefits received by a staff specialist, from both private and public earnings, but disregarded the private earnings of a VMO. To me, that is not comparing like with like. His Honour made no reference to the Scheme D staff specialists who, as will later be seen, are more akin to a VMO in their practice arrangements than are the staff specialists in Schemes A, B or C. Just as the Industrial Commission has declined over the years in fixing salaries for staff specialists to enter the arena of private practice earnings, it seems appropriate to me in fixing sessional remuneration for VMOs to refrain from entering the arena of their private practice earnings. Indeed, no party in the proceedings before me suggested I should do otherwise.

In quantifying hourly rates for VMOs his Honour first adjusted the then existing base rates by the quantum of 3.8 percent as assessed in the *State Wage Case November 1985* ([1985] 14 I.R. 105), and then similarly adjusted the $12.50 interim increase by that 3.8 percent and by the earlier 2.6 percent from the *State Wage Case April 1985* ([1985] 11 I.R. 6) to give

an interim increase of $13.32; and then reasoned a final increase as follows (at pp.17-19):

> I cannot accept a proposition which would measure the effects of Medicare in a flat money sum. No justification was advanced for the adoption of this concept and it runs counter to the history of treatment and relativities in the Determinations going back to the time of the Rogers' Recommendations of 1976. If there is justification for differential ordinary remuneration between a General Practitioner with less than 5 years experience at one extreme and a Senior Specialist on the other, there can be no justification for redressing the Medicare imbalance by way of a flat money sum. Furthermore, if it is appropriate that a General Practitioner with less than 5 years experience should have his "Medicare effect" measured in the sum of $13.32 then the very existence of the subsequent relativities implies that the concession should be applied in a final form so as not to compress existing relativities up the professional ladder. The logic of this extends to whatever sum is applied to compensate for the so-called "Medicare effect."
>
> The real difficulty lies in the fact that the fixation of such an amount calls for the application of intuitive faculties rather than a mathematical mind. It must always be borne in mind that the 1985 V.M.O. is the 1975 Honorary Practitioner. Even when V.M.O.s came to be remunerated for time spent in the public hospitals many looked on payment as unworthy of the dignity of an Honorary and a number declined to accept any payment for work performed as a V.M.O. As time passed the status of the position of V.M.O. at teaching hospitals has, according to the practitioners themselves, greatly diminished. Not only has the proportion of private patients fallen markedly (with the consequential distortion of the "Robin Hood Principle") but it is said that there is now little value in the availability of resident staff and that the privilege of having one's private patients admitted, save for emergency treatment, has been lost. One could go on as to the changes in the practice of hospital medicine but these factors sufficiently state the problem of quantifying in money terms the loss or, or change in, such professional perquisites.
>
> I have great difficulty in attempting to marry an hourly rate that is fair to V.M.O.s with the need for that restraint in the fixation of salary and wage rates, having its origins in the Prices and Incomes Accord, with the resultant principles flowing through to all wage fixation tribunals and the instruments made by them.
>
> I have formed the view that the ordinary remuneration for the General Practitioner with less than 5 years experience should be lifted from $13.32, conceded by the Government, to $17.00. I have carried this amount forward to maintain existing relativities. The ordinary remuneration applicable to the various classifications in the Determination, ignoring the extraneous additions, and rounded off to the nearest dollar, will, therefore, be as follows:

	Per hour
General Practitioner (Less than 5 years experience)	$36.00
General Practitioner (5 years to 10 years experience)	$40.00
General Practitioner (10 or more years experience or Fellowship)	$50.00
Specialist	$58.00
Senior Specialist	$63.00

It will be apparent, therefore, his Honour determined increases in the hourly sessional rate "to compensate for the so-called 'Medicare effect'". In the base rate, the increase for a general practitioner with less than five years experience was $17.00 per hour with proportionate increases for the higher classifications to a maximum increase of $30.00 per hour for a senior specialist. His Honour then turned to the application of the traditional loadings, totalling 49.3 percent, being 7.5 percent for superannuation, 36.8 percent for leave and 5 percent for split sessions. The resultant normal hourly sessional rates determined were therefore -

	Per hour
General practitioner (Less than 5 years experience)	$54.00
General practitioner (5 years to 10 years experience)	$60.00
General practitioner (10 or more years experience or Fellowship)	$75.00
Specialist	$87.00
Senior specialist	$94.00

Details of the increases for the respective classifications were as follows:

Classification	Existing Normal Hourly Rate	New Normal Hourly Rate	Increase	
	$	$	$	%
General practitioner-				
less than 5 years	28.00	54.00	26.00	92.85
5 to less than 10 years	32.00	60.00	28.00	87.50
10 years or F.R.A.C.G.P.	39.00	75.00	36.00	92.31
Specialist	46.00	87.00	41.00	89.13
Senior specialist	50.00	94.00	44.00	88.00

As a general observation, I must say the magnitude of the increases was significant, particularly in the context of the economy in the 1980's and having in mind too the level of increases otherwise being granted at that time to the industrial community. The level of increase granted to VMOs, in itself, and even given the reasoning of *Macken* J., would make one question its validity and certainly more closely consider whether the resultant rates fairly represented a proper basis or datum level on which to base a new determination in current 1992-93 terms.

Before leaving the assessment by his Honour of the sessional rates, reference should be made to claims made by the AMA in 1985, and which his Honour took into account in fixing remuneration for VMOs, as to "an associated time allowance" of 25 percent and "a part-time loading" of 10 percent. Such loadings had not previously been recognised in determinations. In the present proceedings, however, the AMA repeated its claims for associated time and part-time components to be recognised in assessing sessional rates, not as separate loadings but as part of the rolled-up rate. As to associated time, his Honour in the 1985 reasons said (at pp.24, 25):

> The A.M.A. suggested that in order to affect a proper comparison with a staff specialist it is necessary to treat the sessional rate paid

to a V.M.O. as a rate paid for work performed in a "hands on" situation in hospital. Such a concept involves adding to it some remuneration for travelling time between hospitals, the writing of reports and the making of telephone calls, indeed all work associated with the treatment of public patients when such work is performed outside the hospitals themselves. There is no doubt that certain work associated with the treatment of public patients in teaching hospitals is performed in the private rooms of the V.M.O. nor any doubt that, in order to carry out sessional obligations, it is necessary to travel between hospitals. No attempt was made to argue that the initial travelling to and from work should be remunerated by a component in the hourly rate. A number of mathematical exercises were undertaken to show that a V.M.O.'s "hands on" rate should be loaded by 25% to take into account such extraneous hours. It was argued that only when this was done could one be thought to have established a rate with a proper relativity to a staff specialist.

While not accepting as necessarily accurate the 25% assessment contended for by the A.M.A., which in any case would vary greatly between V.M.O.'s, it is appropriate to recognise in a sessional rate such a factor and the rate fixed by this Determination does so.

As to the part-time element, his Honour concluded (at pp.25, 26):

The A.M.A. argued that it was an accepted industrial principle that rates for part-time employment should be loaded to compensate for the intermittency of such work and Mr. *Sperling* sought to have this fact recognized by an addition to the hourly rate in the sum of 10%. He referred to loadings applicable to part-time nurses and in other awards.

As best I can I have reflected in the hourly rate of pay the concept of sessional salary fixation. Although I have not applied the mathematical approach sought by the A.M.A., the sessional rate fixed in the Determination has been set having regard to all factors involved in the performance of the professional duties of a V.M.O. - including that of intermittency.

As was done in assessing the base rates, his Honour evaluated the associated time and part-time components against staff specialists' incomes and the modified fee-for-service comparisons. Specific amounts were not identified in the reasons, but having in mind such elements would necessarily be part of what his Honour found was a re-structuring of the public hospital system following the introduction of Medicare, it may be taken those components were included in the increase which his Honour attributed to the "Medicare effect".

The decision in Hyslop (No.2): After the 1985 determination was made, the significance of the provision for adjusting the ordinary rates of remuneration, to give effect to changes in the basic wage as determined by the Industrial Commission in Court Session under ss.57 and 58 of the *Industrial Arbitration Act* 1940, manifested itself in the decisions of *Bryson* J. and the Court of Appeal in *Hyslop (No.2)* (*supra*). Although such an adjustment provision affecting remuneration for VMOs existed in previous determinations, no problem arose because basic wage increases were generally awarded as percentage increases so that the same percentage could be applied to the hourly sessional rates thereby giving appropriate hourly increases compared to the weekly basic wage increase. For instance, shortly after the 1985 determination was made the Court Session gave judgment in the *State Wage Case - July 1986* (unpublished, 30 July 1986 - 86/696 & 86/697) increasing award wages by 2.3 percent, including an increase in the basic wage by the same percentage giving an increase of $2.40 per week, that is from $103.00 to $105.40 per week; in accordance with the adjustment provision, the remuneration rates for VMOs were increased by 2.3 percent, so that, for example, the hourly rate for a senior specialist increased from $94.00 to $96.00 per hour.

However, in the *State Wage Case March 1987* (*supra*) and the *State Wage Case February 1988* (*supra*) the Industrial Commission took a different course and adjusted award wages by a flat money increase in the basic wage of respectively $10.00 per week and $6.00 per week. The AMA then claimed that the hourly rates of remuneration in VMOs' sessional contracts should be increased automatically by 9.49 percent and 5.2 percent being the percentages by which the basic wage was increased by the *State Wage Cases* in *March 1987* and *February 1988* respectively. The result of that would be, for example, to increase the hourly remuneration rate for a senior specialist from $96.00 to $110.50, an increase of $14.50

per hour. It will be immediately apparent then that for a total weekly increase in the basic wage obtained by employees generally under industrial awards of $16.00 per week, the AMA claimed on behalf of VMOs, using the senior specialist rate as an illustration, an increase of $14.50 per hour; in award terms of a 38-hour week, employees generally under industrial awards received an increase of 42 cents as the hourly equivalent of $16.00 per week. The AMA claimed that higher degree of increase in the hourly rates of remuneration for the same reason as award employees had obtained the basic wage increase. The matter was considered by the Supreme Court, firstly by *Bryson* J. and then on appeal by the Court of Appeal, and the AMA's approach to the true meaning of the adjustment provision in the 1985 determination was found to be correct; VMO rates were adjusted accordingly.

In the present proceedings, Mr. *Kenzie* submitted that the provision in the 1985 determination which led to such a result was industrially unfair and inequitable and should not be continued in any new determination. To the extent that existing rates of remuneration contain such an increase they are thereby unreasonably inflated. I agree.

In adopting the AMA's approach to the construction of the determination as a matter of law, *Bryson* J. said (*supra* at 289, 290):

> It should not be surprising if over time and after several operations of the escalation machinery results begin to emerge which seem inconsistent with *State Wage* case principles or even with principles which the arbitrator expressed and applied himself; this kind of anomaly is probably characteristic of escalation machinery, and must be expected when the escalations are tied to a factor, the adult male basic wage, which was not an important factor in the reasoning which produced the base hourly rates themselves. The arbitrator did not decide that the base hourly rates ought to be some ascertainable factor applied to the adult male basic wage; yet he decided, in effect, that the escalations should be. If the present determination is left to operate into an indefinite future the working of the escalation provisions will cause the base hourly rates to drift further away from the principles on which the arbitrator acted and closer to a fixed mathematical relation to the basic wage.

> This cannot be altered by the court: it can only be altered by some other determination.

Bryson J. recognised that such an escalation provision in the determination would cause in the future rates of remuneration "to drift further away from the principles on which the arbitrator acted and closer to a fixed mathematical relation to the basic wage". Recognising that the Court could not affect that situation, his Honour said that another determination could. As a matter of arbitral discretion, it is my view that a determination should not contain a provision which enables the principles on which it was made to be departed from. In any event, it seems to me industrially inequitable to a most substantial degree for a provision to operate to give VMOs an hourly increase nearly thirty-five times the increase obtained by award employees for the very same reason. In the Court of Appeal, *Samuels* J.A., with whom *Kirby* P. and *Hope* J. agreed, concluded (*supra* at 108):

> It is the most plausible way of effecting what the terms of the escalation provision require. Its cogency is increased by the fact that the appellants' argument is really little more than a consequence of a prior assumption; that is, that Macken J, when he made his determination, must have had in mind industrial considerations which would have precluded applying a wage rise of $10 per week flat as a percentage increase to an hourly rate. If that assumption is not made good the corollary is greatly weakened as an independent argument.
>
> I do not consider that the assumption is established. On the contrary, if Macken J's reasons for the 1985 determination are available as a means of construing cl 9, at least to the extent of establishing any "industrial background" against which that provision must be examined, his Honour evidently regarded the current wage fixation principles or guidelines as "quite impossible" to apply to the task he had in hand. He considered that, notwithstanding that State wage case variations had been applied to the hourly rates, he should not attempt, in making a determination , "to squeeze into the confines of the guidelines a situation with which they were never designed to deal".
>
> I can see nothing therefore in the industrial setting which leads me to reject what otherwise seems clearly to represent what cl 9 intends. The adult weekly basic wage is not paid for 40 hours per week, but for a maximum of 40 hours, which invalidates the use of that approach. The most equitable way, in the particular circumstances, of applying the variation is to take the percentage as

the respondents contend. It is also what the true construction of cl 9 demands.

Unlike *Bryson* J., the Court of Appeal, apart from the strict legal construction of the adjustment provision with which it was essentially concerned, commented on the "industrial background" and the reasons of *Macken* J. for the 1985 determination as making the AMA's approach "the most plausible way of effecting what the terms of the escalation provision require"; from that the Court concluded *Macken* J. could not be assumed to have had in mind "industrial considerations" when making the determination. The AMA here relied upon those observations to support what *Macken* J. provided in 1985 and as a defence in maintaining the increases thus obtained by VMOs in accordance with the adjustment provision.

It is no part of my function as Arbitrator now to comment on the legal construction of the adjustment provision in the 1985 determination, and I expressly refrain from doing so. It is my function, however, to be concerned with the consequences of such a provision in terms of merit. I have absolutely no hesitation in finding that an adjustment provision with such consequences is unfair and inequitable, in industrial terms and otherwise. It will be excluded from the determination I propose to make. To the extent that adjustment provisions of that nature permit disputes as to their true meaning, the situation is support for the approach urged upon me here by the Minister that a new determination should not contain any adjustment provision thereby requiring a considered and deliberate decision on each occasion rates of remuneration for VMOs are reviewed. I think that has much to commend it, but I will defer final consideration until the AMA's present claims for a particular form of adjustment provision are considered later. Suffice it to find at this stage that, in my view, the present hourly rates for VMOs are inflated by the consequences of the adjustment provision as found in *Hyslop (No.2)* and in

the present assessment of rates I propose to discount current rates by that inflated amount.

Private practice costs: *Macken* J. was asked by the parties to fix a loading, but separate from the rolled-up rate where it had previously been included, for private practice costs. At the time of his Honour's consideration there were two levels of loading, one for general practitioners of $2.65 per hour and another for specialists of $3.49 per hour. After noting the difficulty experienced in earlier arbitrations in doing other than fixing a small sum as an allowance for practice costs because of lack of evidence, his Honour referred to the substantial case mounted by the AMA on that occasion for the payment of all private practice costs incurred whilst VMOs were engaged in public hospital practice and those resulting therefrom. His Honour determined an allowance for background practice costs in the amount of $20.00 per hour for general practitioners and $25.00 per hour for specialists, to be paid in addition to the normal hourly rates of remuneration. The AMA claimed an allowance of $57.89 per hour. His Honour in the reasons (at p.23) set out the approach in assessing practice costs as follows:

> Broadly stated the type of expenses included in background practice costs are rental, motor vehicles, printing, stationery, postage, gas and electricity, wages, (usually to employees but sometimes to members of the family of the V.M.O.), office and medical equipment, telephone, insurance and membership of professional associations. On the other hand certain private practice costs I consider to be inappropriate to be levied against work performed during sessional hours in a teaching hospital. These include, for example, surgical and medical dressings; appropriate as a private practice cost but inappropriate to be taken into account while a V.M.O. is engaged in the public hospital system. These examples are illustrative only and are by no means exhaustive of the types of components appropriate to be included or excluded from this computation.
>
> A leading firm of accountants was asked to survey private practice costs for purposes of the Determination and calculated the hourly rate at maxima of $32.14 per hour for General Practitioners and $39.29 per hour for Specialists; the minimum respective levels being $28.57 and $32.14 per hour. Although this falls far short of the V.M.O.'s own estimate of the private practice costs incurred

during sessions in public hospitals it provides a convulsive jump in this cost from the current loadings.

The increases determined for private practice costs were quite substantial, being 655 percent for a general practitioner and 616 percent for a specialist. His Honour acknowledged the allowances determined were "a convulsive jump in this cost from the current loadings", but the reasons do not disclose, other than by reference to a survey, the basis or principle adopted in the assessment process. Certainly, it must have differed from that process adopted by his Honour in making earlier determinations, and, seemingly, it accepted the survey data. Again, in my view, the magnitude of the increases in itself would make one at least question the validity of his Honour's approach and more critically review the material on which the present claims have been made. In noting in the 1985 reasons similar difficulties in assessing background practice costs in 1978, his Honour noted (at p.21) that "the most I could do was to assess an allowance in a small sum and 'thus recognise the principle that the public purse should bear such background private practice costs which result from the performance of work under sessional contract'". However, in the reasons accompanying the 1978 determination, his Honour said (at p.17) - "I remain unconvinced that it is an appropriate principle to adopt that a base hourly rate for a visiting medical officer should be loaded so that, during the performance of his sessional work at a hospital, his rate of pay, while so engaged, should include a loading such as would bear the proportion of private practice costs which are incurred by the visitor." That principle, it would seem to me, was not continued by his Honour in making the 1985 determination even though it was clearly followed in making the determinations in 1980, 1981, 1982 and 1983. Somewhat unfortunately for present purposes, his Honour did not state the principle followed in the 1985 assessment, although it would appear to be a

departure from that previously followed. Indeed, in terms of principle, his Honour further said in the 1978 reasons (at pp.17, 18):

> The costs involved would be incurred by the visiting medical officer whether he undertook sessional work at a hospital or not. Most of the costs involved have nothing whatever to do with the public patients under his care who are in hospitals and who are treated by him during his sessions at the hospital. I accept, as did Rogers Q.C., that any practice costs which can be ascribed to that part of the practice which is devoted to hospital patients should in fairness be borne at public expense. The examples given by Rogers included the use of a secretary to type a report concerning a hospital patient and the postage stamp obtained to mail it.
> ...
>
> At the conclusion of this arbitration I am left in much the same position which finally confronted Mr. A.J. Rogers Q.C. in 1976. It is appropriate that some payment be made to visiting medical officers to compensate them for such increases in their private practice costs as result from their accepting sessional contracts to work in hospitals. There is no reason why they should bear additional private practice costs as a result of their accepting sessional contracts. I accept that this escalation in their private practice costs is small, and would, no doubt, vary widely between practitioners. The quantification of any such allowance, however, is impossible to mathematically calculate.

On-call allowance: A substantial issue between the parties was decided by his Honour where the AMA sought a return to an on-call allowance of 10 percent of the normal hourly rate for each hour on-call whereas the Health Administration Corporation sought to maintain entitlements in the sum of $20.86 for the first on-call period of twelve hours and $1.75 per hour thereafter. His Honour concluded (at pp.29, 30):

> Notwithstanding the changes that took place in the method of calculating the on-call allowance in 1981 (changes which abandoned the percentage fixation and adopted a flat money sum for each on-call period) I propose to return to the percentage approach and, thus, keep the V.M.O. in line with the staff specialist in this regard. The change originally was made because the percentage method of calculation seemed to be "administratively difficult." If it turns out that the 10% system is administratively difficult it can be reviewed in a future Determination.

His Honour was motivated apparently in returning to the percentage approach by consistency with staff specialists. However, at that time staff specialists received an "on-call/re-call" allowance of 20

percent of salary, which, at then current rates gave an allowance of $12,609.00 per annum on an annual salary of $63,046.00 for a senior staff specialist. That allowance represented full compensation for a staff specialists' on-call and call-back commitments and one, perhaps very arbitrary, way to regard the on-call component would be to take half, that is 10 percent or $6,304.00 per annum. On the other hand, by adopting for a VMO an on-call allowance of 10 percent of the normal hourly rate for each hour on-call, a VMO senior specialist who was on-call, like a staff specialist for an entire year of say 47 weeks allowing for leave, but quite apart from any call-back commitment for which he was separately remunerated, would receive a payment of $77,222.00. It is difficult then on that comparison to accept, but as his Honour found, that a return to the percentage approach was to keep the VMO in line with the staff specialist. That, in my view, was an error by his Honour.

Further, as a result of the decision of *Hodgson* J. and the Court of Appeal in *Hyslop (No.1)* (*supra*), the on-call allowance determined by *Macken* J. on an hourly basis was held to be payable during the whole of the period a VMO was rostered on-call so that the payment would continue during that period even though a VMO was subject to a call-back or otherwise tending patients at a hospital for which a separate payment was made. At first instance, *Hodgson* J. found that an on-call roster could be simply noted as excluding ordinary sessional hours so as to avoid a double payment, but insofar as payment of the on-call allowance in respect of call-back time was concerned his Honour accepted that the determination meant both payments were due even though "the failure to expressly exclude call-back time may or may not have been an oversight" (*supra* at 207). His Honour's decision was confirmed by the Court of Appeal. In the present proceedings the Minister sought an exclusion for payment of the on-call allowance during a call-back to avoid what was said

to be double-counting. In 1985, *Macken* J. did not seem to attend directly to the question, although by moving from payment for on-call according to a money amount for a period of twelve hours to an hourly payment, his Honour would seem to have intended, at least implicitly, the on-call and call-back payments to be separated. As I said earlier, the payment for on-call by an allowance of 10 percent of the normal hourly rate involved a significant increase in the on-call payment from about $1.75 per hour to $9.40 per hour for a senior specialist, an increase of 437.15 percent. Those aspects, including any double-counting, will have to be considered later when the present on-call claims are dealt with.

Payment for call-back: The AMA sought substantial increases in the call-back loadings and the inclusion of paid actual travelling time with a maximum of thirty minutes. His Honour rejected those claims for lack of evidence. The new determination made clear that the call-back clause applied when a VMO was called to attend a hospital at the request of the hospital. That question arose for further consideration in the present proceedings in the context of the circumstances in which a VMO attends a hospital at the "request" of the hospital. I will deal with that later.

His Honour in the new determination provided for a call-back period of a minimum of one hour, but exclusive of travelling time, whereas under the previous determination travelling time was included in the minimum payment of one hour.

Time of payment: Delays in the payment of remuneration to VMOs was an issue in the present proceedings as it was in 1985. The AMA then sought payment of remuneration within fourteen days of the submission of an account to the hospital, and in default, payment of interest at the rate of 20 percent per annum. The Health Administration Corporation proposed that hospitals be instructed to pay accounts, where practicable, soon

within one month of receipt and, in view of that undertaking, his Honour left the determination as it was.

Committees: The AMA sought payment for a VMO attending meetings of the Medical Staff Council or the Board of Directors of a hospital. The Health Administration Corporation opposed payment for such meetings. His Honour accepted the Corporation's approach as reasonable. Payment for committee work is again an issue in the proceedings before me.

Challenge to the 1985 determination: The determination made by *Macken* J. in 1985 was subject to vigorous and lengthy challenge in a detailed way by Mr. *Kenzie*, in terms that it was so fundamentally flawed as to require major changes in a new determination. Further, it was also unsafe on which to base any new determination and the appropriate determination as a base or datum point was that made by *Macken* J. in 1982, being the last work value assessment, as up-dated by the 1983 determination. The AMA just as vigorously defended the correctness of the 1985 determination, and Mr. *Sperling* exhaustively examined much of the evidence before *Macken* J. in those proceedings to establish the proposition that his Honour had the perception that VMOs had been under-valued since the initial assessment in 1976 and the introduction of Medicare had brought about such significant reductions in VMOs' incomes as to require a proper assessment. Even though the increases granted by his Honour were not small, they represented consideration by an experienced arbitrator, having in mind comparisons with staff specialists and fee-for-service arrangements, of what was there said to be a fair result.

It is impracticable here to detail the respective arguments put by counsel. At best, I am only able to attempt a summary of them.

Some of the problems, perhaps the most significant ones, have been identified above by me in reviewing the 1985 determination by reference

to the reasons published by his Honour and my comments there indicated a view that in a number of vital respects the determination was erroneous, particularly having in mind the consequences thereof. I affirm those findings.

The major points made by Mr. *Kenzie* against the 1985 determination and as justifying a different prescription in a new determination were -

- Serious deficiencies in the actual hours system which the Minister's present up-front hours claim addressed.
- Serious problems resulting from the on-call rate and prescription.
- Difficulties associated with the operation of the call-back prescription.
- Inequities and cost consequences associated with the interpretation of the 1985 determination by the Court of Appeal in both the *Hyslop (No.1)* and *Hyslop (No.2)* decisions.
- The chronic difficulties experienced in seeking to convert the 1985 determination into comprehensive and reasonable commercial contracts with VMOs, to be viewed particularly in light of the AMA's present argument on jurisdiction.
- The considerable problems experienced with the interpretation of the 1985 determination in terms of its operation on a day-to-day basis with respect to on-call and call-back provisions and the auditing of VMOs' claims from inadequate records of attendance, and methods and time for payment.
- A number of senior, experienced, and well respected hospital administrators gave extensive evidence of the problems of the 1985 determination in practice as to such matters as:

- the current determination constrains hospitals in that they can only pay for patient care related work;
- some features of the determination are in the way of structural efficiency goals;
- there are too many interpretations of the determination available, for example as to necessary records/claim details;
- the current determination provides VMOs with too much discretion;
- disputes as to claims are more likely under the current determination due to hospital administrations inability to prove abuse or unacceptable practice;
- a better structure should ensure relations with VMOs, and their level of co-operation, will improve;
- the current contracts/determination make it too difficult to effectively deal with VMOs who engage in unacceptable behaviour; and
- no equity or fairness to the public hospital system under the actual hours prescription.

. The increases in hourly rates of pay in 1985 were according to the industrially unacceptable notion that VMOs were entitled to compensation for income loss said to be associated with the introduction of Medicare.

. The sheer magnitude of the increases awarded to the rates of ordinary remuneration and of background practice costs, and, consequently the on-call allowances, created serious problems for the public hospital system in both financial and administrative terms; the end result of such increases was a

movement in VMO expenditure from around $50 million per annum to $200 million per annum.

- Between 1985 and 1991 health service management within the State changed substantially as a result of initiatives at both government and Department of Health level; the overall effect of those reforms has been such as to justify, in themselves, changes to the 1985 determination.
- Although the AMA initially sought no changes to the 1985 determination, other than with respect to the indexation of rates provision and the disputes clause, it now sought wholesale changes to the structure and wording of the determination; therefore, not only do the parties require change, but so does the DRS as intervener.

Specifically as to hourly rates for remuneration, Mr. *Kenzie* examined the reasoning in the 1985 reasons of *Macken* J. and identified the following challenged conclusions therein -

- The introduction of Medicare and other structural changes in the public hospital system had laid the foundation for a review of the rates of pay for VMOs.
- Fee-for-service VMOs had been adequately compensated already for the "Medicare effect" by significant improvements to the scheduled fee made by the Commonwealth Government.
- Staff specialists had been adequately compensated also for the "Medicare effect" by agreed changes to their rights of and entitlements to private practice in the public hospital system.
- Fee-for-service VMOs had received such compensation without any, or any due, regard for the wage fixation principles.

- Staff specialists had received their compensation also without regard for the wage fixation principles, but that had been achieved by an alteration to the staff specialists private practice arrangements so as not to give rise to additional public expenditure.
- The parties in 1985 were agreed that VMOs were entitled to receive some compensation for the "Medicare effect" and for the adverse effect of the other structural changes that had been persistent in the system. The AMA's claims that VMO rates had been the subject of discounting factors for many years, that the discounting factors had disappeared and that it was time to set more realistic rates were accepted by the then Minister.
- The Minister contended that the $12.50 per hour offer was sufficient to bring VMO rates to an appropriate level, whereas the AMA contended that it was not a sufficient increase to achieve that goal.

In the result, as Mr. *Kenzie* submitted, the following points against the conclusions of *Macken* J. could be made -

- His Honour acceded to the AMA's contention by increasing the $12.50 per hour proposal to $17.00 per hour for a general practitioner with less than 5 years experience and scaling up to an amount of $30.00 per hour for a senior specialist.
- His Honour incorporated the increases, other than those for background practice costs, into the normal hourly rate because to do otherwise would identify the increases as "funny money".
- Although his Honour recognised that the AMA sought any "Medicare effect" to be determined as a separate amount and

even his Honour was concerned at having that type of allowance in the base rate, it was nevertheless included in the base rate and hence amenable to indexation and also to the 49.3 percent loading.

- His Honour was not prepared to have "funny money" or income maintenance money identified as a component of the normal hourly rate, although he felt compelled to allow it in a determination.
- In those circumstances, his Honour had no need to evaluate or place any reliance on the VMO fee-for-service and staff specialist comparisons suggested by the AMA, and, at best, used those comparisons simply as a test or check of the rates otherwise determined by him.
- The exercise conducted in 1985 was not a traditional work value change exercise.

On 16 January 1989 the AMA prepared a submission to the Public Accounts Committee on the cost of VMOs, and the submission was tendered in the present proceedings. It set out the AMA's reasons for supporting the 1985 determination. Reference to the submission is a convenient way of succinctly summarizing Mr. *Sperling's* oral submissions to me on this important aspect. The submission as to its major points is set out below:

Background to the 1985 Macken Inquiry

8. The Committee's attention is directed to the two main issues arising from the 1985 Macken Inquiry namely:-

   (a) Medicare effect

   (b) Background practice costs.

9. These two matters gave rise to the biggest part of the increases in sessional payments to visiting medical officers arising from the Macken Inquiry and in the submission of the

Branch such increases were overwhelming supported by the evidence given to the Inquiry.

10. As the Committee may recall the Macken Inquiry followed in the wake of the Medicare dispute which had its origins in the introduction of Medicare.

11. The Medicare system was imposed by the Federal Government without any proper consultation with the medical profession or with State Governments. No adequate provision was made for the funding of Medicare in relation to treatment of patients in public hospitals. Medicare transferred the responsibility for funding patient care in public hospitals from the Commonwealth Government and private health insurance funds to State Governments (see opening by Mr. Sperling Q.C. pages 23 to 56 of the 1985 Macken Inquiry transcript of evidence).

12. Following the introduction of Medicare some visiting medical officers suffered drastic reductions in their remuneration (e.g. see confidential exhibit numbers 10, 43 and 47). This was because up until the introduction of Medicare the so called Robin Hood principle had operated within the public hospital system. That is to say, visiting medical officers were able to and did provide services free of charge, to the needy, as they were adequately compensated by being able to charge appropriately those persons who had private health insurance or persons who chose to be treated privately. With the advent of Medicare there came a massive transfer of patients from the private to the public sector thereby depriving visiting medical officers of their main source of income.

13. This together with other authoritarian measures introduced by Government resulted in the 1984 Medicare Dispute. Throughout the 1984 dispute the New South Wales Government remained intransigent although ultimately it was resolved that the matter of remuneration and conditions of work be determined by an arbitrator pursuant to part VC of the Public Hospitals Act (the 1985 Macken Inquiry).

Reduction in Insured Patients

14. The introduction of Medicare increased the demand on the public hospital system almost three fold. In 1970 only 20% of the NSW population were uninsured, and now over 50% of that population are uninsured. The table set out hereunder shows the fall in the number of people in NSW covered by private health insurance since March 1983 by reference to the re-insurance pool for registered health funds.

DATE	NUMBER OF PEOPLE COVERED IN NSW
March 1983	2644851
March 1984	2256637

March 1985	1841194
March 1986	2004010
March 1987	2089891
March 1988	2088461

(Also see Exhibit 6 to the Macken Inquiry)

15. This swing from private to public patient care automatically resulted in a transfer of the cost of patient dare from private insurance funds to State Governments with a resultant increase in the volume of payments to visiting medical officers by the public hospital system.

Increase in Normal Hourly Rates

16. The introduction of Medicare dramatically reduced the income of many visiting medical officers especially the proceduralists. This led Mr. Justice Macken to increase the normal hourly rates for visiting medical officers receiving sessional payments ...

17. These increases awarded by Mr. Justice Macken resulted in an increased cost to the State Government apparently without any compensation from the Commonwealth Government.

Background Practice Costs

18. Up until 1985 the Branch had not had available at previous arbitrations sufficient materials to substantiate its claim for a component to compensate visiting medical officers for the overheads and expenses they incurred in their private practices during those periods when they were providing services to public patients in public hospitals. Mr. Justice Macken having heard all the evidence accepted that Visiting Medical Officers should be properly compensated for such overheads, which incidentally had been made that much more burdensome to carry, following the introduction of Medicare,. Accordinly, he provided for a background practice cost component to be paid in accordance with the table below:

(i)	For a senior specialist and a specialist	$25.00 per hour
(ii)	For a general practitioner	$20.00 per hour

19. The increase in payments to visiting medical officers awarded by Mr. Justice Macken in this regard resulted in a significant additional cost to the State Government, once again apparently without any compensation from the Commonwealth Government.

Indexation

20. The 1985 Macken Determination includes at Clause 9 an automatic indexation provision. The inclusion of this provision was principally made to avoid further costly arbitrations in relation to the sessional rates payable to visiting medical officers. Whilst on the Branch's submission the operation and construction of Clause 9 of the Determination is quite straightforward, the Department of Health has until recently, resisted any increase and it has been necessary for the Branch to approach the Supreme Court of New South Wales to obtain any increase in the Sessional Rates....

...

Conclusion

32. The Branch submits that the 1985 Macken Inquiry had access to a wealth of material and evidence submitted by the Branch to enable Mr. Justice Macken to award appropriate rates for remunerating visiting medical officers. After a long and comprehensive arbitration Mr. Justice Macken made his Determination and gave reasons to support that Determination wholly supported by the evidence.

33. As referred to earlier in this submission, the principal reasons for the marked increase in public hospital payments to visiting medical officers over the last five years have been:

    (a) the substantial (and continuing) drop in insured patients leading to a great increase in the number of hospital (non-private) patients; and

    (b) the drop to a negligible level of the amount of honorary work being performed within the public hospital system.

It will be seen then that the AMA joined issue with the Minister as to the conclusions which should properly be drawn from an analysis of the 1985 reasons for determination.

Findings

On consideration of the respective arguments put in analysing the 1985 decision, I prefer those advanced for the Minister as being consistent with what in fact *Macken* J. said in his reasons and also with the evidence and submissions put by the parties in 1985 as disclosed by the material tendered before me. I therefore make the following findings as to the previous determinations -

. The 1976 private arbitration was foundational in nature as to the terms and conditions of work for VMOs; as to rates of remuneration, the amounts assessed excluded any consideration for the "Robin Hood principle" so as to be fair and reasonable rates in accordance with the work performed and the conditions under which it was performed.

. The determinations made in 1978 and 1980 adopted the framework of the 1976 agreement and the changes made related to matters of the quantum of remuneration and allowances consistent with basic wage increases and movements in industrial awards generally. Adjustments were made as to matters of implementation and interpretation

. The determination made in 1981 provided a radical departure in concept from previous determinations relating to the concept of sessions, the times over which sessions were worked, the basis for prescribing ordinary remuneration, leave of absence, extended sessions, and on-call and call-back allowances.

. The determination made in 1982 was essentially a work value case in the traditional sense and in which many of the underlying concepts were challenged. It was recognised that the sessional rates fixed in 1976 provided the basis for all subsequent determinations subject to adjustment on economic grounds, and it was inappropriate to fix VMOs' sessional payments at a level equivalent to that received for the treatment of private patients because that would first require the private fees being unloaded to take into account the "Robin Hood" element. Rates were fixed predicated on a

correct fixation having been made in 1976 adjusted by economic movements with deferral of the work value component under the policy of restraint. The determination also adopted the average hourly concept in the rendering of services and payment therefor.

. The 1983 determination allowed the work value increases deferred from 1982 and made further adjustments to remuneration rates in economic terms and in light of general community movements. Particular reliance was placed on award rates for staff specialists. As to hours, the determination permitted a VMO to elect between the average hours concept and actual hours worked.

. The 1985 determination was a watershed in the assessment of VMOs' terms and conditions of work. It was made in the context of the settlement of the 1984-85 doctors' dispute of continuing and serious disruption to the public hospital system following the introduction of Medicare.

. At that time, VMOs complained that the introduction of Medicare had the effect of reducing the number of their private patients and increasing the number of public patients so that their incomes generally were reduced; the so-called "Medicare effect".

. Although government acknowledged at the time that the additional remuneration of $12.50 per hour contained in the settlement package compensated VMOs for any reduction in their income due to the reduced number of private patients under Medicare, that payment was a true dispute settlement payment on an interim basis pending a proper arbitration of sessional rates and it was not an acknowledgment that VMO

remuneration should be assessed on an income maintenance basis nor according to any concept other than proper and ordinary principle.

- Sessional rates fixed by the 1985 determination were assessed erroneously as income maintenance to compensate for the "Medicare effect" and as relief against the previous "Robin Hood principle" which only survived as a component in the private fee structure. The 1985 approach was, therefore, fundamentally flawed.
- The failure to apply, or even consider, the principles of wage fixation further compounded the error in the 1985 approach, as did the apparent absence in the decision-making process of the economic consequences of any determination.
- The resultant rates of sessional remuneration represented significant and inordinately high increases, but unsupported by proper principle.
- The provisions of the determination as to automatic adjustment following increases in the basic wage, as interpreted in *Hyslop (No.2)*, compounded the excessive increases in the sessional rate and were contrary to industrial merit and principle.
- The increases in background practice costs were unsupported by any statement of the principle on which they were assessed, and indeed ran counter to the approach adopted in previous determinations; the increases determined were inordinately high.
- The change in the prescription of the on-call allowance to keep it in line with that for staff specialists resulted in an increase in the allowance of an extremely high order,

whereas a staff specialist in fact received a much lower payment.

The provisions in the determination, as interpreted in *Hyslop (No.1)*, requiring the on-call allowance to be paid during a period of call-back resulted in double counting.

On those findings, I would conclude that the 1985 determination was made according to concepts and principles which were fundamentally flawed and with consequent provisions which were not just and reasonable. It is therefore unsafe and inappropriate to use that determination as a base on which to make a new determination. The appropriate determination for use as a basic reference was that made in 1982, as adjusted and up-dated by that made in 1983. As part of the total review, however, the 1976 private arbitration and recommendations remain foundational and to which particular weight should be given.

CHAPTER 6 - CONTRACT FOR SERVICES

Although an important, if not the most important, feature of this arbitration may be the rates of remuneration, it seems to me to be necessary to first settle the form and structure of a new determination as the conditions under which the work to be valued is performed. It is in those respects that many of the Minister's structural efficiency claims were contained and as to which the AMA raised jurisdictional impediments to the granting of them. It is timely also to repeat the finding made earlier by me from the background as it has evolved to the present context of the public hospital system in terms that that context, and the way in which it has developed in the last decade or so and the needs in the foreseeable future, firmly make out the Minister's case for the implementation of structural efficiency measures and for a determination affecting VMOs under sessional contracts to recognise that by appropriate provisions. A consideration of the particular claims concerned follows.

Form of sessional contract

The Minister sought a determination in two parts: the first part to cover matters applicable generally to VMOs, such as definitions for the purpose of the determination, base hourly rates for the respective classifications, loadings in lieu of allowances and paid leave, calculation of normal hourly rates, amounts to compensate for background practice costs, calculation of total hourly rates according to a concept of "core services", on-call allowance, call-back payment and payment for public holidays; the second part of the determination to lay down the form of sessional contracts and to make provision for the terms and conditions of work to be performed by individual VMOs and the amounts and rates of remuneration to be paid. That second part was effectively a draft sessional contract and made provision for the insertion of the date on which it was made, names of the particular parties thereto and those

details from the first part of the determination applicable to the VMO and the hospital or area health service concerned. The form of sessional contract was designed to cover the term of the agreement, nature of the relationship between the parties, classification of the VMO concerned, clinical privileges allowed to that VMO and the services to be rendered, agreed number of hours during which "core services" were to be rendered, rate of remuneration, on-call allowance, terms as to payment for a call-back, leave provisions, facilities to be provided, suspension and termination of the contract, disputes procedure, service of notices and records of attendance. In other words, the Minister's claim sought the prescription of those terms and conditions affecting the relationship, including a draft sessional contract, to be totally comprehended within the determination. An analogy in industrial arbitration would be for an award to lay down the form and structure of all of the terms and conditions of contracts of employment for employees covered by the award rather than the usual position where the award deals with those matters to be applied generally leaving it to individual parties to make a contract of employment to which the award would then apply.

Mr. *Kenzie* submitted that jurisdiction existed to enable a determination to be so made to formulate a sessional contract within s.29M(1) of the *Public Hospitals Act* as a determination of "the terms and conditions of work, the amounts or rates of remuneration and the bases on which those amounts or rates are applicable, in respect of medical services" provided by VMOs. Reliance was placed on the meaning and scope of "terms" and "conditions" as dealt with by the High Court in *Booth* (*supra*), and it was submitted that as the arbitrator had power to determine the *substance* of the terms and conditions applying between the parties it was obviously within power to determine the *form* in which those terms and conditions should be expressed.

The AMA challenged jurisdiction to make a determination in the form sought by the Minister. Mr. *Sperling* submitted in his final address as follows:

> The Act specifically envisages what the Minister says usually occurs in determinations in industrial tribunals; that is, imposing award conditions, leaving it to the particular parties to enter into a particular form of contract. That purpose is seen from a reading of Section 29M(1) and Section 29R.
>
> The legislature clearly intended the parties to attend to the form of the contract themselves. They could have terms and conditions additional to those imposed by the arbitrator, so long as they were not inconsistent with the terms so imposed. Those additional clauses may be necessary or appropriate to suit the particular area or hospital.
>
> Section 29M does not state that the arbitrator will determine a contract, but that he will determine the terms and conditions of work etc. Once determined there is machinery in place in Section 29R to transport those terms into an existing contract and in effect into all future contracts. The legislation contemplates that the parties will make the contract in their own terms and that s.29R will then operate upon it. It does not contemplate that the arbitrator will formulate a form of contract which the parties are then required to enter into.

I am satisfied as Arbitrator that I have power under s.29M(1) of the *Public Hospitals Act* to make a determination, if otherwise made out on the merits, in the form sought by the Minister. I agree with Mr. *Sperling* that the scheme of the legislation envisages a situation similar to that occurring in ordinary industrial arbitration whereby award conditions are imposed leaving it to the parties themselves to enter into a contractual relationship to which the award will attach, but that, in my view, does not mean the arbitrator is thereby precluded from making a determination for a sessional contract to be in a particular form. Section 29M(1) enables a determination as to the terms and conditions of work; s.29RA requires the terms and conditions to which a VMO is to be subject to be in the form of a written service contract; and s.29R deems a sessional contract to be varied to include the terms of a determination so made and to make a sessional contract of no effect if it is inconsistent with a determination. I

see nothing in that scheme to necessarily make a sessional contract separate and distinct from a determination, even though the scheme may well envisage the possibility of separate instruments. But, in the view I take, a sessional contract as the agreement between the parties under which services are provided may be required by a determination to be in a particular form; that is simply a prescription of the "conditions" under which services are rendered being "the elements that constitute the necessary requisites, attributes, qualifications, environment or other circumstances affecting" the service: see *Booth* (*supra* at 263). The Minister's claim, therefore, as to the form of a sessional contract is within power.

The AMA submitted, as a matter of discretion, that the form of contract sought by the Minister would not be granted as being unnecessary. The Minister relied upon the evidence of difficulties which had been experienced in incorporating the terms of prior determinations into individual VMO contracts as justifying a standard formulation.

As to the making of a particular form of contract where an industrial award applies, and the distinction established between the two types of instruments, *Latham* C.J. in *Amalgamated Collieries of W.A. Limited v. True* ((1938) 59 C.L.R. 417 at 423) said:

> When any person is employed to do work to which an award applies, the parties are bound by a contract. Their legal relations are in part determined by the contract between them and in part by the award. The award governs their relations as to all matters with which it deals....Thus, the award controls the relations of the parties as to all matters to which it applies.
>
> But an award never deals with all the matters which affect the relations of any particular employer and any particular employee. The creation of the relation of employer and employee depends upon an agreement between them and not upon any award. Thus, the existence of the obligations under an award in relation to a particular employer and employee always depends on the existence of a contract between them. So, also, there are terms of their relationship which do not depend upon any award.

That approach to the nature of an award was followed by the former Commonwealth Industrial Court in *Re Waterside Workers Awards* ([1957] 1 F.L.R. 119 at 122, 123). There, *Morgan* J., with whom *Dunphy* J. agreed, said (*ibid* at 123) - "The provisions of the awards with which the Court is concerned in this case are so elaborate that they do not perhaps leave much room for the operation of the common law, but in my view it remains to operate to the extent to which it is not supplanted or modified by the provisions of the awards." And, in my view, the same comment may be made as to the present case.

The question then is whether as Arbitrator I should make a determination specifying the form of sessional contract as a matter of discretion. I am against doing so. Mr. *Kenzie* conceded that in the normal course of events an industrial tribunal ordinarily would do no more than impose award conditions leaving it to the individual parties to enter into an appropriate form of contract. He conceded also that an industrial tribunal ordinarily would not enter into the management role of determining the particular form of a contract. However, the present case, as he submitted, established good reasons why the determination should give rise to a comprehensive commercial contract and relied principally on the evidence of Curtis John Berry, Director-Human Resources of the Department of Health, who said the Minister's proposal would thereby promote efficiency. Mr. Curtis was asked a question by me on this topic and responded thus:

> HIS HONOUR: Q. You say I have got to do that rather than the Department of Health, circularising the various hospitals and saying well the determination has been made, it contains these various things. This has been said, here is an appropriate contract which should be used for all VMOs and if there is to be any departure from this it is to be referred to the Regional Director - can I indicate my basis which may have some impact on your role as a Human Resources Director I don't know.

> One hesitates in an area as complex and as widespread as Visiting Medical Officers to enter into what otherwise might be thought to be a management area because after all I don't manage nor do I wish to manage any part of the public health system. But one has a role here in determining basic terms and conditions. So it is a question of in the Human Resource management sense and the overall management of Visiting Medical Officers and the utilisation of their services in the hospital context, that perhaps one ought to stop and hesitate, pause to think about the implications of even accepting, in whole or in part, the Minister's proposal in that respect of a contract because one might be entering into the management role?
> A. I think that in normal circumstances one would hesitate and from a professional perspective the ideal position with most things is that we have the significant role in determining, communicating them to the system and having them implemented and I agree with that.
>
> The great difficulty which arises in the sense this is almost like a dispute notification if one can put it in that context, that there has been a 5 to 6 years dispute between the parties about this very issue and what is now being sought, in a sense, is resolution of that dispute through an arbitration process.
>
> Yes, I would accept the points you make but it has to be seen against a background of where the parties have failed to reach agreement on this very issue for many years and we see it as critical that the matter now be resolved rather than us battling away at all sorts of levels with individual VMOs about individual contract arrangements.

Mr. *Kenzie* referred also to the evidence on this aspect by Dr. Horvath, Dr. Spring and Mr. Clout to the general effect that there were advantages in having a comprehensive sessional contract incorporated in a determination because VMOs would thereby have express and clear statements of their particular duties and responsibilities. I have reviewed that evidence but have formed the view that the determination itself may properly specify a VMO's duties and responsibilities, and in a detailed way, without moving to the next step of drafting the sessional contract. I am of the view that the form of contract to be entered into is a matter for management to determine and I think it undesirable for me as Arbitrator to intrude into that area. The advantages seen in having express statements of a VMO's duties and responsibilities in a sessional contract, which I may say I fully endorse, is achievable, in any event, by a determination being made to contain such matters but not in the *form* of a

sessional contract; the *Public Hospitals Act* by s.29R would operate automatically to deem those provisions included in a sessional contract, and it would simply be a matter for management to communicate the determination to VMOs. Therefore, it seems to me, the argument really comes down to a matter of *form* rather than *substance*.

Most importantly, in my view, the course I propose to take would not inhibit a hospital or an area health service, as the case may be, making a sessional contract with a particular VMO containing a term or condition necessary to meet an individual case rather than generally; Mr. *Kenzie's* proposal would directly inhibit that. Also, if a determination were to lay down the form of sessional contract any departure in form, and however minor, would result in a breach of the determination - I do not think parties should be placed in that situation. Further, it seems to me a determination prescribing the form of sessional contract to be followed may frustrate the operation of s.29RB if the Minister were to later make an order as to standard conditions for inclusion in service contracts on the recommendation of the AMA. That would clearly be undesirable and I do not think anything I do should affect that process available under the statute.

Although Mr. *Kenzie* pressed for a determination to contain a draft form of contract, he made available a document, referred to in the proceedings as a merging of the Minister's claim into one draft determination, which effectively contained the structural efficiency measures sought but leaving it to management to make individual sessional contracts with VMOs. I think that is the appropriate method to adopt. I turn now to a consideration of the structural efficiency measures claimed as part of the proposed contracts for services.

Written sessional contract

The Minister claimed a provision in the determination requiring a sessional contract between a VMO and a hospital or an area health service, as the case may be, to be in writing and to direct that all of the terms and conditions of work should be incorporated in a sessional contract. The AMA said that such a provision was unnecessary by reason of s.29RA of the *Public Hospitals Act* which provides that "a visiting medical officer must not be appointed unless the terms and conditions to which the officer is to be subject are reduced to the form of a written service contract". That may be so, but that does not prevent a determination being made containing a condition consistent with the statutory requirement. That a contract of employment is required by an award to be so framed is not unusual in industrial regulation; many awards contain provisions requiring particular terms or conditions of employment to be reduced to writing. I am of the view that such a claim is for no more than something which may properly be described as a "condition" of work in the sense defined in *Booth* (*supra*), and where there is, as here, evidence of difficulties in the implementation of sessional contracts then it is desirable there be a reinforced requirement for applicable terms and conditions to be contained in a written sessional contract. The determination will so provide.

Clinical privileges

This was a matter which engendered much debate. Clinical privileges, that is the clinical work to be performed by a VMO under a sessional contract, is the subject of the definition of "privilege" in the existing determination as meaning "the right granted by a Contracting Hospital to a Visiting Medical Officer to provide such medical services within such Contracting Hospital as are delineated in the instrument granting such right". The existing determination defines "service" as

meaning "service provided by a Visiting Medical Officer pursuant to the provisions of this Determination". Clause 4, Duties of the existing determination is in the following terms:

> 4. Duties
>
> Subject to the privileges granted by the Contracting Hospital the V.M.O. shall render medical and/or surgical services within the range of his professional qualifications to the Contracting Hospital for the care and treatment of hospital patients, provided that such service shall be rendered at the Contracting Hospital or at such hospital or health facility administered by the Contracting Hospital as agreed to by the Contracting Hospital and the V.M.O. at the time of entering into a Sessional Contract.

In the 1985 proceedings the parties did not seek any change to the then existing position in relation to clinical privileges, and in fact it would appear the existing provisions were formulated originally in the 1978 determination by following the 1976 agreement. A review of the earlier reasons discloses little of assistance in this respect. However, the present proceedings raised significant issues on this matter in respect of -

- Whether the arbitrator has jurisdiction to include within the determination a term or terms seeking to regulate the prescription and the variation of a VMO's clinical privileges.
- Assuming jurisdiction, whether the arbitrator should, as a matter of discretion, include such a term or terms.
- If such a term or terms is to be included in the determination, what would be an appropriate formulation of such term or terms.

By reference to the Minister's "merged claim" for a determination, "clinical privileges" are defined in cl.2 as follows:

> "clinical privileges" means the kind and extent of work which the Principal determines a Visiting Medical Officer shall be allowed to perform at a specified hospital(s).

Clause 5, Clinical Privileges claimed as follows:

5. CLINICAL PRIVILEGES

(i) Subject to sub-clause (ii), a Visiting Medical Officer's clinical privileges shall be as specified in the contract.

(ii) The Principal may review and vary the clinical privileges granted to a Visiting Medical Officer at any time in accordance with any applicable Act or regulations or by-laws in force at the specified hospital(s).

(iii) The medical services which the Visiting Medical Officer provides to patients at the specified hospital(s) shall be consistent with the clinical privileges determined by the Principal in respect of the Visiting Medical Officer from time to time.

Mr. *Kenzie* made it clear the intention was that the clinical privileges granted to a VMO were to equate with those granted to the VMO as a visiting practitioner for the treatment of private patients in the public hospital. That, if I may say so, is a perfectly understandable and sensible approach. It accords with the legislative scheme which requires a VMO to be a visiting practitioner appointed to perform work under a service contract with a hospital or area health service and under which service contract the visiting practitioner agrees to provide medical services to all patients at the specified hospital or hospitals or to a specified class of those patients: see s.29K, Definitions. The provisions of the existing determination and prior determinations recognise and accommodate that result. I therefore see no jurisdictional impediment in equating clinical privileges of a VMO with those granted to a visiting practitioner; the question posed, of course, is whether otherwise I have power to make a determination regulating the prescription and the variation of a VMO's clinical privileges.

The AMA's original claim was for the continuation of the provisions of the existing determination, but later it amended the claim for the deletion of all reference to clinical privileges on the general ground that

the legislative scheme made such reference unnecessary. As to the Minister's claims, the AMA strenuously resisted them to avoid any possible inconsistency with the legislation, which was said to be a code for the fixation of clinical privileges. Consequent on the removal of any reference to clinical privileges, the AMA considered it appropriate for the phrase "within the range of his professional qualifications" to be deleted from cl.4, Duties so as to ensure the limits of a VMO's work be fixed according to the legislative scheme.

The Minister submitted that his proposed provisions merely reflected the existing rules and practices with respect to the granting and variation of a VMO's clinical privileges. Jurisdiction for me as Arbitrator to deal with clinical privileges was open because such a subject matter was a "term and condition of work" within the meaning of s.29M(1). The board of a hospital or of an area health service had the power under the legislation to set clinical privileges in the first instance and it was inconceivable to suggest, as the AMA did, that the board could not alter those privileges to meet circumstances as they might change from time-to-time. It was necessary, in view of the evidence, for the clinical privileges to be clearly stated in a written sessional contract; reference was made in that respect to the evidence of a number of VMO witnesses, namely Dr. Korbel, Dr. Beatty, Dr. Howard, Dr. Pennington, Dr. Howsam, Dr. Barnett, Dr. Harris and Dr. Oldfield, to the effect that they did not presently have written statements of their clinical privileges and that it would be preferable to have such statements of their responsibilities. There was evidence in the proceedings too that some VMOs, notably Dr. Itzkowic and Dr. Brooks, were unaware the board of a hospital or an area health service had the ultimate power to set and vary clinical privileges. And, so it was submitted, if clinical privileges were not provided for in the determination there would be at least the potential for confusion and

disputation on the question. That was most undesirable. Mr. *Kenzie* made the following points, of some persuasion in my view, in his final written address by reference to the evidence:

> It is submitted that there is general agreement with the medical profession that delineation of clinical privileges is a major requirement especially given the abolition of age retirement and a specific programme for the definition of clinical privileges for VMOs, staff specialists, and academics is already under way or being contemplated.... That programme serves not only as an administrative tool in implementing and controlling the application of hospital policy concerning the kind of work and the volume of work a particular institution would carry out but it would also serve as a major tool with respect to quality assurance ....
>
> The inclusion of clinical privileges in the sessional contract will mean that the whole question of clinical privileges will be "properly in the negotiation environment" where Managers and VMOs can endeavour to reach a match between what the organisation can cope with (because of its resources) and what the VMOs can cope with within their own capacity. This negotiation process is subject to the safeguard of an appropriate credentialling process involving one's peers as set out in the relevant by-laws. It is preferable to seek to reach agreement as to what the VMO will do or not do rather than to leave a situation in which the administrators simply hope that the VMOs do what they want them to do (and nothing more) and where the VMOs hope that the administration is not unhappy with what they have done (or not done) ...
>
> It is also appropriate that the hospital or Area should retain the right to vary clinical privileges (or suspend them) as a means of addressing persistent unacceptable behaviour by a VMO, without resorting to the more dramatic and difficult step of dismissal ....
>
> It is submitted that the combined impact and strength of the above submissions in favour of the inclusion of an express provision dealing with clinical privileges in the sessional contract demonstrates the complete unacceptability of the AMAs final position with respect to this matter, as expressed in Exhibit 181, namely the complete deletion to all references to clinical privileges in the Determination because reference thereto in the determination is unnecessary....

Finally, Mr. *Kenzie* summarised the Minister's position on clinical privileges as follows:

> Ultimately the strong body of evidence called by the Minister in relation to clinical privileges and the desirability of clinical privileges being dealt with in the determination has to be

contrasted with the AMA assertion (unsupported by any evidence whatsoever) that in view of the legislative provisions (described by the AMA as a "code" in relation to clinical privileges) references to clinical privileges in the determination would be "calculated to lead to difficulty". It is submitted that the Minister's proposals would give rise to no difficulty whatsoever all that they do is to proceed on the basis that the legislative provisions are there and provide a mechanism for the determination and variation of clinical privileges. The determination then specifies that the work to be performed by a VMO under the sessional contract will be within the limits of the clinical privileges so set.

Mr. *Sperling* outlined the strong objection by the AMA to the Minister's claim in that the board of a hospital or an area health service should not have the authority to determine or to change clinical privileges without the recommendation of a Credentials Committee and contrary to such recommendation. He put that clinical privileges should not be used as an instrument to implement administrative decisions about the type of work to be done at a hospital, either by a particular VMO or generally, but rather they should be used purely as an assessment of a VMO's professional qualifications and competency to provide services as specified. Mr. *Sperling* summarised the AMA's position in his final written address as follows:

The AMA's position in relation to clinical privileges is as follows:-

(a) Clinical privileges should be limited to the question of professional qualification and competency and should not involve the implementation of administrative decisions.

(b) Clinical privileges should be determined only pursuant to the recommendations of a Credentials Committee:

  (i) The board does not have the necessary expertise. A Credentials Committee does.

  (ii) There is also the possibility that such a power might be misused in the event of a personality clash between an administration and a VMO.

(c) Guidelines are appropriate and a consultation process should occur.

(d) Whether there should be a power to vary clinical privileges during the term of the contract (ie. other than consensually), including how (if at all) that should be done, should be resolved in the context of a general consultative review of

guidelines as has been proposed by the department. The AMA is not implacably opposed to variation against the wishes of the VMO but is very concerned about when and how that might be done.

(e) The AMA does not delete the reference to clinical privileges in its draft determination and oppose the Minister's draft because it regards clinical privileges as unimportant. Quite the contrary. VMOs regard clinical privileges as being very important and being a mark of their professional qualifications and standing. It is for that reason, not despite it, that the AMA wishes to resolve matters relating to clinical privileges by consultation as the Department has proposed.

(f) The AMA is seriously concerned about possible abuse of a unilateral power in a hospital board to vary clinical privileges other than on the recommendation of a Credentials Committee.

The AMA's submissions are therefore as follows:

(a) It is unnecessary to have any provision relating to clinical privileges in the determination.

(b) The code makes detailed provision in relation to clinical privileges. They may be inadequate. If so, that is a matter for government (hopefully in consultation with the profession). It would not be satisfactory for both the code and the determination to make machinery provisions which might be inconsistent or might be construed as being inconsistent with each other.

(c) There is a process of consultation in train to flesh out the code. That is appropriate.

The opposition to the determination containing provisions as to clinical privileges as a matter of power was based upon the proposition that the relevant legislation constituted a code whereby clinical privileges had to be specified as a term of a written service contract and being those clinical privileges decided by the board of the hospital or area health service concerned. The code, recognising the clinical privileges so decided would persist contractually until the service contract expired, did not make provision for the board to vary them during the currency of a service contract. On the code argument, Mr. *Sperling* put it was not open for me as Arbitrator to make a determination as to provisions which might be inconsistent, or might be construed as being inconsistent, with the code. I do not accept Mr. *Sperling's* code argument. The answer to it is found in

other provisions of the legislative scheme, namely the *Public Hospitals Act*, s.29T and the *Area Health Services Act*, s.33 dealing with the effect of service contracts within the meaning of Pt.5C of the *Public Hospitals Act*. Those sections lay down that where a provision of those Acts, or of a regulation or by-law made thereunder, is inconsistent with any of the rights and obligations under a service contract then the provision shall, to the extent of the inconsistency, have no force or effect in relation to the visiting practitioner. Because the *Public Hospitals Act*, s.29R deems a service contract, such as a sessional contract relating to a VMO, to be varied so as to include the terms of a determination made by an arbitrator under s.29M(1), then, in my view, the said ss.29T and 33 expressly contemplate that a determination, like a service contract, may be made with provisions inconsistent with the legislative provisions. Where legislation so contemplates the making of inconsistent provisions it cannot, it seems to me, constitute a code. I should not be taken as finding that one may disregard the provisions of the legislative scheme as such an approach would be an improper exercise of discretion. In my view, an arbitrator has power to make inconsistent provisions if otherwise thought appropriate in the circumstances, but with full weight being given to the legislative provisions. I propose, therefore, to consider the subject matter of clinical privileges on a discretionary basis and according to the circumstances.

The first thing to observe is that the Minister's claims did not seek in any way the making of a determination which in itself specified *the* clinical privileges to be enjoyed by a particular VMO but rather sought the determination to require the *subject matter* of clinical privileges otherwise decided to be specified in a sessional contract. The claim defined "clinical privileges" as meaning the kind and extent of work which a hospital or an area health service determined a VMO was to be allowed to perform at the

hospital concerned and then sought to limit the medical services provided by a VMO to be consistent with those clinical privileges. True it is a claim was made enabling a hospital or an area health service to review and vary the clinical privileges, but that was to be in accordance with the legislative scheme. In other words, it seems to me, the claims were for a determination to recognise the statutory mechanism as to clinical privileges and to ensure that sessional contracts contained a specification of them. The rationale for such a determination as affecting sessional contracts was said to be the need for VMOs to have a clear statement of their clinical privileges as delineating the areas or types of work they may be required to perform under sessional contracts. In a period of rapid and dramatic change occurring in medicine generally and in technology in particular, I accept the desirability of a determination, like an industrial award, acting in aid of what is happening in the workplace by containing appropriate provisions suitable to the circumstances. Also, once it be accepted, as I do, that a determination, like an industrial award, should contain terms and conditions relevant to the workplace as structural efficiency measures, the arguments put by Mr. *Kenzie* for reference to clinical privileges in a determination become overwhelming. The approach of Mr. *Sperling* that provisions are simply unnecessary because the legislation adequately deals with the subject really miss, in my view, the whole point of a determination laying down terms and conditions in a relevant and current sense.

I did have some concern from Mr. *Sperling's* submissions, however, that the Minister's claims may be seen to move beyond the statutory mechanism for determining clinical privileges, and so I think short reference should be made to that. I will do so by reference to the legislation covering hospitals under the control of an area health service, which deals with the major teaching hospitals, but with the reminder that

similar provisions exist for other public hospitals under the *Public Hospitals Act*, the Public Hospitals Regulation 1991 and the Public Hospitals Model By-law.

The *Area Health Services Act*, s.32(1) enables an area health service to make by-laws for or with respect to the management of any hospital or other health service under its control and for the appointment, control and governance of visiting practitioners in connection with hospitals under its control, including the conditions subject to which visiting practitioners may perform work at any such hospital. Section 38(2) enables the making of regulations for or with respect to any matter to which a by-law may be made by an area health service. The Area Health Services (Visiting Practitioners) Regulation 1989, cl. 3 contains the following definitions:

> "clinical privileges", in relation to a visiting practitioner to a hospital or hospitals under the control of an area health service, means the kind and extent of work which the area health board for the service determines the visiting practitioner shall be allowed to perform at the hospital or hospitals;
>
> "medical appointments advisory committee", in relation to an area health service, means a committee:
>
> (a) established by the area health board for the service; and
>
> (b) having the function of advising the board in relation to the appointment of persons as visiting practitioners to a hospital or hospitals under the control of the area health service and the clinical privileges that should be allowed to persons so appointed.

Clause 5 of the Regulation provides:

> 5.(1) A person shall be appointed as a visiting practitioner to a hospital or hospitals under the control of an area health service by written agreement between the person and the area health service.
>
> (2) The written agreement shall specify the conditions to which the appointment is subject, including the clinical privileges of the visiting practitioner.
>
> (3) ...

The Area Health Services Model By-law defines "clinical privileges" in a similar way to the Regulation and cl.17 allows a board to establish one or more committees to provide advice or other assistance to it in relation to various matters in order to assist the board to achieve its objectives and perform its functions under the *Area Health Services Act*. Part 7 - Medical Appointments Advisory Committee and Credentials Sub-Committee of the Model By-law sets out in quite some detail the establishment, composition and functions of that Committee and Sub-committee in relation to *inter alia* the clinical privileges which should be allowed to visiting practitioners, including of course VMOs. Relevant provisions in cll.40-44 are as follows:

> Establishment of Medical Appointments Advisory Committee
>
> 40. The board shall establish a Medical Appointments Advisory Committee which shall---
>
> (a) ...
>
> (b) ...
>
> (c) if so directed by the board, provide advice, and where appropriate, make recommendations with reasons, to the board concerning the clinical privileges which should be allowed to visiting practitioners or staff specialists.
>
> Composition of Medical Appointments Advisory Committee
>
> 41. The Medical Appointments Advisory Committee shall be composed of---
>
> (a) two members of the board, one of whom shall be nominated by the board as chairperson of the Committee;
>
> (b) two representatives of the Area Medical Staff Executive Council or Area Medical Staff Council (as the case may require) nominated by the relevant Council to be on the Committee;
>
> (c) such of the following persons (being medical practitioners or dentists) as are necessary, in the board's opinion, to the proper consideration of a matter, or class of matters, referred to the Committee by the board and are appointed by the board to be on the Committee:

(i) one representative of the appropriate hospital or health service (having regard to the matter or class of matters to be considered by the Committee);

(ii) one representative of an appropriate professional medical college or body, whose discipline is relevant to the matter under consideration;

...

(iv) the Medical Superintendent of the appropriate hospital or a representative of the Medical Superintendent;

(d) ...

(e) where a matter, or class of matters, referred to the Committee by the board concerns the clinical privileges of a visiting practitioner---a representative of the Medical Staff Council, if any, for each hospital to which the visiting practitioner is appointed or is to be appointed who is nominated by the Council to be on the Committee.

...

Credentials Subcommittee

43. (1) The Medical Appointments Advisory Committee shall establish a subcommittee called the Credentials Subcommittee to provide advice to the Committee on all matters concerning clinical privileges of visiting practitioners or staff specialists, including the following matters:

(a) the clinical privileges to be allowed to an applicant for, or person proposed for, appointment as a visiting practitioner;

(b) the clinical privileges to be allowed to a staff specialist on appointment;

(c) the review of the clinical privileges of a visiting practitioner or staff specialist at the request of the visiting practitioner or staff specialist; and

(d) the review of the clinical privileges of a visiting practitioner or staff specialist at the request of the Medical Appointments Advisory Committee.

(2) The Medical Appointments Advisory Committee shall refer any matter concerning the clinical privileges of any person who is to be appointed as a staff specialist or a visiting practitioner to the Credentials Subcommittee for advice.

Composition of the Credentials Subcommittee

44. (1) The Credentials Subcommittee shall be composed of—

(a) at least two members of the Medical Appointments Advisory Committee who are medical practitioners or dentists, nominated by the Medical Appointments Advisory Committee to be on the Subcommittee; and

(b) any other medical practitioners or dentists who, in the opinion of the Medical Appointments Advisory Committee, are necessary to the proper consideration of a matter, or class of matters, referred to the Credentials Subcommittee for advice and who are appointed by the Medical Appointments Advisory Committee to be on the Subcommittee.

(2) The Medical Appointments Advisory Committee shall nominate, from among the members whom it nominates to be on the Subcommittee, a chairperson of the Subcommittee.

The subject matter of clinical privileges will be seen to be directly addressed by the statutory scheme. Shortly stated, an area health board has the power, indeed the duty, to determine the clinical privileges in relation to a VMO as being the kind and extent of work which the VMO shall be allowed to perform at the hospital or hospitals concerned. In performing that function, the board may direct the medical appointments advisory committee to provide advice and make recommendations with reasons concerning the clinical privileges which should be allowed; the committee is essentially composed of persons who are medical practitioners and who, it may be said, would be a VMO's colleagues and peers, including a representative of the medical staff council for each hospital to which the VMO had an appointment or was to be appointed. The credentials sub-committee in providing advice to the committee concerning clinical privileges is wholly composed of medical practitioners who have the function of considering the clinical privileges to be allowed to a VMO on appointment or in a review situation. As I understand the Minister's claims, they are entirely reflective and consistent with the specification of clinical privileges under the legislative scheme. I rather apprehend the opposition by the AMA was concerned with a fear that clinical privileges may be altered unilaterally, that is by the board of a hospital or an area health service without any consultation or negotiation with the VMO concerned. In the examination-in-chief of Dr. Child, the following evidence was given:

Q. If it was suggested that the process of alteration of clinical privileges, that you describe, is a unilateral process, what would you have to say about that?
A. I don't remember using the word unilateral, but I guess if it is done without the willing cooperation or without the request of the VMO it could be seen to be unilateral, but it is an activity not carried out by administration. If you like, it is an activity carried out by his peers.

...

Q. What do you say as to the suggestion of a unilateral right to vary contract agreed privileges in the current situation. Is there such a right?
A. There certainly is a right and I believe that right should exist that clinical privileges must be able to be varied during the course of a contract which may in fact be a 5 year contract. The use of the word 'unilateral' if it refers to hospital administration I think is a little strong or a lot strong.

The process of varying clinical privileges is that it is an activity carried out by one's peers not by a hospital administrator sitting at his desk or Board of Directors sitting around a table. It is done by a credentials committee, a sub committee of the Medical Appointments Advisory Committee and, by Statute, has to be proposed entirely of medical practitioners. Obviously a hospital administrator could refer a concern to the Medical Appointments Advisory Committee and onward to the credentials committee but it is up to the credentials committee then to make its recommendations based on a facts report.

Later, Dr. Child gave this evidence:

Q. In paragraph 5 you go to the question of clinical privileges and you express the view, at page 5.4, that the Minister's claim reflects the regulations and by-laws and does not alter the existing situation in respect of the hospital/area health services capacity to change VMO privileges, is that so?
A. That is so. In listening to some of the evidence I was a little surprised that some of the witnesses were unaware of the legislative provisions in regulations and by-laws relating to clinical privileges. The Minister's claim in fact reflects those provisions. Those provisions are already in existence and they have been placed in the claim. The by-laws in respect of credentials committees certainly do give the credentials committee on the motion of either the VMO or the medical appointments advisory committee power to review clinical privileges at any time; review, at least to me, means "vary" and I believe the Minister's claim merely reflects what is in the regulations and by-laws.

Q. And in your experience do such reviews take place?
A. In my experience rarely. I would not anticipate the situation arising. However, clearly they can arise if in fact the role of the hospital or a hospital's department changes. They certainly can arise in relation to change in competence.

My review of the Minister's claims as to clinical privileges in the context of the legislation bears out the correctness of Dr. Child's evidence. Further on the question of the unilateral variation of clinical privileges, Dr. Horvath made the following statement in evidence:

> As to the hospital's right to vary clinical privileges (AMAs Amended Response p.14.7)-whilst the AMA asserts that the hospital administration should not have a unilateral right to vary contractually agreed privileges, it must be pointed out that the processes that exist in by-laws, which are empowered by the regulations to the Act, already set out the mechanism for determining and varying clinical privileges. The Hospital Board has a duty to review clinical privileges under specific circumstances, as a result of which it maintains its right to vary these unilaterally - particularly given its duty to protect the safety of patients and staff. If a privilege committee, duly constituted, recommends extending or restricting the clinical privileges of a VMO (or a salaried specialist for that matter) the Board should act on this, and cannot be limited to those circumstances which the particular (sometimes errant) VMO may find acceptable. The AMA's emphasis on "unilateral right" contains no recognition or acknowledgement of the fact that such a unilateral variation could not seriously be contemplated by the hospital unless it had the support of the relevant medical privileges committee (dominated by doctors in any event).

That evidence by Dr. Horvath, which I accept, provides a practical answer to the AMA's fear of the unilateral determination of clinical privileges. Apart from the duty of a board to determine and vary clinical privileges, that evidence establishes the reasonableness of the mechanism already established, particularly having in mind the medical representation on boards, medical appointments advisory committees, and credentials sub-committees. The importance placed by the Department of Health on the establishment of clinical privileges and of willingness to consult with the medical profession was shown by a letter dated 23 July 1992 from the Chief Health Officer of the Department to the Honorary Secretary of the AMA enclosing draft guidelines for the delineation of clinical privileges in order to standardise the credentialling process across the State. Comments from the AMA were sought on the proposals. As to the delineation of clinical privileges, the document stated:

> The delineation of clinical privileges by Credentials Committees in public hospitals is a process which encompasses quality assurance, risk management and the improvement of health outcomes. This circular is specifically designed to be read with Area/Hospital by-laws to ensure that formal credentialling processes are developed and implemented in Areas and Regions. All Regions/Area Health Services should ensure they have a properly constituted Credentials Committee that comprehensively reviews and determines the clinical privileges for all medical staff, other than Junior Resident Medical Officers, who are working in the public hospital system in New South Wales.
>
> The purpose of delineating the privileges of medical staff is to allow the matching of work which a practitioner wishes to perform in a hospital with demonstrated competence and professional skill, as assessed by a Credentials Committee. The privileges designated should also take into consideration the delineated role of the hospital and its support capabilities. The Medical Services Committee has supported the establishment of Credentials Committees. It has been involved in the drafting of the Area Health Service Model By-laws and Public Hospitals Model By-laws which include the requirement for a credentialling structure. It is essential that formal credentialling processes are in place in order to ensure that appropriate services of a high quality are maintained for patient safety and as an effective risk management tool for medico-legal purposes.
>
> Delineation of clinical privileges should occur at the time of appointment/re-appointment of Senior Medical Staff and should be regularly reviewed with the aid of their peers through their Credentials Committee. The By-laws should also allow for review of clinical privileges where particular circumstances deem it necessary. The credentialling process should also apply to Academic Medical Staff in relation to clinical duties and should not be based solely on the tenure of academic appointments if such tenure is greater than five years.

That extract succinctly emphasised the importance of clinical privileges and the appropriateness of the present means for determining them. It must be a matter for concern, as the evidence disclosed, that so many VMOs are unclear about or unaware of their clinical privileges and how they are ascertained from time-to-time. If a determination may assist in meeting those difficulties, then, in the view I take, it should do so. That is what the Minister's claim seeks to do. Nevertheless, Mr. *Sperling* in his final submissions dwelt at length on the subject in resisting the Minister's claims, and my debate with him concluded in the following way:

HIS HONOUR: I understand all the concerns that you are expressing, do not misunderstand me. It is the translation to a Visiting Medical Officer that I am having difficulty with.

SPERLING: The conclusion of the course in these terms is going to be construed we apprehend; to the boards to exercise a power without close concern to the opinion of the Credentials committee because the mere absence of a qualification that that power should only be exercised on the opinions of the credentials committee, at least when it concerns matters of qualification and training is as good as an indication that consideration has been given whether that qualification should be made or not. Indeed, one can foresee without any difficulty at all that in a dialogue with a hospital administration it is going to be said well, in the proceedings before His Honour Mr Justice Hungerford this clause was sought and supported by an argument that the board should be free to determine clinical privileges irrespective of the opinion of a Credentials committee because the boards might for various reasons not wish to follow such an opinion. This Clause has been included when there was really no need for it to be included other than the matters that were advanced in those proceedings. We see it as unnecessary. We see it as the wrong signal and an unnecessary signal. I would like to give consideration to perhaps a closer answer to what Your Honour has raised.

...

The AMA's concerns would be greatly relieved if the minister were content with a provision in what has been proposed that the board would only vary clinical privileges on the advice of the Credentials committee in the way that Doctor Child and Dr Horvath say is the practical situation: The safety net, the safeguard against action by the board on a basis which may be uninformed or even motivated by some extraneous consideration. What we are most concerned with in this is that by selectively including reference to a power to review and vary clinical privileges without including in that the desirability that it should only be done on the recommendations of a Credentials Committee at least in relation to qualifications and competency is to give a signal to hospital administrations that they are free to vary clinical privileges irrespective of the opinion of Credential committees.

I think that extract, and in a telling way, puts the real basis for the AMA's fears as being that clinical privileges should only be varied by a hospital or an area health board on the advice of the medical appointments advisory committee, itself acting on the advice of the credentials sub-committee, but according to clinical considerations. Of course, the legislation, as explained in the evidence, adequately and comprehensively deals with that aspect, but there is the further consideration of variations to clinical privileges necessary to meet the

changing roles of a particular hospital, support capabilities and resource allocation. Those further considerations, which for a particular VMO may not involve clinical matters, seem to me overall to be of the utmost significance and emphasise the need for a clear communication to VMOs of the position as to clinical privileges. Again, that is precisely the intent of the Minister's claims. I have reached the conclusion, on balance, that the AMA's concerns are more supposed than real. The determination will contain appropriate provisions giving effect, as a structural efficiency measure, to the substance of the Minister's claims.

Provision and performance of medical services

The claims in this area as part of a VMO's sessional contract were made almost entirely by the Minister and had as their purpose structural efficiency considerations in the determination specifying terms and conditions of work in a clear and comprehensive manner. Generally speaking, I think it fair to say, counter claims not being made, that the AMA did not seriously challenge many of these matters; some, however, were challenged on a jurisdictional and merit basis. I will deal with each in turn.

Duration of sessional contract: The existing determination provides for a sessional contract to have a duration of three years or such lesser period as the parties may agree. The AMA did not seek any particular term, whereas the Minister sought a period of not more than five years as specified in the sessional contract. The Public Hospitals Regulation 1991, cl.7(1) and the Area Health Services (Visiting Practitioners) Regulation 1989, cl.6(1) both provide for the appointment of a person as a visiting practitioner, for such period not exceeding five years, as the board of the hospital or area health service, as the case may be, may determine. No challenge was made to the Minister's claim, and I think it appropriate for

the determination to be consistent in this respect with the regulations; it will so provide.

Entitlement to further sessional contract: The Minister sought the inclusion in a sessional contract of a provision that nothing therein shall be construed as giving rise to an entitlement by a VMO to a further sessional contract upon the termination or expiry of the existing contract. The claim was said to be based upon a provision in the existing determination which led VMOs to expect the renewal of their sessional contracts and difficulties experienced where a hospital or an area health service did not wish to renew the contract. The troublesome provision in the existing determination was identified as that in cl.12, Duration of Sessional Contract as follows:

> Subject to the proper performance of the services to be rendered under a V.M.O.'s Sessional Contract and to the rules and by-laws of the Contracting Hospital, now or hereafter in force the duration of a V.M.O.'s services shall be as follows:
>
> (a) for a period of three years or such lesser time as the parties may agree and, subject as hereinafter provided, for such further period or periods not exceeding three years each as may be agreed between the parties within three months prior to the expiration of the then current period; ...

The problem was referred to in the evidence given by Mr. Clout who said in his statement:

> The provision contained in (ii) makes it quite clear that the contract entered into has a fixed life. In my experience as the senior industrial officer responsible for visiting medical officer matters for the Department of Health I am aware of a number of cases where hospital administrators have had great difficulty in not continuing with an appointment of a visiting practitioner who is remunerated on a sessional basis when in the opinion of the hospital the services were either no longer required for the particular visiting practitioner or the hospital is of the view that they would be better served by a different visiting practitioner. The provisions of the Public Hospitals Act have in the past led to a situation where there is a presumption that there is a continuing visiting practitioner appointment unless the hospital can prove gross incompetence by the visiting practitioner. It is considered by most hospital administrators that they should be able to reassess their options at the end of a fixed term of appointment of a visiting medical officer

> and if they so desire they should be able to advertise the appointment as a VMO appointment and obtain the services of the most appropriate practitioner.

Although recognising this question as to re-appointment was not an important issue, Mr. *Sperling* opposed the claim as involving a lack of jurisdiction to the extent it was inconsistent with Pt.6B-Appeals of the *Public Hospitals Act* which by s.33I(1) enabled a VMO who was not re-appointed as a visiting practitioner to appeal to the Minister; the Minister by s.33J(3) was required to appoint a committee of review; and s.33O(1) empowered a committee to determine the appeal and to make such order with respect to the matter the subject of the appeal as to it seemed proper. Section 33P deemed an order of a committee to be the final decision of the board of the hospital concerned. Mr. *Sperling* submitted that s.29T of the *Public Hospitals Act* did not operate to save the claim by giving precedence to a determination because the subject matter of re-appointments was not a term or condition of work. He summarised his submissions on this aspect - "Our position is that the contract should simply be left to operate in accordance with its terms, including a term that the period of appointment is such and such number of years and whatever effect Part 6B has had, there it lies. I do not believe there is further contention than that".

I regard the question of the re-appointment of a VMO as having a direct connection with the duration of a sessional contract, and, it must therefore follow, as being a condition of the work performed under that contract. The matter may be tested this way - it must be unarguable that a condition for the performance of work under a sessional contract granting a right under certain circumstances for the renewal of the contract on its expiry would be a condition of the work; logically, it seems to me, a condition in a contract that on its expiry there should be no entitlement to renewal of the contract may properly be said to be a

condition under which the work was performed. I find the Minister's claim to be within power.

To the extent the existing provision recognises the duration of a sessional contract in successive periods, each of not more than three years, it is unexceptional and no more than a recognition of the parties' rights to agree to a further sessional contract. Of course, it is unnecessary to achieve a new contract for the determination to contain such a provision. Apparently, on the evidence of Mr. Clout, difficulties have arisen where VMOs asserted an expectation of re-appointment by reason of the provision of the existing determination when clearly, in my view, no such presumption of continuity exists. Indeed, the limitation of five years in the regulations is against any such presumption. The appeal process is available to a VMO who is not re-appointed as a visiting practitioner and the Minister's claim does not affect that at all, simply making it clear that nothing in the sessional contract should give rise to an entitlement not otherwise existing. A sessional contract should not be ambiguous nor capable of construction so as to give rise to uncertainty and dispute. The Minister's claim on this aspect will therefore be granted.

Nature of relationship: There is agreement between the AMA and the Minister that a VMO appointed to perform work under a sessional contract is appointed otherwise than as an employee. Section 3 of the *Public Hospitals Act* defines a "visiting practitioner" in that sense. The Minister seeks the inclusion in the determination of a provision clearly recognising that a sessional contract shall not establish the relationship of employer and employee and that a VMO shall, in providing medical services under the contract, be regarded as an independent contractor. The determination will so provide.

Services to be rendered: The services to be rendered by a VMO under a sessional contract, by reason of the definition of "service contract" in

s.29K, must be "medical services". Whatever may be the scope of medical services, as I have earlier considered, there arises the question as to the form of requirement to be imposed on a VMO by the determination for the rendering of those services. On the one hand, the AMA's claim was direct and to the point in requiring the VMO to "render services within the range of his professional qualifications to the (public hospital) for the care and treatment of patients during the term of the sessional contract". On the other hand, the Minister's claim sought that the VMO "provide medical services to hospital patients at the specified hospital(s) consistent with the clinical privileges granted to him/her". The essential difference between the two claims was that the Minister limited the services rendered to medical services consistent with the clinical privileges granted whereas the AMA defined services according to the range of the VMO's professional qualifications in the care and treatment of patients.

The existing determination in cl.4, Duties, as earlier discussed when considering clinical privileges, is an amalgam of the present claims by limiting the services rendered to the privileges granted by the hospital to the VMO being those within the range of his professional qualifications for the care and treatment of hospital patients.

Two questions arise: firstly, whether the determination should clearly specify that the services rendered are to be consistent with the clinical privileges or merely within the range of a VMO's professional qualifications; and, second, whether the services are to be restricted to the care and treatment of public patients in the somewhat limited clinical sense as understood by the AMA. It is necessary, in the approach I take, for the determination to directly deal with those issues in order that there be no potential for misunderstanding of the obligations which a VMO has in the discharge of his sessional commitments. The existing duties provision, although of long-standing, has proven to be inadequate, no

doubt because it mixes the seemingly inconsistent concepts as highlighted by the present competing claims.

Following my earlier conclusion that clinical privileges should be dealt with in the determination as claimed by the Minister, it reasonably follows, as the Minister also claimed, that services should be rendered by a VMO as consistent with those clinical privileges rather than, as the AMA claimed, within the range of a VMO's professional qualifications which may well be wider. Once the clinical privileges had been determined and a sessional contract made, then, it seems to me, structural efficiency considerations support the determination imposing on a VMO the obligation to render services to public patients consistent with the clinical privileges granted. The determination will so provide.

The AMA's limitation on the services rendered to be limited to the care and treatment of patients raises what was discussed earlier in these reasons as to the scope and meaning of the phrase "medical services". The AMA regarded services as being essentially concerned with the care and treatment of patients whereas the Minister viewed them in a wider way. I found earlier that "medical services", to which a sessional contract was confined, meant services the proper performance of which required a person to be medically qualified; the narrow approach, as pressed by the AMA, of limiting medical services to the clinical treatment of a particular patient and leaving it to others to provide the necessary administrative support was unfounded. It followed, as I concluded, that where a VMO was required to utilise medical knowledge for the better administration and allocation of resources in a public hospital then that would involve the rendering of medical services. That finding will have relevance in a consideration later of the Minister's claims for a sessional contract to require a VMO to participate in various committees and meetings within a public hospital. For present purposes, however, it is sufficient to justify

the narrow phrase "the care and treatment of patients" being excluded from the determination as to the duties to be performed by a VMO and to support the Minister's claim for the determination, and hence a sessional contract, to require a VMO to provide medical services to public patients consistent with the clinical privileges granted to him.

Teaching and training services: As I understand the development of the practice of medicine and its essential purposes, the function of a medical practitioner being engaged in teaching and training activities is quite fundamental. The Minister, again as part of structural efficiency measures, submitted that the determination should impose on a VMO the requirement to participate in the teaching and training of post-graduate medical officers as reasonably may be required by the relevant hospital or area health service. The AMA did not actively resist such a prescription, but again its claim for the services rendered by a VMO to be for the care and treatment of patients raises in a very real sense a potential for disputation as to the scope of a VMO's duties if a sessional contract were to refer to them in such a general way. If otherwise a hospital or an area health service may reasonably require a VMO to participate in teaching and training activities then, in my view, the determination should expressly so provide.

I think it perhaps timely to emphasise the duty cast on a medical practitioner in the teaching of his art as stated in the Hippocratic Oath - "...to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction."

Mr. Clout in his evidence dealt with the importance of including in a determination provisions, such as those claimed for teaching and training, which make the responsibility of a VMO abundantly clear in the

sessional contract to avoid disputation. Dr. Horvath too dealt with this aspect in her evidence, and I have had that in mind in forming a view. Specifically, I was impressed by Dr. Horvath's general evidence to this effect:

> The VMO contract currently assumes that the only services which a hospital wishes to pay for are related to patient care. It is a regrettable fact that since payment was introduced, there has been a tendency for VMOs to revalue downward any roles in the hospital which are not specifically remunerated. As an unintended consequence, participation in the corporate activities of the hospital is lessening. It would be better if a hospital could determine what it wished its contractor to do, and pay for that - rather than be constrained to paying for some only of the services. Activities such as clinical budgeting, postgraduate teaching etc. are simply not covered. The Minister's claim addresses these matters.

I consider the Minister's claim in relation to teaching and training commitments for a VMO to be justified. The determination will so provide.

Participation in on-call roster: The question of the participation of VMOs in an on-call roster has, as Mr. Clout said in evidence, "been one of the most vexed questions in respect of the implementation of the 1985 Macken Determination". The Minister's claim sought the determination to require a VMO to participate in an on-call roster where reasonably required by the hospital or area health service and to be readily contactable at all times and able to attend the hospital concerned within a reasonable period of time. The AMA's claim was for a VMO rostered on-call "to be available to attend patients during the hours stated in the roster"; the existing determination is in similar terms, that is without the specificity of the Minister's claim.

I have referred earlier in these reasons to the evidence of Dr. Spring as to the difficulties with on-call rosters at hospitals under the control of the Northern Sydney Area Health Service, and from that evidence it is clear to me the rostering of VMOs to be on-call must be within the control

of the hospital or area health service concerned. And when so rostered on-call a VMO must be able to look to the sessional contract to ascertain his responsibilities as to being readily contactable and able to attend the relevant hospital within a reasonable period of time. Mr. Clout also dealt with this problem in his statement as follows:

> I am aware of numerous instances where an attempt by a hospital to change the traditional on call rosters have been vehemently opposed by the practitioners concerned and the AMA .... In most cases the argument put by practitioners is that if they are not rostered on-call patient services will be threatened. It may well be that this argument has some credence given that one could argue that for abundant caution every visiting practitioner should be on call. Nonetheless, rostering on call has a significant cost whether it be at the Macken rates or at the proposed rates by the Department and the management of the hospital must take the decision as to whether or not that cost is justified given the budgetary constraints that exist and the other priorities for the provision of services. The Hospital's decision should not in fact be able to be a question of dispute between the practitioners concerned and the management. Good management practice will indicate that where a change is intended, consultation would take place with the persons affected so as to ensure that management has all appropriate information available to it when taking that decision.
>
> This consultation clearly occurs now and the degree to which such decisions are actually taken by clinical managers has changed markedly with the devolution of responsibility and accountability in the last six years. This involvement of clinicians in the management/decision making process is recognised at the highest levels within the public hospital systems as evidenced by the comments of the Minister, senior DOH officers and Area CEO's in papers delivered to a conference on Area Health Services in February 1991.... In addition, it is clear that in making decisions of this nature Area and Hospital Board are required under their By-Laws to obtain the advice of the respective medical staff councils.
>
> Nonetheless the decision as to who and in what services the VMOs should be on call should not be treated any differently than the decision taken in respect of whether a particular nurse or physiotherapist is required to be on call. It should be a management decision, which should be accepted.

Mr. Clout illustrated the difficulties with on-call by reference to specific cases at Royal Prince Alfred Hospital and at Lidcombe Hospital. As to the situation at Royal Prince Alfred Hospital, Dr. Horvath gave the following evidence:

Q. And you refer to being involved in dispute committees at Royal Prince Alfred Hospital. Did that provide any basis for the view expressed?
A. Yes, it did. It was quite a difficult time formalising the content of the on-call rosters. Individual divisions, medical divisions within the hospital met to determine what their on-call requirements were and to pass motions about that, but despite a resolution of the Division of Medicine that they did not expect their staff to be on call during normal working hours, because of the numbers of staff who were on duty at that time, there were numerous individuals who put in claims which were at variance with that determination, and called for payment during the complete 24 hours and finally, a disputes committee was set up, and hearings took place to try to sort that out, and one of the issues was whether or not the roster actually set out precise starting and finishing times of on-call period. Now, most rosters actually give you a day of the week, and a date, so if you find your name, say, is on for Friday the 20th of November, you normally expect that that also means Saturday up until the early morning at the very least, but in fact, we were obliged to then put precise starting and finishing hours on those sheets because custom and practice was no longer held to be sufficient, nor were the resolutions of the Division held to be binding on the individual member.

Q. So, at least with respect to that dispute and the resolution it was in terms of more particularity and more precision in the arrangement, is that correct?
A. Yes, we found also that for the convenience of some of the VMOs one or two departments actually had come to an agreement where they would issue a roster a day earlier for those who would not be in the near vicinity on the day the normal roster went out, so the secretary sent one a day earlier which didn't have the hours printed on it because, department heads had mentioned it to her and the disputes committee had found there was an expectation that those VMOs might not have to rely on the decision of their Department or the Division that they could hold to the roster which had been unofficially issued for their convenience the day before, and so on. There was a great deal of dispute, concern, and debate over the nature of the on-call roster and the on-call period, which had never occurred in the past.

Q. Would it be fair to say that it is on that basis that you presume that it is the changes brought about in 1985 that have given rise to the problems you have been talking about?
A. Yes, I have also been advised by numerous VMOs over the years that it was not important to them until that time, and, as I say, I was quite dismayed to find that one group would even write to another asking them to go off the roster as they couldn't gain to be on it. It was a very difficult time.

Q. How long ago are you talking about in that evidence that you have just given?
A. That occurred at the time the change to the on-call arrangement was first made.

Q. 1985, was it?
A. Yes, right at the time of that determination.

> Q. What about now, in 1991, your more recent experience, are you able to says if there are any problems with the current on-call arrangement of a like nature or a different nature?
> A. It is still an area of contention. We still have situations not uncommonly where VMOs will submit claims for on-call arrangements beyond that which is on the normal roster because they set themselves as being individually on-call for their in-patients and you have to indicate that that is not in accordance with the roster, and there are numerous situations where on call rosters persist despite very limited use and even in circumstances where the VMOs may be seeking another appointment, and you say you have actually got it within the capacity of the hospital budget if you simply don't have that small group on call for the three occasions last year that they actually got run up. The view comes back but this is all part of the determination, and it is not to be touched, that on call payments must be made and we will not trade it in for this additional individual. It should be found from other parts of the budget. So it is a continuing grumbling issue in the system.

On the evidence, the Minister's claim has structural efficiency benefits and which make certain a VMO's reasonable responsibilities when rostered on-call. I propose to allow it.

Professional and ethical responsibilities: All prior determinations have been silent on the provision of services by a VMO in terms of professional and ethical responsibilities. Rather, as the AMA maintained in the present proceedings, those matters have been presumed as being included in a sessional contract by implication so as to make it unnecessary to insert an express provision. On this occasion, however, the Minister said the determination should clearly state that a VMO was professionally responsible for the proper clinical management and treatment of patients under his care and that he should adhere to the accepted ethics and conduct of medical practice in relation to colleagues, other hospital staff and to patients under his care.

The need for such a provision at the present time was stated by Dr. Horvath thus:

> ...
>
> whilst the AMA says that these provisions are unnecessary because they are implied in the contract, it is my view that it is useful for them to be included because there are constant queries from VMOs about their medico-legal responsibility for patients admitted under

> their care, particularly where RMOs and Registrars are on staff. Such provisions serve to emphasise that when the doctor's name is "the name on the head of the bed" that he/she is ultimately responsible for the proper clinical management of that patient ... so that VMOs are left in no doubt as to their responsibilities by way of "services" under the contract and appointment.
>
> The obligation to be involved in peer review/audit activities is a well established requirement of hospital access - in both the public and private hospital sectors ... Since the 1985 dispute, however, it has been far more difficult to involve VMOs in these corporate activities. These were once regarded as collegiate responsibilities cheerfully undertaken, but the introduction of payment, plus the acrimony the 1985 dispute engendered, have created a climate where VMOs are not censured by their colleagues for eschewing these parts of their role, and it has become a management task to seek compliance. In my view, setting them out clearly in the contract establishes the expectation of the parties at the beginning, rather than relying on the chancy business of intuition.

Later in her oral examination, Dr. Horvath gave the following evidence:

> Q. Do you have any view as to whether or not setting those responsibilities out in the contract will have any bearing on the incidence of disputes about responsibilities in the hospital?
> A. Well, I would hope it would reduce them. If people know what they are letting themselves in for at the beginning and it is on a piece of paper so they can refer to it, the opportunity for misunderstanding should be reduced, unless we don't write it out very well.
>
> Q. What do you say in the current situation is the incidence of misunderstandings and/or the incidence of disagreements as to what the expectation is of a particular VMO. Is that something that happens once in a blue moon or is it common or is uncommon? How would you describe it?
> A. It's not uncommon. It has become more common in the last few years as people have been less inclined to take things for granted and have wanted to know what all the detail of the situation is. I think that is in part related to the follow-on from the dispute and may well in part be related to just the nature of change in society as a whole where people in all walks of life are wanting to have things set down for them to know where they will happen and the time and they are disinclined just to do it because it has always been that way.

I have already in these reasons quoted an extract from the submission made by The Association of Medical Superintendents of New South Wales and the Australian Capital Territory dated November 1988 to the Public Accounts Committee Inquiry which referred to the lack of real authority by health service administrators in general and medical

superintendents in particular over the actions and behaviour of VMOs in public hospitals. That Association recommended contracts with visiting medical officers should clearly specify the requirements imposed on them for compliance with hospital policies and accountability for specific functions; the recommendation was made after the Association gave examples of VMO conduct and behaviour. What was there said, of course, was not the subject of cross-examination and, ordinarily, it would be rated accordingly. However, the Association saw fit to include it in a written submission. Importantly for present purposes, that material received confirmation by the evidence of Dr. Horvath, Dr. Spring and Mr. Clout. The AMA's opposition to the Minister's claims in this respect was that a determination in those terms was simply unnecessary. I am not prepared to ignore the evidence which shows, as I assess it, a wide range of behaviour by VMOs and of disputes arising as to the extent of their responsibility where the sessional contract is either silent or equivocal.

Accepting the AMA's position that a sessional contract already imposed, by implication, appropriate professional and ethical standards on a VMO, there seems to me therefore to be no difficulty in the determination containing a provision laying down what those standards are. Unlike the AMA, however, I have formed the view on the evidence that it is necessary for those standards to be specified in a sessional contract by way of an appropriate determination so as to remove uncertainty and to ensure consistency. There is real utility in a determination providing in accordance with the Minister's claim on this subject, and I propose to do that.

Clinical records and hospital rules, by-laws and policies: Consistent with the overall approach, the Minister sought express provisions in the determination to require a VMO to ensure clinical records and other clinical documentation, including discharge summaries,

were adequately maintained for patients under care; also, compliance with all rules, by-laws and policies of the hospital concerned should be required of a VMO by the determination. Dr. Horvath said about the need for such provisions:

> Q. What do you say, if anything, about the need for all staff members - whether they be visiting or otherwise - to adhere to policies once developed in the hospital?
> A. It's enormously important. It would be quite unreasonable to find that an individual would work outside of those. If say you had an agreement that you would only perform certain procedures in the operating theatre, for an individual VMO to decide to perform it in the ward, that would be - it just would not occur. There is compliance with that type of clinical protocol which exists now and which is ongoing and I think it would be quite unwise, unsafe and imprudent to move away from that practice at present.

Dr. Spring, as to clinical records said in evidence:

> Whilst it is accepted generally that the overall direction of patient care is under the direction of the Senior Medical Staff, he or she cannot be held responsible for the record keeping of non medical staff. In so much as the records of other categories of staff might be in error or adversely affect patient care, it is reasonable to believe that the Senior member of the Medical Staff responsible for the care of the patient should supervise the content of those records and correct them when appropriate.
>
> In relation to junior medical staff it is the case that the record keeping is usually delegated the them, where those staff exist or are available. The absence of staff cannot be used as a reason for non maintenance of records as payment for this is made within the overall payment.
>
> If junior staff are available then, whilst the duties may be delegated - accountability must still rest with the Senior Doctor responsible for the case. Medical Record keeping is Hospitals is generally regarded by Senior Clinical Staff as inadequate and the supervisory role of the Senior Clinical Staff is an essential ingredient in achieving high quality records.
>
> Increasingly good medical record keeping is essential to an adequate level of clinical care and the good management of the hospital. If the public health system moves to a case based payment system similar to that presently found in the private hospital system - accurate medical records will be vital to the success of the organisation to an even greater extent than currently exists.

As to compliance with rules, Dr. Spring said:

> In the complex environment of a hospital, rules, policies, guidelines, directions etc are developed and refined constantly, with the aim of improving the management of the institution or patient care. The medical staff themselves generate a significant number of the policies or are very involved in their development.
>
> Such policies, rules etc can only be implemented with the support of all staff and in general sanctions for non-compliance are not available. However inclusion in such a contract may assist in compliance and will serve to bring to the awareness of staff their role in the good management of the hospital.

The AMA took the position that a VMO should only have responsibility for the medical records concerning the service which he had actually provided whereas the Minister's claim sought to impose responsibility, by the VMO taking all reasonable steps, for all patients under the VMO's care. The distinction is not unimportant because a VMO may have a patient under his care but many of the services provided to that patient will be by either resident medical officers or registrars, or, of course, nursing staff. From the viewpoint of the administrator, Mr. Clout said - "I am aware from my experience as Senior Industrial Officer for Visiting Medical Officers that hospitals have in the past had difficulty in getting a few VMOs to comply with such rules, by-laws and policies of a particular hospital. There is not much point having a By-Law in respect of the credentialling of visiting practitioners if the VMOs says 'I am sorry but this does not apply to me because it is not in my contract'".

Dr. Horvath reasoned the medical requirements in terms of the Minister's claim in her statement of evidence as follows:

> ... the AMA seems to be seeking to ensure that the VMOs' responsibility with respect to those medical records is confined to services actually provided by the VMO. I do not believe that this is at all wise. The fact of the matter is that the medical record contains the history as given by the patient, physical examination, diagnostic tests, presumptive diagnosis, treatment and prognosis. The accuracy of this record must surely be the responsibility of "the captain of the ship". RMOs and Registrars are in training, they get things wrong - that is the nature of their role. They are working to a senior doctor. Only the senior medical attendant is in a position to know if the record accurately reflects his understanding of the patient's ailment and its management. This is a record on which any subsequent investigation - by coroner, medial board or court of

law - will be based. It is not only a critical check on the learning of the RMO, it is the record of the care given in the name of the VMO. In my view it is important to have a provision in the contract that makes clear the VMO's responsibility fo the medical records of his own patients - whether they be written up by himself or by staff members under his control. The clause only requires that he should take reasonable steps and does not imply that he is guaranteeing their accuracy in every minute detail.

... the AMA regards as unacceptable the notion that a hospital should have the unilateral right to vary the contract via its capacity to amend rules, by-laws or policies. I do not agree with this response. The Act gives the Board the duty to manage the hospitals and health services under its control....a responsibility to create a safe environment for staff, patients and visitors. It is the role of management , to establish rules for the conduct of the facilities and to ensure these are reasonably adhered to. The Board also has a special role in relation to changing the by-laws - as set out in the by-laws themselves.

In my view it is nonsense to say that the independent contractor shall not be subject to these rules if they are changed by the hospital after the contract is entered into. Such rules will need to change, as a matter of necessity, as circumstances change. Rules and policies in relation to patient care are legion. Some arise from duties imposed by the law e.g. Poisons Act, Public Health Act - recently completely re-written including the duties of infectious disease reporting imposed on all doctors.

Others are introduced following recommendations made by the Coroner - e.g. need for certain alarms to be fitted (and not disconnected) on anaesthetic machines - and others arise from debate generated internally by the medical and nursing staff during clinical review. If a decision is taken that the pharmacy will only stock a set range of drugs and any additions must be approved by the Drug Committee - the VMO must abide by that. The safe handling of blood and blood products brings forth rules that alter as our state of knowledge alters. The hospital may determine that all patients in coronary care must be cared for by a cardiologist, or that children under 10 will not be admitted for elective surgery because that particular hospital is not appropriately staffed or equipped for the care. The list is endless. Many of these rules are collectively decided by the medical staff themselves. It is quite contrary to longstanding custom and practice, as well as to legislated responsibilities, for such rules to be subject to individual approval by each independent contractor.

The thrust of the evidence called on behalf of the Minister on these aspects was not relevantly affected by cross-examination and no evidence was led to rebut it. I am persuaded by the Minister's evidence and the claims will be granted.

Facilities

The existing determination requires a hospital, where reasonably practicable, to provide a VMO with various specified facilities reasonably necessary for the proper performance of the professional services rendered by the VMO, together with suitable outer uniforms and duty garments. The parties are agreed for that provision to be repeated in a new determination, and I will do so.

Committees and meetings

As I observed earlier, the 1985 determination for the first time included a provision enabling a VMO to claim payment for the proportion of time spent in attending various committee meetings; the payment was according to the ratio of public to private patients treated by each individual VMO. Committees were specified as those concerned with the clinical planning administration of a department of a hospital, peer review and hospital patient management, but not including attendance at meetings of the medical staff council or board of directors of the hospital. In his reasons (at pp.36, 37), *Macken* J. dealt with committees as follows:

> A minor dispute arose over the eligibility of a V.M.O. to claim payment for a proportion of time spent by the V.M.O. in attending various hospital committee meetings. The practice is for a V.M.O. to be paid for a proportion of time determined in accordance with the ratio of hospital to private patients treated by each V.M.O. The Corporation sought to have committee meetings defined and limited to the clinical planning administration of a department of a hospital, to review hospital/patient management but not to include attendance at meetings of the Medical Staff Council or Board of Directors. The A.M.A. sought to have such attendances paid for.
>
> The Corporation argued that the directorship of a public hospital is an honorary appointment and that V.M.O.'s should not be distinguished to their advantage by receiving payment when other directors do not.
>
> The exclusions sought by the Corporation are reasonable and I propose to include them in the new Determination. I do not propose to depart from the current practice of proportional payment as nothing was shown to me to indicate that it is unfair.

The AMA originally sought the continuation without change in a new determination of that 1985 provision, but a later amendment sought a substantive new provision for the payment of a VMO attending various committees and meetings. Mr. *Sperling* identified the committees attracting payment as follows -

- Committees established by the board of a hospital or an area health service in accordance with the by-laws, being committees to provide advice or other assistance to the board in relation to quality assurance, resources, finances, planning or such other matters as the board may determine, and including medical appointments advisory committees and the credentials committee or sub-committee of such a committee.
- Any other committee to which a VMO has been appointed by a hospital or an area health service or which the VMO has been requested or authorised to attend, including management committees of departments, infection control committees, theatre management committees, planning committees, and the like.
- Meetings of an institute, division or department of a hospital, such as meetings of VMOs and staff specialists of the orthopaedic department of a large teaching hospital.
- Grand rounds.
- Peer review and quality assurance committees.
- Meetings of a medical staff council of a hospital or of an area health service, and meetings of the executive thereof.

In addition, preparation time for meetings and time for activities arising out of such meetings were to be treated as attendance time and paid as such. In summary, the AMA sought payment for committees established by the board of a hospital to which a VMO was appointed or

was requested or authorised to attend; in addition, payment was sought for named committee meetings.

The Minister's claim, on the other hand, conceded payment for a VMO participating on committees expressly established or authorised by the board of a hospital or an area health service and to which the VMO was expressly appointed, but excluding attendance at meetings of a medical staff council, grand rounds and continuing medical education programmes. The criteria for paid committee work was where the committee was reasonably required for the proper and efficient functioning of the hospital concerned. The Minister's claim in this respect was outlined by Dr. Child in his statement of evidence as follows:

> Committees in hospitals are often established on an ad hoc basis by the medical staff acting on their own accord. Such committees although lacking a recognition in a formal sense may contribute to patient care. However it should be the Board's responsibility to determine which are the recognised committees and to determine such committees are required for the functioning of the hospital and whether the appointed members should receive remuneration.
>
> A member of meetings such as "Grand Rounds" are part of the continuing education process and are part of maintaining professional standards akin to keeping up with the medical literature. In my opinion attendances at such meetings should not be remunerated.
>
> The Medical Staff Council exists in part to protect the interests of its members which includes all members of the Visiting Medical Staff. In my opinion members attendance should not be remunerated.

Dr. Child covered also the nature of the work of medical practitioners in a hospital setting by reference to the AMA's claim that the medical services performed by a VMO were limited to the clinical treatment and care of patients and did not include administrative matters, such as financial and budgetary activities. I have referred to that earlier in identifying the AMA's jurisdictional argument against a determination being made comprehending services performed by a VMO wider than the

AMA's understanding of "medical services". On this aspect, Dr. Child said:

> In my opinion all the work traditionally and currently performed by medical officers in public hospitals is medical work.
>
> The duties that medical officers are required to undertake in the hospital is determined by the fact that they are medical officers.
>
> This work includes allocated teaching and administrative duties and appointments to various committees. Such committees whilst predominantly involving clinical matters also can include project planning committees, strategic planning of future services or committees relating to minor and major capital works programs where the opinion of the user is a valuable input.
>
> Visiting Medical Officers generally are only on hospital committees where a medical perspective is seen as necessary and desirable.
>
> The work of medical administrators which generally does not involve any direct patient care is nevertheless recognised and regarded as medical work.
>
> The Royal Australian College of Medical Administrators founded in 1968 is generally recognised and treated as a Medical College. Its nominees sit on numerous Committees related to patient care.
>
> The objectives of the College as stated in the Annual Report 1991 are as follows:
>
> . To promote and advance the study of the principles and practice of health services administration by medical practitioners.
>
> . To establish and maintain the highest standard of learning, skill and conduct by medical practitioners engaged in health services administration.
>
> . To establish, conduct and promote educational programs in health services administration.
>
> . To promote and advance research in medical and health services administration.
>
> . To promote mutual understanding between persons engaged in the field of health services administration and to promote good relations between such persons and other persons engaged in the practice of medicine and between such persons and the community.
>
> . To recognise by Honorary Fellowship or special award persons of distinction in the fields of medicine and health services administration.

> The College in keeping with these objectives is establishing short courses in administration for clinicians. This program which was initiated by the NSW State Committee is being extended nationally. The participants include Academics, Salaried Specialists and Visiting Medical Officers.

Having in mind my earlier findings as to the meaning of "medical services" as covering teaching and administrative duties, I accept Dr. Child's evidence as supporting the existence of jurisdiction to make a determination for the services provided by a VMO to cover teaching and administrative type work as set out in the Minister's claim. I might note, perhaps curiously, that the AMA itself in supporting its committee claim relied upon the fact that many of the committees established in hospitals were "essential to the proper administration and delivery of medical services in the public hospital system".

The AMA relied upon what was said from the evidence to be an "enormous commitment to and involvement in committee work within the public hospital system by visiting medical officers." Much of the evidence led from the various VMO witnesses referred to their commitment and participation in meetings of the medical staff councils of their respective hospitals, attendance at grand rounds and at meetings of institutes, divisions and departments of hospitals. That participation, relied upon in support of the submission for increased rates of remuneration on work value grounds, was supplemented by evidence from the various annual reports of hospital boards over the last six years demonstrating, as the AMA noted, that the hospital system could not run efficiently without the input of VMOs on the various committees to which they were appointed. There is no issue between the parties that VMOs should be remunerated for services rendered as members of a committee where the committee is established or authorised by the board of a hospital and to which the VMO is appointed; the issue arises essentially as to those committees where the VMO, although appointed as a member thereof, has a discretion to attend

and those committees established regardless of appointment by the hospital or area health service concerned. The contentious committees are those of medical staff councils, grand rounds and continuing medical education programmes conducted by institutes, divisions and departments. Those areas require examination.

Medical staff council meetings: The Public Hospitals Model By-law and the Area Health Services Model By-law each in Pt.6-Councils Representing Medical Staff require the board to establish a medical staff council to which all visiting practitioners and staff specialists appointed to the hospital concerned shall be members. The function of a medical staff council is to provide advice to the board of a hospital or an area health service on medical matters. As to the exclusion of payment for attendance at meetings of a medical staff council, Dr. Child said in evidence:

> Q. His Honour has had a great deal of evidence about work being performed by VMOs in relation to medical staff council and the normal functions of the medical staff council. Where does work in relation to the medical staff council fit into the scheme of things in the Minister's amended claim?
> A. It is expressly excluded from the remuneration.
>
> Q. And is there a reason for that?
> A. Yes. The medical staff councils are required to exist. They are required to exist in terms of the by-laws. I understand that the insertion of the provisions regarding medical staff council appears in the by-laws at the urging, if you like, of the medical services board. It was not an urging that was vigorously resisted by the department but, nevertheless, it was not initiated by the department, and I understand that that urging was on the basis that the medical services committee thought that it was appropriate for the medical staff to have some, if you like, recognition, that medical staff as a body have some recognition in the running of the hospital. The objection in the Minister's claim to paying for this is the fact that attendance at medical staff councils is discretionary. The subject matters discussed at medical staff councils certainly, in my view, don't always relate strictly to improvements in patient care. They do sometimes relate to matters relating to the benefits of the medical staff council itself and if one is paying for attendance at medical staff councils, they can become extraordinarily expensive meetings. If you have a large teaching hospital with a VMO staff in excess of 100, a two hour meeting, that would be a meeting which would cost say 100 times 270, times 2, which makes it a pretty expensive meeting.

Q. Do you find industrial issues being discussed at medical staff council meetings?
A. Yes, issues relating to industrial matters and arguments occupy a large amount of time at medical staff council meetings, yes.

Q. What about the attendance that you might find say at a large teaching hospital at a medical staff council meeting?
A. I can only speak with any authority in respect of one large teaching hospital. It depends upon what is on the agenda. If matters relating to remuneration are on the agenda then the attendance would tend to be larger than if they were not.

Q. Have you witnessed large attendances at medical staff council meetings in relation to remuneration matters?
A. Yes, in fact probably the largest attendances I ever saw at medical staff council meetings at Prince Alfred were when term contracts were being discussed. I would regretfully have to confess that most of the medical staff council's meetings at Prince Alfred, which are described as medical board meetings, are pretty poorly attended.

Dr. Horvath gave the following evidence:

Q. Finally, some questions were addressed to you in relation to the medical staff council and you were asked to consider the effect of the by-laws and other matters in relation to the assigned roles the medical staff council have in advising hospitals on clinical matters - do you remember that?
A. Yes.

Q. You have described in your statement on p 6, meetings of the medical staff council as being "Quasi industrial medico political"?
A. Yes.

Q. Does that, the matters put to you in relation to the contents of the by-laws et cetera, cause you in any way to alter those words as a proper description and function of the medical staff council?
A. Medical staff council in the major hospitals doesn't take on a direct clinical management role.

Q. Is it correct, notwithstanding the matters that have been put to you, to describe the medical staff council in the terms that you have put it in par 6?
A. As a generalisation, yes.

Mr. *Sperling* relied very much on the terms of the model by-laws to support the claim for payment to attend medical staff council meetings, and referred to the evidence of Dr. Burke, a surgeon at Western Suburbs Hospital, as to the need for the secretary of a medical staff council to attend meetings in relation to hospital closures; the evidence of Dr. Brooks, Dr. King, Dr. Burke and Dr. Budd dealt with the frequency of

meetings of medical staff councils as being sometimes once or twice a month. Reference was made by Mr. *Sperling* to the evidence of Keith Howitt, a physician at Maitland Hospital, to the effect that the medical staff council was really an essential committee in order to maintain appropriate communication between all medical staff and the administration of hospitals. Peter Robert Charles Wakeford, a physician at Tamworth Hospital, and Barry John Springthorpe, a physician at Royal Newcastle Hospital and John Hunter Hospital, talked in their evidence of the function of the executive of the medical staff councils as really equivalent to the former medical boards as generating proposals and as providing the means for the medical superintendent or director of medical services to address the meeting and acquaint the medical staff with what was happening in the various organisational structures of the hospital. John William Burkhart, an anaesthetist at Bankstown Hospital, spoke of medical staff council activity as follows:

> Q. And you set out some of the detail concerning that activity. Is the Medical Staff Council the organ for communication between administration and the medical staff?
> A. It is.
>
> Q. And what kind of information comes down from administration through that council?
> A. Well, they advise us of various closures of the hospital, perhaps curtailments of services, budgetary problems that they might have. They disclose appointments that have been made. They discuss changes in the larger administration of the hospital and the hospital area group; and this seems to have been a constant recurring theme over the past several years as we have changed from a hospital board to a South Western Sydney Area Health Service and now an amalgamation of Lidcombe and Bankstown hospitals. These are all bureaucratic and administrative changes which reflect on the organisation of our services and they want medical input every time these changes are made. So we have spent a lot of our time on the Medical Staff Council discussing and trying to improve the implementation of these bureaucratic and, I guess, largely political changes.
>
> Q. Is any of that paid for?
> A. Some of it is paid for. Some of it is done on an informal level. Much of it is done on an informal level. I think for official committees payment is offered, but is not automatically granted,

and it is granted at the level of public/private patients in the hospital.

Q. You say in addition to the formal meetings there is informal communications?
A. Much time is spent - I mean, I think that one of the keys to it is to really discuss the problems that you have with the various administrators that you can arrive at a common goal. The unfortunate thing is that the goal we are looking at often is not a patient oriented goal. It is an administratively oriented goal.

Q. What do you mean by that?
A. Well, instead of concentrating on providing better patient care and overcoming the shortcomings in the hospital we are trying to battle with the rearrangement of administration and services outside the hospital, and so that we spend much of the time discussing the relocation of pathology services from Bankstown hospital to the South Western Area Pathology Service and the implications of how this will be implemented so it does not endanger patients so that we can run an efficient service, so that when in the middle of the night we are looking for urgent information about a patient we are not going to be caught short with inadequate services, I mean; and this is because of a bureaucratic rearrangement.

An illustration of a VMO with a relatively heavy committee load was provided by Anthony Roland Buhagiar, a general practitioner at Westmead Hospital, who said in his statement of evidence as follows:

23. I attend the following administrative meetings:-

(i) Obstetric and Gynaecology Division Administrative Committee Unit Meeting at Blacktown Hospital for three hours every three months. Since December 1991 I have not been paid for these meetings.

(ii) Division of Medicine Meeting at Westmead Hospital for one and a half to two hours every two months. I am not paid for this meeting.

(iii) Executive of Medical Staff Council Meeting for one and a half hours per month. I am not paid for this meeting.

(iv) Full Medical Staff Council Meeting for one to one and a half hours per month. On occasions there might be more than one meeting per month. I am not paid for these meetings.

24. I attend the following Peer Review Meetings:-

(i) The Morbidity and Mortality Peer Review Meeting at Blacktown Hospital. The nurses and paediatricians also attend these meetings. I am no longer paid for my attendance since December 1991.

(ii) Peer Review Meeting for specific case discussion at Blacktown Hospital. These meetings run for one hour and are attended by VMOs and the head of the Units. They are held every two months. I have not been paid for my attendance.

(iii) Palliative Care Meeting at Westmead Hospital for one hour every Tuesday afternoon. I could claim for this meeting but choose not to do so.

25. Extra meetings:-

(i) Sub-Committee for Medical Staff Council DRG (Diagnosis Related Grouping). This meeting is an attempt to work out a formula for the Government to use to assign the budget of the hospital. These meetings run for one and a half hours on average although not on a regular basis. I am not paid for my attendance.

(ii) Lectures by general practitioners at Westmead for three to four hours approximately every three months. I am not paid for these meetings.

Grand rounds: Dr. Jensen described the nature of grand rounds, in a manner generally accepted as being factually correct, in the following way:

1. Since my appointment as a VMO st St Vincent's Hospital grand rounds have taken the form of a weekly meeting in one of the meeting rooms at St Vincent's Hospital.

2. Grand rounds ("the meeting") is attended by VMOs, staff specialists, registrars, interns, medical students, nurses, social workers and other paramedical staff including, for instance, the quality assurance executive officer at some hospitals.

3. At St Vincent's Hospital the meeting is held once a week between 12.45 pm and 1.45 pm, and I am informed by my colleagues that at other hospitals the time of the meeting varies from hospital to hospital but is usually during the hours 9.00 am to 5.00 pm. The meeting's duration is approximately one hour.

4. At St Vincent's Hospital the meetings are organised by the Division of Medicine. The person in charge, who may be either a VMO or a staff specialist, puts together the program for the meeting and calls on different departments to be responsible for the particular week. Annexed hereto and marked with the letter "A" is a copy of the program for the meeting until December 1992 at St Vincent's Hospital.

5. One week in four the meeting is a mortality and morbidity meeting entitled in the program "Medical Audit". The statistics from various units are analysed and discussed. The number of deaths in the hospital that month are presented

and, for instance, several deaths might be targeted for discussion. Those cases are then looked at in detail and discussed. The aim of this meeting is to implement an improvement in patient care.

6. At the meeting on other days cases may be presented. For instance, a topic such as fractured hips or pulmonary embolism or breast cancer would be targeted and a particular patients treatment is outlined by the various specialties and then the matter is thrown open for discussion from the floor. Sometimes a patient will be physically present at the meeting, usually the presentation is done without the patient being present. An alternative to the case presentation as described above is the meeting at which an overseas guest or colleague from another hospital may speak on new procedures or new developments in a specialty or field in which he is eminent.

7. The purpose of the meeting and the effect of it is to provide interdisciplinary patient management. It is really the only opportunity for the whole of the medical, nursing and paramedical staff to be together for the purpose of providing detail on patients and feed back on patient management so that each specialty or branch of the profession can have a contribution to the better management of patients by the hospital. I believe that this is extremely important for the hospital. It is used to inform other units within the hospital of the scope of therapy and the latest developments in therapy for better patient care.

8. There is an educational component in the meeting but it is of enormous benefit to the hospital to ensure that the interdisciplinary approach to patient management is fostered and that the hospital has feed back on the appropriate way in which patients should be cared for in its hands.

Whilst conceding the obvious educational component of grand rounds, Mr. *Sperling* emphasised the necessity for the meeting as being the maintenance of standards in the hospital and for the continued delivery of competent and careful medical services, particularly in the area of inter-disciplinary patient management. Dr. Child regarded grand rounds as being part of a continuing medical education programme and pointed out that attendance in grand rounds was "totally voluntary and (was) not limited to visiting medical staff or even the medical staff of that individual hospital. It may well include senior nursing staff, other paramedical staff, visiting medical staff or staff specialists from other hospitals, general practitioners who wish to attend, RMO staff, staff

specialists." He pointed out large attendances were not unusual at grand rounds and illustrated that by reference to Royal Prince Alfred Hospital where, in his experience, grand rounds conducted at 5.00 p.m. on Friday afternoons had been known to have somewhere between one hundred and one hundred and twenty attendees; sometimes grand rounds were held at lunchtime. Dr. Horvath in her statement of evidence commented also on grand rounds as follows:

> There seems to be continuing pressure to see Grand Rounds as Clinical Services rather than education. Grand Rounds is the title given to a meeting where two or three patients of interest are presented by members of the Resident Medical Staff to the assembled group of senior staff. These cases are then discussed by the relevant specialists, and the Chairman asks them to comment. The matter is then debated often vigorously. It can hardly be regarded as anything other than educational for all who participate.

Dr. Horvath amplified that evidence by reference to her experience at Royal Prince Alfred Hospital in the mid 1980s when the Division of Medicine, which conducted medical grand rounds, advised her as Medical Director that grand rounds were regarded by the whole Division as an educational exercise and should not be subject to payment as a patient care activity.

Other meetings: In dealing with these types of meetings, the various VMO witnesses generally concluded they were intended within particular specialties to maintain standards, efficiencies, setting of priorities for competing demands for equipment, and maintaining and developing a system of audit and quality control.

The question of committees is of some importance in the determination I am asked to make. Significantly, the Minister has moved away from the concept of the 1985 determination which allowed payment on a proportionate basis only according to the number of public patients under the care of a VMO to a system whereby full payment is to be related to participation in those committees expressly established or authorised

by the board of a hospital or an area health service and to which the VMO has been expressly appointed by the board where the committee concerned is required for the proper and efficient functioning of the hospital. Consistent with the traditional practice, educational committees are to be excluded as are grand rounds as being voluntary and of an educational nature. It seems to me that the Minister's proposal involves an extension of a liability to pay for committees beyond that of the 1985 determination in a way which is consistent with the Minister's overall structural efficiency measures and the desire to involve VMOs more in the decision-making process for the operation of public hospitals. I think the Minister's claims are reasonable, and I am not prepared to extend payment for attendance at medical staff council meetings, grand rounds or other continuing medical education programmes because to do so would be to depart from what I regard to be the essential criterion, namely the proper needs of the hospital as determined by the board, and its replacement by a criterion of largely uncontrolled VMO voluntary attendance at meetings for which the hospital would incur a substantial financial outlay.

The decisions made above as to the contract for services will be given effect in appropriate form in the new determination.

CHAPTER 7 - TERMS AND CONDITIONS OF WORK

The respective claims sought the prescription in a determination of various terms and conditions of work. A consideration of those matters is set out below.

Definitions

It will be apparent in an area as complex as the public hospital system that in the formulation of an instrument, such as a determination as to the terms and conditions of work, it is essential for there to be clarity of expression. Both the AMA and the Minister proposed definitions of the key expressions. I think it fair to say, generally speaking, the parties were not really at issue on appropriate definitions, other than those for "call-back", "specialist" and "senior specialist". Those exceptions may more conveniently be dealt with later in dealing with the substance of the subject matter. Otherwise, the definitions which I intend to include in the determination, and whilst not precisely in accord with the respective formulations of the parties, adopt definitions used in the *Public Hospitals Act*, the *Area Health Services Act* and the regulations thereunder in order to ensure consistency between the relevant instruments.

I should perhaps refer to the description of a "patient", who was variously referred to in the proceedings and in the documents as a "patient other than a private patient" by the AMA, as a "hospital patient" by the Minister and as a "Medicare patient" by the DRS. It is common ground, of course, that the services rendered by a VMO under a sessional contract in a public hospital are to patients other than those patients treated as part of a VMO's private practice. It may not be a major issue in the overall scheme, but I think appropriate terminology should be used; indeed, the DRS made a submission that the appropriate expression was "Medicare patient" and not "public patient" or "hospital patient" because such terminology was "historically obsolete". The *Health Insurance Act* 1973

(Cth.) uses the expressions "private patient" and "public patient", and, for reasons of consistency and comity, I will adopt those expressions. The determination will therefore include a definition of "patient" by reference to that defined in the *Public Hospitals Act* as including "any in-patient and any out-patient" and a definition of "public patient" using the concept in the *Health Insurance Act* as being "a patient in respect of whom the hospital or area health service provides comprehensive care, including all necessary medical, nursing and diagnostic services, by means of its own staff or by other agreed arrangements".

Classifications of VMO

There is agreement between the parties for the existing classification structure to continue of general practitioner (with less than five years' experience, with five years' but less than ten years' experience, and with ten years' experience or Fellowship of the Royal Australian College of General Practitioners), specialist and senior specialist. The issues concerned the definitions of "specialist" and of "senior specialist".

Specialist: This definition has changed only marginally over the years, mainly to reflect changes in the designation of the Health Commission of New South Wales and the recognition in 1985 of the National Specialist Qualification Advisory Committee of Australia under the *Health Insurance Act* as a body concerned with the recognition of medical practitioners as specialists in particular specialties. The present definition is consistent with that for specialists in the Medical Officers - Hospital Specialists (State) Award and the Minister considered that that should continue. The AMA sought a change to the definition to make a medical practitioner a specialist where he had obtained a higher medical qualification, that is a post-graduate qualification in medicine recognised by the National Specialist Qualification Advisory Committee as an appropriate qualification in an accepted specialty, or recognition as a

specialist where, after consultation with the appropriate learned college relating to the particular specialty, the AMA and the hospital or area health service concerned agreed that the standing of the VMO warranted classification as a specialist. The real issue between the parties on this definition was that the Minister said the AMA's claim was less limiting by not restricting the recognised higher medical qualification to those accepted for Fellowship of the learned colleges specified in the Minister's claim. Further, it was put for the Minister that the definition of "specialist" in a determination should be closely aligned with the similar definition in the award for staff specialists.

I must say I find the difference between the parties on this aspect somewhat illusory as both definitions have as their base a higher medical qualification; I think perhaps it is more a matter of drafting in an area which I would have thought was well settled. In any event, during the proceedings I suggested an appropriate definition may be that appearing in the *Health Insurance Act 1973* (Cth.), namely:

> "specialist", in relation to a particular specialty, means a medical practitioner in relation to whom there is in force a determination under Section 3D, 3E or 61 that the medical practitioner is recognised for the purposes of this Act as a specialist in that specialty.

The purpose of that Act, as its long title indicates, is to provide "for Payments by way of Medical Benefits and Payments for Hospital Services and for other purposes"; Pt.II- Medicare Benefits of the Act provides for the payment of Medicare benefits calculated by reference to the fees for medical services set out in the general medical services table - the schedule fee - according to the service provided by a medical practitioner either as a general practitioner or as a specialist on a fee-for-service basis. The schedule fee has relevance both for VMOs under modified fee-for-service contracts and for Medicare benefits obtained by the private

patients of a medical practitioner. It seems to me, therefore, that the status of a medical practitioner recognised by the *Health Insurance Act* has a direct analogy with VMOs rendering services under sessional contracts so as to justify compatibility within the total system. Indeed, the *Health Insurance Act*, s.3D(1) recognises as specialists in particular specialties members of certain organisations which are the learned Colleges referred to in the Minister's claim here: see Health Insurance Regulations, reg.4 and Sch.4.

The DRS urged recognition by the determination of the Australian College of Venereologists (the ACV) as a College for the purpose of its members being granted specialist status. Dr. *van Lieshout* tendered the ACV's Constitution which stated its objects as being:

> 1.2.1. To prevent and control the spread of sexually transmissible diseases, including the Acquired Immune Deficiency Syndrome, and related diseases among human beings.
>
> 1.2.2 To work for the cure of human beings with those diseases.
>
> 1.2.3 In particular
>
> . to promote the science of all such diseases, and
>
> . to educate the community about such diseases.

I was informed the ACV was established in 1985. A Chair in Venereology was established at Sydney Hospital in 1990 and post-graduate qualifications are now available through the University of Sydney. Dr. *van Lieshout* submitted that with the global HIV/AIDS epidemic in the past decade venereologists have evolved into recognised specialists.

A similar claim confronted Mr. *Rogers* in 1976 in relation to the Royal Australian College of General Practitioners, but it was rejected on the basis that specialist recognition was substantially a medical issue and a matter between the College concerned and the National Specialist

Qualification Advisory Committee. In the 1978 proceedings, *Macken* J. declined also to recognise Fellowship of the RACGP at the specialist level. I feel constrained to similarly find as to the ACV on this occasion. I should not be taken in so deciding as in any way commenting adversely upon the educational or professional standards of the ACV Fellowship examinations nor upon the medical standards of its members - far from it; some of those members in their venereological work may well be specialists anyway as being Fellows of The Royal Australasian College of Physicians or the Royal Australasian College of Surgeons. My decision has been based on the approach that specialist recognition is for the medical profession itself, through a recognised statutory machanism, and not for me to intrude into so long as an established and recognised system exists for declaring a professional organisation in relation to a particular specialty.

I think it appropriate to incorporate in the determination a definition of "specialist" in the terms contained in the *Health Insurance Act*, but with two modifications. First, it should be made plain that a specialist is a medical practitioner other than a general practitioner; and, second, it should be made plain that a specialist under a sessional contract is required to render services the adequate performance of which services requires a medical practitioner of that status. That latter qualification, in my view, is necessary to ensure that a medical practitioner who may happen to have a higher medical qualification is in fact providing services at a specialist level so as to attract the higher rate of remuneration. There can be no doubt that the mere possession of a qualification does not, in itself, entitle the holder to a higher rate unless the higher level of work is being performed. If it were otherwise then a medical practitioner with a VMO appointment as a general practitioner would be entitled to the specialist rate if he obtained a higher medical qualification even though no change occurred in the nature of the services provided by him to the public

hospital. That cannot be right. Also, it seems to me the modification I propose may well advantage some VMOs in a situation where the only appointments available are to general practitioner positions and a specialist is prepared to accept such a position, albeit performing lesser work than his specialty, rather than no position at all. I consider the definition of "specialist" should be in terms to facilitate that situation. Any concern that a hospital may unfairly classify a qualified specialist as a general practitioner is met by the objective test contained in the proposed definition, namely that the services rendered under the sessional contract require for their adequate performance a medical practitioner of specialist status.

Senior specialist: The AMA claimed a definition of "senior specialist" as meaning a specialist who has practiced as such for seven years so that a specialist would be entitled to the higher classification on the mere effluxion of time. The definition in the existing determination adds the test for the specialist to "be required to render services calling for a specialist of (senior specialist) status". The Minister sought retention of the work requirement condition. He desired also for the definition to qualify the seven years' experience as a specialist as "full-time" experience.

The AMA's case for change was based on opposition to a definition which gave a hospital the absolute discretion concerning classification where cost considerations would be likely to result in a specialist being declined senior specialist status and payment as such. Mr. *Sperling* relied upon the evidence of a number of witnesses who said that the transition from specialist to senior specialist status was, and should continue to be, automatic; that evidence was given by Dr. Jensen, Dr. Stening and Dr. Trew, although it was usual for an application to be made for promotion to senior specialist.

Direct reliance was placed by Mr. *Sperling* on the case of Geoffrey Stewart Oldfied, a cardiologist with an appointment as a VMO specialist at John Hunter Hospital. Dr. Oldfield made application for senior specialist classification on 20 June 1991 to the Hunter Area Health Service. It was referred to a sub-committee which apparently considered it at a meeting on 13 December 1991 and requested Dr. Oldfield to supply further information regarding his current work practices revolving around peer review, quality assurance programmes, contribution to health education, contribution/involvement in research and administrative contributions. Dr. Oldfield supplied the information requested on 2 January 1992 but has not received any communication since. I must say I find that situation to be quite extraordinary. One can understand the need for proper consideration of applications, but a period of just on twelve months since Dr. Oldfield made his application to the time he gave evidence in these proceedings of no decision is inordinately long. There may well be good reasons why it has taken so long, but no explanation was offered in evidence. Dr. Oldfield's case was the only illustration given, and it may well be that it is aberrant. Nevertheless, I am not prepared on that isolated evidence to depart from the general concept of the existing definition in this respect because, it seems to me, and as I said above when considering the "specialist" definition, the nature of the work required to be performed is an essential ingredient.

I think the matter would be appropriately met by the definition of "senior specialist" in the determination containing not only the requirement for practice of a specialty for a period of seven years but also the objective requirement for the services rendered under a sessional contract to require for their adequate performance a specialist of that senior status. I think the condition of "full-time" experience to be unnecessary, and also perhaps confusing; I will not include it.

Leave of absence

The present hourly rates of remuneration for VMOs are "rolled-up" rates which include a loading of 49.3 percent of the base rate made up of 7.5 percent for superannuation, 5 percent for a split session and 36.8 percent for leave of absence. The loading resulted from the 1981 determination when *Macken* J. accepted the proposal made by the Health Commission for paid leave and other benefits to be included in hourly rates in a rolled-up sum so that the benefits would be allowed at the time remuneration was paid rather than later as earlier determinations had allowed. As I indicated earlier in reviewing the 1981 determination, the move to remuneration by way of a rolled-up concept was opposed by the AMA because of the fear that if loadings were incorporated into the hourly rate then it may be prejudiced in future arbitrations when it sought to have such loadings reviewed; his Honour considered that fear to be "more ephemeral than real" and adopted the Health Commission's approach. His Honour's reasons for decision (at pp.6-12) set out in detail the changes made, the basis for them and precisely how remuneration was calculated. That method was continued without comment in the 1982, 1983 and 1985 determinations. In the present proceedings, the original positions of the parties was that no review was sought as to the 49.3 percent loading nor as to its components. However, as Mr. *Kenzie* said in opening - "They are in the Minister's contention amenable to attack. Many of the components of the loadings leading to the 49.3 are components which would lead one to immediately ask this question, what have they got to do with independent contractors who have a contractual relationship with a hospital". The Minister then had cause to reassess the position with respect to the loading once it became apparent the AMA was proposing a substantial increase in remuneration based on increases allegedly granted to the superannuation entitlement of staff specialists. The AMA subsequently

claimed an amount of $18.00 per hour should be included in the rate of ordinary remuneration to compensate VMOs for those improved superannuation benefits for staff specialists, and so the Minister reconsidered his approach with respect to the 49.3 percent loading.

Insofar as the leave component of 36.8 percent was concerned, the Minister said it should be reduced to 13.04 percent. A comparison of the existing make-up of that loading with the Minister's claim is as follows:

Leave	Existing determination weeks per annum	Minister's claim weeks per annum
Annual leave	5	5
Public holidays	2	-
Sick leave	2	-
Study and conference leave	3	1
Long service leave	2	-
Total weeks:	14	6
	14 weeks = 36.84%	6 weeks = 13.04%

Whilst the rates of remuneration will be considered later in these reasons, the provision in the determination for unpaid leave of absence for the above-mentioned five types of leave may conveniently be considered now. The conclusions thereon, of course, will affect the quantum of loading to take into account in calculating the rolled-up rates as well as the terms of the leave of absence provision in the determination.

Dr. Child gave evidence as to his experience of the amount of leave taken by VMOs and said the average amount was just in excess of three weeks per annum; that assessment was supplemented by a survey conducted by Dr. Child of leave taken by VMOs from the public hospital system at Royal North Shore Hospital, Prince Henry Hospital, Prince of Wales Hospital and Tamworth Base Hospital. The results were:

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Leave	Total Weeks	No. of VMOs	Average leave per VMO
Royal North Shore Hospital - 1988/89			
Annual	267.5	131	2.04
Study/ Conference	113.5	131	0.87
Sick	4.0	131	0.03
Unspecified	11.5	131	0.09
Special	16.0	131	0.12
Total	412.5	131	3.15
Prince Henry & Prince of Wales Hospitals - 1990			
Annual	240.2	98	2.45
Study/ Conference	91.5	98	0.93
Sick	1.2	98	0.01
Special	10.0	98	0.1
Total	342.9	98	3.49
Tamworth Base Hospital - 1990/91			
Total	80.5	24	3.65

Combining all of those hospitals the result is 3.3 weeks of leave per annum per VMO, which, with 2 weeks for public holidays, makes a total annual period for leave of 5.3 weeks.

Dr. Child summarised also, as to twelve of the VMO witnesses who were asked in evidence, details of the leave taken by them which disclosed an average of 5.66 weeks' leave per annum per VMO, consisting mainly of annual leave and conference/study leave.

It is necessary to examine each type of leave separately.

Annual leave: The parties agreed to retain a loading to take account of five weeks' annual leave. That is appropriate, and the determination will so provide. Annual leave is an amenity and therefore should be taken;

consistent with the *Annual Holidays Act* 1944, s.3(4) the determination will provide for annual leave to be taken within six months of it becoming due.

Public holidays: Over a period of twelve months these days amount to two weeks. The parties agreed a VMO should be entitled to absent himself on public holidays unless the hospital or area health service concerned had given reasonable notice he was required to render services on any such day in which case he was to be paid his ordinary rate of remuneration plus a loading of 50 percent, together with the allowance for background practice costs. The determination will so provide. I will deal later with the payment to a VMO required to render services on a public holiday by way of call-back.

However, two issues arise for decision: first, whether a VMO should be permitted to perform routine work under a sessional contract on a public holiday and attract the loading of 50 percent or whether the public hospital should retain the right to decide whether a VMO may be required to work on a public holiday; and, second, whether a period of two weeks should be allowed for public holidays in the leave component of the hourly rate of remuneration by way of an equivalent percentage loading.

As to the first issue, the Minister submitted "that one cannot countenance a situation in which routine or other non-urgent sessional work, capable of deferral to another time, is performed on a public holiday at the election of the VMO, thereby attracting a massive loading." The AMA, notwithstanding its original claim, finally raised no objection to the regime proposed by the Minister in this respect, namely a 50 percent loading to be paid where a VMO was required by a hospital or an area health service to render services on a public holiday, but where a VMO was not required to render services on such day then ordinary rates of remuneration for services rendered to be payable. This is a slight

departure from the present determination which entitles a VMO to payment of the 50 percent loading "where the V.M.O. renders necessary medical services on a public holiday", but I think the concession was properly made by the AMA on structural efficiency considerations. The determination will so provide.

As to the second issue, the AMA pressed for retention of the two weeks or equivalent percentage component in the hourly rate. In his 1976 reasons (Pt.10 at p.1), Mr. *Rogers* said:

> There is no doubt but that if V.M.O.s were employees, working under any normal Award, they would receive pay even though they were not required to work on the public holiday in question. Is the fact V.M.O.s are working only on a part-time basis and as independent contractors, sufficient to disqualify them from this benefit? On the whole, I am inclined to think not and I recommend that the provisions included in the A.M.A. draft contract in this regard should be adopted.

In the result, the sessional agreement reached between the parties provided that a VMO was entitled to absent himself on public holidays "without loss of remuneration" but where services were rendered on a public holiday remuneration was to be "at twice his normal sessional hourly rate for the actual time during which he rendered service on the public holiday". That prescription was retained in the 1978 and 1980 determinations until it was converted to an unpaid public holiday provision in the 1981 determination with the allowance of two weeks per annum by way of a percentage loading allowed as part of the hourly rates of remuneration. Those public holiday provisions have been continued since that time by the 1982, 1983 and 1985 determinations.

Mr. *Kenzie* supported the deletion of the public holiday component with the following propositions -

- There has never been a proper or adequate debate as to the appropriateness of paying independent contractors for public holidays when they do not in fact work them.

- The 1976 recommendations contained no reasoning that would justify the retention of the provision in 1992.
- Staff specialists receive no additional payments for public holiday work, nor indeed for weekend work. Like VMOs, they receive five weeks annual leave per year.
- VMOs are independent contractors who by and large can elect which particular days they attend the public hospital system. They can, and do, cancel theatre sessions, clinics and other time committed to the public hospital system when necessity or other commitments require them to do so.
- The idea of providing workers with extra leave on public holidays is by way of relief from what would otherwise be a full-time commitment to the employer on a thirty-eight or forty hour per week basis.
- Other independent contractors working in the public hospital system no doubt do not get paid for public holidays unless they actually work on those days, and there is no reason why VMOs should be treated any differently.
- The Minister's claim by and large reflects the prescription that has been in place since 1981 and provides a loading of 50 percent for each hour actually worked on a public holiday when that work has been required by the hospital or area health service.
- Unless the public holiday component is removed, the reality would be that a VMO who elected to work on a public holiday (as opposed to being required to work) would receive a loading for simply going to work on that day, namely the proportion of the 49.3 percent that is designed to ensure if the VMO does not work on a public holiday he will be paid.

> There is no justification for the VMO receiving such a loading when he or she elects to work on that day. The compensation should be the normal hourly rate, not loaded by such a component. Similarly, if the VMO is in fact required to work on the public holiday the 50 percent loading for being so required should be calculated on a true normal hourly rate and not on an hourly rate already loaded on the basis that the VMO will not be at work.

Against those submissions, Mr. *Sperling* replied as follows:

Paid public holidays were allowed by Mr Rogers Q.C. in 1976, and provision by way of two calendar weeks was made in the 1981 loading for this factor, as proposed by the Health Commission and perpetuated to this date.

The Minister says that staff specialists receive no additional payment for public holiday or indeed weekend work. However, in the absence of evidence to the contrary, one would assume that staff specialists are not required to work in the ordinary course on a public holiday. It is reasonable therefore to treat the public holiday as being paid leave in the same way as annual holiday is treated as paid leave. There is no conceptual difference.

There is a strong admission from the history of this provision that the true facts are such as to make the provision reasonable. A heavy evidentiary burden therefore rests on the Minister to show that the facts are such as to make the provision unreasonable, if that is his contention.

The Minister says there should be no payment to an independent contractor unless work is done on the day. Again, this point does not address the question raised by the AMA's case, namely the value of the remuneration and other benefits obtained by the staff specialist related to each hour that he works.

The Minister says that if the VMO works on a public holiday he will be paid for that work. To make the point good the Minister needs to show that this occurs significantly and that staff specialists are not given an extra day's annual leave for a worked public holiday. Again, a heavy evidentiary burden rests on the Minister to show that the true facts are such as to make the loading unreasonable.

The Minister's proposal for the rate of payment for work by a VMO on a public holiday is dealt with elsewhere. Suffice it to say at this point that the provision for payment at a penalty rate for public holidays worked when required has been in place since 1976.

I find the AMA's submission persuasive on this aspect. I point out the observations made by *Cahill* J. in *In re Medical Officers, Hospital Specialists (State) Award* ([1972] A.R. (N.S.W.) 675 at 683), namely - "There is also evidence of some work being performed on public holidays, although it must be stated that the annual leave clause of the award provides that where a specialist is required to perform work on a public holiday and time off in lieu is not subsequently granted an additional day is to be added to the period of his annual leave". His Honour then awarded staff specialists an amount of five weeks' annual leave, although the additional days added to the leave period were those in respect of public holidays occurring during that period and not in respect of public holidays actually worked; his Honour applied the position obtaining to chief executive officers and to employees under the Public Hospitals (Medical Superintendents) Award. Whether the practice of adding a day to the annual leave of a staff specialist for a public holiday worked has continued or been changed to the award provision made by his Honour is not clear from the evidence, but the AMA's submission as to the heavy evidentiary burden placed on the Minister in that respect, in my view, is made good. A further reason supporting the AMA's approach is that the thrust of the Minister's submission was directed to VMOs as independent contractors being able to elect attendance in the public hospital system and to very much organise their commitments to that system at times convenient to their other commitments. In view of the Minister's claims here as to obligations to be imposed on VMOs for the economic and efficient operation of the public hospital system, I am by no means convinced, indeed I would seriously doubt, VMOs will have in the future the degree of freedom they may have enjoyed in the past. It is those claims by the Minister which, for structural efficiency considerations, I have earlier indicated should be allowed in a new determination.

Another aspect which moves me towards the AMA's argument is the proposed scheme for public holidays whereby a VMO will only be paid the loading of 50 percent when he renders services on such a day where so required by the relevant hospital or area health service. If a VMO elects to work on a public holiday he will not receive that 50 percent loading but will be paid the ordinary rate of remuneration. In other words, it seems to me, the Minister's submission as to the 50 percent loading has been accepted, but that means the Minister may not then use that result to support the claim for deletion of the public holiday component in the hourly rate. Also, of course, if that component were removed then the loading of 50 percent payable to a VMO required to work on a public holiday, either by way of call-back or at the direction of the hospital or an area health service, would have to be reassessed because most awards, including those in the health industry, contain payment for work on public holidays at the rate of double time and one-half. A VMO who now works on a public holiday receives the ordinary rate of remuneration plus a loading of 50 percent, together with the public holiday component as part of his regular ordinary rate of remuneration equivalent to ordinary time. Thus, a rate of double time and one-half results if work is performed on a public holiday and ordinary time through the leave component in the hourly rate of remuneration if the holiday is taken free from duty. That scheme would be seriously disturbed if the Minister's present claim were granted. Like Mr. *Rogers* in 1976, I am satisfied VMOs are entitled to have built into their remuneration as independent contractors a component to allow for the benefit of public holidays.

The inclusion of a period of two weeks per annum to compensate for public holidays has effectively been a feature of determinations from 1976, and I am unpersuaded by the arguments advanced for the Minister to remove such a long-standing benefit. I propose, therefore, to retain the

public holiday component of two weeks by way of an equivalent percentage addition to the hourly rates of remuneration.

Sick Leave: Consistent with the present determination, the parties agreed that a VMO shall be entitled to unpaid leave of absence during periods when services cannot be rendered due to illness. The issue was that the Minister proposed the component of the 49.3 percent loading for sick leave of two weeks per annum be removed. The AMA pressed for its retention. The original prescription for sick leave in 1976 was not the subject of any recommendation by Mr. *Rogers*, but the parties agreed to allow a VMO paid sick leave of two weeks for each year of service and a prescription in substantially those terms was included in the 1978 and 1980 determinations. As with other leave entitlements, the 1981 determination converted the sick leave provision to an unpaid period but included a component of two weeks as part of the calculation of hourly rates of remuneration. That approach has continued unchanged to the present time. The position as to sick leave being included as part of the rolled-up rate was dealt with by *Macken* J. in the 1981 reasons at pp.7, 8.

Mr. *Kenzie* supported the Minister's claim for deletion of the sick leave component by the following propositions -

- It is inequitable and unreasonable, and contrary to the policy of sick leave, for VMOs to receive a monetary entitlement in lieu of the availability of sick leave. Staff specialists do not get sick leave payments unless they are sick, and, whilst their sick leave entitlements accrue, the monetary value is not paid out to staff specialists on termination of employment.
- There is in fact no proper basis upon which this component can be maintained if any concept of equity or fairness is to be applied in determining normal hourly rates for VMOs.

. The case for removal of the component for sick leave is even stronger in light of the AMA's claim for background practice costs as including the costs of sickness and accident insurance in the survey of VMO's practice costs, which survey formed the basis for the hourly amount claimed as background practice costs. Double-counting should be avoided.

In pressing for the continuation of a sick leave loading to account for the lack of paid sick leave, the AMA deleted the premiums for sickness and accident insurance from the survey data for the purpose of computing an allowance for background practice costs.

It must be undoubted, as the survey conducted by Dr. Child showed, that VMOs get sick from time-to-time and are thereby unable to conduct their practices. However, and also as Dr. Child's survey disclosed, the incidence of sickness is quite low, being on average no more than one day per year. It may well be unusual for persons to be paid for sick leave as part of their remuneration, but, of course, VMOs are independent contractors for whom compensation is by a rolled-up rate and out of which they are required to fund the vicissitudes affecting their working life. Sickness is one of those circumstances. It was common ground too that the concept of a rolled-up rate should continue.

I have formed the view that a sick leave component should be included in the rolled-up rate in the new determination, but equally I consider a more realistic amount should be fixed. Where regular payment for sick leave is made as part of the ordinary remuneration, as here, the fixation of a realistic amount in accordance with sick leave actually taken is even stronger. An amount of two weeks is wholly excessive. On the other hand, the survey conducted by Dr. Child was somewhat limited as covering four hospitals only, but it represented two hundred and fifty-

three VMOs or nearly 10 percent of the VMO population. The incidence of sick leave from the oral evidence of the VMO witnesses was given but passing mention, and, I would think, therefore consistent with Dr. Child's survey results. Even so, one was there dealing with averages and so care needs to be used in making an assessment from such information, although an average of less than one day per annum speaks for itself.

I am prepared to allow, but as a generous assessment, an amount of one week per annum for sick leave in the rolled-up rate by way of a percentage loading in lieu of the present two weeks.

Study and conference leave: The provision of three weeks' unpaid leave of absence for study and conference leave in the existing determination and the corresponding percentage loading in the rolled-up rate was sought to be reduced by the Minister to an amount of one week's unpaid leave per annum for conference leave only with a corresponding change in the percentage loading in the rolled-up rate.

The initial fixation of this element in 1976 by Mr. *Rogers*, as indicated earlier, was much more generous than that available to staff specialists but was found to be justified due to the requirement for VMOs to attend conferences in Australia and overseas from time-to-time. The recommended entitlement was three weeks' leave per annum for the purpose of attending medical conferences and study leave of which two weeks could be accumulated each year up to a maximum of six weeks. A further recommendation was made that if a VMO were found not to be utilising the time allotted for conference and study leave then the entitlement could be suspended. Those provisions were continued in the 1978 and 1980 determinations. As with the other leave provisions, however, in the 1981 determination they were converted to unpaid leave on the basis of including in the normal hourly rate a percentage loading to compensate for the loss of the paid leave.

The Minister's claim was supported by the proposition that there was no basis in equity for independent contractors spending approximately one-quarter to one-third of their time in the public hospital system receiving an equivalent amount of study leave as received by full-time staff specialists. However, the Minister raised no objection to VMOs being allowed to retain conference leave of one week per annum consistent with staff specialists. The AMA relied directly upon the leave allowed to staff specialists, and submitted that to the extent a comparison could be made then it had to be taken into account; in any event, in fixing a proper professional rate for VMOs provision for such factors as periodic study leave had to be relevant.

As to the one week for conference leave conceded by the Minister, the determination will make provision accordingly. Consideration of the claim for study leave of two weeks per year remains to be dealt with.

The provisions recommended in 1976 were based upon the evidence found by Mr. *Rogers* in his reasons (Pt.13 at pp.1, 2) to make "it quite clear that in order to maintain an up to date knowledge of a specialty, a V.M.O. is required to attend conferences of the appropriate specialists in Australia and also to pay visits overseas from time to time. ... The provision which is sought in respect of V.M.Os. is much more generous than that presently available to staff specialists. However, in my view, there is a demonstrated need for the availability of this facility." No distinction was made in the reasons between conference leave and study leave, but it is clear the provisions recommended were much more generous than those afforded staff specialists. The evidence in the present case is sparse as to study leave actually taken by VMOs, although, like in 1976, I am prepared to accept that VMOs, particularly specialists, utilise such time. The above-mentioned survey undertaken by Dr. Child disclosed an average period for study and conference leave of about one

week per year. The summary of leave taken by twelve of the VMO witnesses who gave evidence in the proceedings resulted in an average of 5.66 weeks leave per year for annual and study/conference leave. At best then, I would conclude study leave would amount on average to one or two days per year, but I would think VMOs may tend to use annual leave for study purposes.

Study leave allowed to staff specialists is set out in par.7 of Circular No. 90/39 of 23 May 1990 (see Appendix "K") to the effect that three months' leave shall be allowed after each five years of continuous service in one or more public hospitals in the State, with such leave capable of being deferred to a maximum of six months in any one period; fares and subsistence allowances are also payable. Whilst I understand the argument put for the Minister that VMOs as independent contractors may not necessarily be entitled to the same benefits as their counterpart staff specialists, or indeed even the money equivalent of those benefits, it nevertheless seems to me that the study leave benefits allowed to staff specialists must provide some guide in determining an appropriate provision for VMOs. Immediately, of course, that raises the fact staff specialists have no entitlement until a qualifying period of five years has been served, but which on a proportionate basis equates to 2.6 weeks' leave per year of service. Also, of course, a VMO's contract is for a maximum period of five years and it may or may not be renewed. By the very nature of the method for allowing benefits to VMOs, they do not receive a period of paid leave but rather a loading built into the rolled-up rate for each hour of service provided. Those differences, in my view, are not unimportant and I have had them in mind in making an assessment. There is too the agreed provision to be inserted in the determination, which I will do, allowing additional periods of unpaid leave of absence to

be granted to a VMO at times mutually agreed between the VMO and the relevant hospital or area health service.

On the basis of the evidence available, I consider it appropriate for a period of study leave to be allowed to a VMO as unpaid leave in the amount of one week per year. With the one week for conference leave that gives a total of two weeks per year of unpaid leave, with a corresponding percentage loading in the hourly rate. The determination will so provide. The very nature of conference and study leave, in my view, makes it appropriate to permit some accumulation from year to year of leave not taken, and I propose to provide that such leave may be accumulated up to a maximum of four weeks.

Long service leave: The Minister seeks to delete any consideration for long service leave in the new determination. At the present time, VMOs are entitled to unpaid leave in one or more periods aggregating two calendar months after completion of ten years' service; thereafter, further unpaid leave is to be granted on the basis of one calendar month for each additional two years' service. The quantum of leave is consistent with a similar entitlement to paid leave allowed to staff specialists. Because it is unpaid, like other forms of leave, the hourly rates for VMOs are loaded to cater for two weeks of long service leave per annum. The AMA claimed a continuation of those provisions. As with other forms of leave, the original 1976 agreement following the recommendations by Mr. *Rogers* contained a prescription for paid long service leave according to the existing standard. The prescription was continued in the 1978 and 1980 determinations but was converted to an unpaid entitlement in the 1981 determination along with other forms of leave; compensation for the change was reflected in the leave loading as part of the hourly rates. The Health Commission, the moving party for the rolled-up rate, included the long service leave component in an amount of two weeks per annum, although it will be

apparent that two months for ten years' service equates to 0.87 weeks of leave and not two weeks' leave per annum. Mr. *Kenzie* suggested that that allowance of two weeks appeared to be an error, although it may have been an attempt to reflect in the loading the quantum of leave of one month for each additional two years' service following the initial period of ten years, for which the annual equivalent is 2.16 weeks. If that were so, then, in my view, it would be an extremely generous approach to the loading, particularly when the entitlement does not arise until the completion of at least ten years' service and the loading approach grants a VMO advance payment by a considerable period of time.

The standard of long service leave available to employees generally is two months in respect of ten years' service so completed and one month in respect of each five years' service thereafter, with a proportionate payment where an employee is terminated after at least five years' service as an adult: see *Long Service Leave Act* 1955, s.4(2).

Mr. *Sperling* submitted that if staff specialists' remuneration was to be used for comparison purposes then the entitlement to long service leave allowed to staff specialists had to be factored into the hourly rates for VMOs by some means. To the extent VMO rates were to be assessed independently then it would be reasonable to make provision for a long service leave component in accordance with community standards.

I am of the view that a component for long service leave should be allowed to VMOs in accordance with community standards because it is reasonable that an independent contractor should include in his fees an amount to cover an extended period of leave. However, the amount of two weeks per annum seems to me to be clearly excessive; the community standard is equivalent to 0.87 weeks per annum, and I find as inexplicable the component allowed since 1981 of two weeks per annum. The additional amount may well have been to recognise the additional leave

allowed to staff specialists, but even then it would be excessive and all the more so because the amount was paid well in advance as a loading in the hourly rate. I think an appropriate amount for long service leave would be according to community standards as provided in the *Long Service Leave Act*, but, making some allowance for the additional leave allowed to staff specialists after ten years' service of one month for each additional two years' service and bearing in mind it is paid in advance, I assess as an appropriate amount a period of one week per annum by an equivalent percentage loading in the hourly rate.

Having in mind my conclusions as to leave of absence, the total amount of unpaid leave adds up to eleven weeks, in lieu of the present fourteen weeks, for one year's service for which the equivalent loading to include in the rolled-up hourly rate is 26.83 percent, in lieu of the present 36.8 percent. The determination will so provide. In summary, the unpaid leave to be allowed under the new determination, with the consequent loading in the rolled-up rate, is -

Leave	**Weeks per annum**
Annual leave	5
Public holidays	2
Sick leave	1
Study and conference leave	2
Long service leave	1
Total weeks:	11

Loading: 52 - 11 = 41

$$\frac{11 \times 100}{41} = 26.83\%$$

Superannuation

A loading for superannuation exists in the current determination of 7.5 percent as part of the 49.3 percent loading on the hourly rate to give

the total "rolled-up" rate for VMOs. As stated earlier, the Minister's original position was that the 49.3 percent loading, and hence the superannuation component, should be retained in a new determination but that position changed when the Minister amended his claim to seek a reduction in the 49.3 percent loading to 18.04 percent comprised of 13.04 percent for leave and 5 percent as an extended sessions allowance. Thus, the Minister sought the removal of the 7.5 percent superannuation loading in a new determination. The AMA claimed a continuation of the 49.3 percent loading, and hence the 7.5 percent superannuation component, together with an increase in hourly rates of remuneration for VMOs based on improved superannuation benefits for staff specialists. Mr. *Sperling* put the claim this way:

> SPERLING: May I suggest the way to look at that is to consider what happens when the staff specialist is, let us say, on annual leave, is paid his salary, and for every week that he is on annual leave he is acquiring a superannuation benefit because for every week's salary that he is paid while on annual leave he is acquiring an entitlement to superannuation at some time in the future.
>
> If a VMO is to be placed in the same position as a staff specialist something has to be done to give the VMO something that will equate with that superannuation benefit the staff specialist acquires while he is on annual leave.
>
> That is not going to be achieved if what one does is to treat the staff specialist as earning 52 weeks in the year with superannuation benefit accruing in relation to each week and treat the VMO as working for only part of the year.
>
> HIS HONOUR: That is precisely the same argument in the discussion we had in relation to other aspects.
>
> SPERLING: It is. It is a matter of having to incorporate into an hourly rate for VMOs something which will give to them the equivalent of what staff specialists receive in certain respects, that is not directly paid for hours of work such as holiday pay and such, but which has to be translated into a benefit attaching to hours of work.

Nevertheless, in replying to Mr. *Kenzie's* submissions against including superannuation as a component in hourly rates, Mr. *Sperling* said in the AMA's written submission - "The AMA does not say that VMOs

should have the same entitlement for superannuation as staff doctors. What it says is that, insofar as the remuneration and other benefits received by staff doctors are a relevant factor, one has to include superannuation benefits". On the basis of the hourly rate for a senior specialist, Mr. *Sperling* identified the current 7.5 percent loading as being equivalent to $5.50 per hour as the superannuation factor in the current normal hourly rate; he then relied upon a report from Geoffrey McRae, a consulting actuary with William M. Mercer Campbell Cook & Knight Pty. Limited, to establish that about $18.00 per hour represented the cost to a VMO to obtain the superannuation benefit allowed to a staff specialist. Thus, Mr. *Sperling's* case was that if the 7.5 percent loading were continued then an additional amount of $12.50 per hour would have to be added to the normal hourly rate to fully compensate a VMO for superannuation. That approach was vigorously resisted by Mr. *Kenzie*, generally on the basis it was wholly inappropriate to put VMOs in the same position as staff specialists because of the differences arising from the fact that they are independent contractors and of the general difficulty in making appropriate comparisons between the two groups. It will be necessary later in considering the assessment of total hourly rates for VMOs in a "rolled-up" form to consider a comparison with staff specialists as the AMA relied very much on a number of exercises using staff specialists rates to show that the claim for VMOs' rates was reasonable. Those exercises, as will be seen, showed the AMA relied on a continuation of the 7.5 percent superannuation loading and used the other superannuation material as a counter-balancing factor to the Minister's claims to reduce rates and allowances. The issue as it arose may be demonstrated by the following exchange which I had with Mr. *Sperling* during the debate as to superannuation:

SPERLING: To do so would be to ignore the benefit a staff specialist receives from his employer by way of superannuation. It would not matter what the method was by which the employer calculated the superannuation benefit, if the employer related it to years of service or related it to some other consideration it wouldn't matter. It is only a matter of how much it is that the staff specialist gets by way of superannuation benefit however calculated; and how much it is for every hour that he works, how much superannuation benefit does he get for every hour that he works.

May I say this, that is a detail which has obviously to be examined but so far as the general thrust of things is concerned it was only when my learned friend adduced evidence that the holiday pay component in the 49% was asserted to be, whatever the language is, more than it was worth, that we started asking questions about superannuation and we did it in the course of his case when we put questions to Mr Clout and Dr Child because it seemed to us if the leave question was going to be opened up one was entitled to examine other components of the 49%, and as we became better informed this situation developed until it is as now presented.

HIS HONOUR: I must say, Mr Sperling, I did not understand the Minister going quite that far. I rather understood the Minister to be saying: well here is a 49.3% loading. It has these components we say, and there will be some evidence on it that your Honour would feel comfortable with by continuing to award the 49.3%, that that would be reasonable and would provide no unfairness to the VMOs because there is some padding in there; we are not going to be precise about it but we will be saying that the leave amount is generous. We are not going to say it should be reduced but your Honour would feel comfortable with continuing that 49.3%.

That is as I understood it. Whether it was intended that way I do not know. I really did not, I must say, take it any higher than that as the AMA obviously have done. But it may well be that if the 49.3% is going to be put because of superannuation into such sharp focus, if the figure of $18 per hour et cetera is to be the subject of an amended claim by comparison with staff specialists, then I would have to say to both of you I think that it raises in my mind a whole basis for VMO independent contractor arrangements.
It raises the whole basis of what an independent contractor should get visa vis an employee. It goes very much to the details which I have seen an amount of evidence on but really have not gone into what is behind it because I did not think it was necessary, VMOs assets both in terms of private practice, particularly also in terms of those "benefits" that an independent contractor in this situation has by running his own race; eg, trusts, wife's earnings, et cetera. Now that is a very detailed area but it seems to me that if one is going to go into the aspects as is suggested by a balancing between the staff specialists on the one hand and the VMO on the other there is this enormous potential, enormous counter-balancing area which might make the nett worth that a staff specialist gets pale into insignificance.

SPERLING: It could be the other way, if I may say so.

HIS HONOUR: It might do that, of course, I just do not know, but at least it raises the question and I must say to both of you that if

there is going to be anything more than a balancing that we have talked about with the argument and counter-argument, I must raise my concern and interest in the subject matter of the general survey.

SPERLING: The implications of these things have to be considered and I can assure your Honour the implications are being carefully considered and we will give that further consideration over the weekend. Either way it would seem that it has to be presented but whether it has to be used merely as a counter-balancing to the points that have been made in relation to the loading or whether it has to be something that does open up a wider consideration is the point that needs to be resolved.

HIS HONOUR: I do not think that I am over-stating the wider area. Perhaps you could both think about it, but it just seems to me if one is going to get down to that extended sort of comparison necessarily to be fair on all points of view one has to do it in a thorough way.

I have the feeling, certainly for myself, that there were many questions that were running through my mind as I heard witnesses answering questions in Duesbury's material, but I discarded those questions because they seemed to be irrelevant and that was affirmed by cross examination which really did not explore those areas. I did not really worry about them, but I must say I think some of those questions would at least revive.

It is not necessary for the purposes of superannuation to rule finally on the effect of the "independent contractor - employee" comparison, that will be an exercise when considering the "rolled-up" hourly rates, and I limit present consideration to the 7.5 percent superannuation loading having in mind the additional superannuation benefits received by staff specialists since 1985.

In his 1985 reasons (at p.20), *Macken* J. considered "the loadings traditionally paid in lieu of superannuation" of 7.5 percent and as "no argument was advanced against the continued payment of these additions ... formed the view that they should continue to be paid as part of a rolled-up rate". The 7.5 percent loading was fixed by the 1978 determination when his Honour increased it from the 5.25 percent recommended by Mr. *Rogers* in 1976. The AMA then claimed a loading of 15 percent of the base hourly rate and the Health Commission sought a continuation of the 5.25 percent amount. His Honour reviewed the superannuation scheme

applicable to full-time staff specialists in hospitals and concluded in his 1978 reasons (at p.15):

> At the time of the Rogers' Report the Local Government and Other Authorities Pension Fund provided for an employer contribution of five and one quarter per cent. However, in 1977 the terms of the Local Government and Other Authorities Pension Fund was amended to make it more favourable to employees. The amended scheme allowed employees to elect varying proportions of their salaries as deductions and thus vary the employer contribution toward the fund. E.g.: staff specialists may now elect to have six per cent of their salary deducted (formerly three and one half per cent) and an employer contribution in this event amounts to nine per cent. On the other hand if a staff specialist was to elect to have two per cent of his salary deducted for payment for superannuation purposes, the employer contribution would only be three per cent.
>
> The amendments made in the Local Government and Other Authorities Pension Fund since the Rogers' Report point in principal toward justifying some improvement in the loading to be fixed in this Determination. They provide very little assistance in quantifying such an improvement, however.
>
> Given the fundamental differences between a visiting medical officer and an employee, the various schemes and the evidence relied upon by Mr Shaw to justify a loading of fifteen per cent assist even less in quantifying a proper figure to be arrived at in this Determination. In trying to reflect the 1977 improvements made to the Local Government and Other Authorities Pension Fund, while accepting that this cannot be done on a mathematical basis, I determine that the superannuation loading should be increased to seven and one half per cent.

As I indicated earlier, Mr. *Rogers* in 1976 allowed a loading of 5.25 percent which was the loading paid in respect of a full-time staff specialist by the Health Commission as a contribution to the Local Government and Other Authorities Pension Fund. In ruling against the AMA's then submission for a loading of 15 percent on the basis of the taxation liability of VMOs compared to their full-time salaried colleagues, however, Mr. *Rogers* said (Pt.4 at p.3):

> It is the desire of the A.M.A. that Visiting Medical Officers should not become employees of the Commission, but should be independent contractors. Indeed, a specific recital to this effect, has been inserted in the draft contract proposed. This may involve consequent taxation disadvantages. It is not clear to me why this taxation disadvantage, if any, should be borne by the Commission.

> In any event, I am not satisfied that Visiting Medical Officers are unable to obtain taxation deductions by subscription to independent superannuation benefit funds, which would compensate them for any liability to taxation on the amounts received from the Commission by way of superannuation loading.

Although Mr. *Rogers* recommended a superannuation loading equivalent to the contribution rate paid for a full-time staff specialist, the position of a VMO as an independent contractor was recognised, and, importantly, the Health Commission took the attitude it was fair and proper for some contribution to be made towards superannuation benefits for VMOs but disputed the quantum. Further, the assessment made by *Macken* J. in 1978, whilst recognising the 1977 improvements gained by staff specialists under the Local Government and Other Authorities Pension Fund of a maximum employer contribution of 9 percent, determined a superannuation loading of 7.5 percent. That has since continued. However, the AMA here led evidence that since 1985 superannuation contributions for staff specialists have increased from two sources. First, an amount of 3 percent of salary from the *State Authorities Non-Contributory Superannuation Act 1987*, s.22 following the 3 percent benefit afforded salaried employees generally and public service employees in particular emanating from the *National Wage Case June 1986* ([1986] 14 I.R. 187 at 212-219); and, second, from amendments to the *State Authorities Superannuation Act 1987*, s.37 whereby the multiplier for service from 1987 was increased resulting in a 2 percent increase of the rate as assessed in 1985. Those two benefits resulted in a total adjustment of the 1985 rates by 5 percent to reflect the increase in superannuation benefits obtained by staff specialists since that time, being the amount of $12.50 per hour for senior specialists referred to above which, with the 7.5 percent loading equivalent to $5.50, gave a total superannuation benefit for a senior specialist of $18.00 per hour.

The Minister's submissions put by Mr. *Kenzie* for the deletion of all consideration for superannuation benefits allowed to staff specialists in the calculation of VMO's remuneration may be summarised as follows -

- The superannuation benefits received by staff specialists are, in nature, not unlike workers' compensation benefits and it would be very unusual for an employer to take out workers' compensation insurance with respect to independent contractors performing work pursuant to a commercial contract.
- The principles within the *State Wage Case* deal only with superannuation benefits to employees and do not countenance the payment of superannuation to independent contractors.
- The mere fact that an independent contractor, like a VMO, may be undertaking work the same as or very similar to the work of a staff specialist employee is not a sufficient basis for concluding that every component of the employee's remuneration package should therefore flow to the VMO independent contractor. Differences between the two groups include:
  - staff specialists are subject to the direct control of the hospital or area health service;
  - staff specialists have no right to demand a particular standard of office facility or the quality of the workplace; on the other hand, VMOs are completely unfettered in their decision as to the nature, standard and quantity of support staff and resources that they may maintain in their own rooms;

- staff specialists as employees do not have the capacity, like VMOs and other self-employed persons, to claim a 75 percent tax deduction for any level of superannuation payments they might make over and above the $3,000.00 level, up to which level is 100 percent tax deductible; and
- VMOs are not required, even though they currently receive a 7.5 percent superannuation loading, to put all or any part of that into superannuation whereas staff specialists have no option in that respect.

. It is unreasonable and inequitable for VMOs to have a dollar sum equivalent to the value of superannuation benefits received by staff specialists in their hand on an hourly basis to spend as they please when staff specialists are unable to gain access to their superannuation entitlements until retirement or early retirement.

. The AMA ignored in the 1987 superannuation exercise a corresponding reduction in the maximum accrued benefit points which had the effect of neutralising the multiplier effect so that the additional 2 percent was illusory. (That would seem to reduce the AMA's $18.00 per hour figure to $15.00 per hour.)

. There are, in any event, significant limitations on making direct and complete comparisons between the remuneration package to staff specialists and the overall remuneration of VMOs by including their private practice earnings.

I must say the question of superannuation has caused me some trouble in attempting to balance the competing arguments, particularly in view of the fact a loading for superannuation has formed part of VMO

determinations from 1976 by consent and the only issue has been as to quantum. What the history does disclose, however, is that the loading granted to VMOs has not equated with the superannuation contribution amount paid in respect of staff specialists. What must be acknowledged too is that a VMO is an independent contractor conducting a private practice for the overwhelming amount of his time - the evidence disclosed that on average a VMO spends 5.6 hours per week in the public hospital system so that, again on average, he spends about forty to fifty hours per week in private practice. A further factor is that payments to a VMO, including those in respect of superannuation, are made at the time of the rendering of services and not as a deferred benefit on retirement. The VMO is not obliged to spend the payments received in any particular way; he has complete freedom of choice as to when, where and how to invest the monies and to provide for his future. Against those considerations, in my view, must be the undoubted truth that a VMO as an independent contractor is entitled to a payment for services rendered to appropriately compensate for the work and for other incidents of life. Superannuation falls into that category. *Prima facie*, therefore, I would be prepared to include some loading in a VMO's remuneration to compensate for the superannuation element, but not at an equivalent level with staff specialists. The differences between a VMO and a staff specialist as I have outlined them would, in the opinion I have formed, compel that result. Having in mind the present loading of 7.5 percent, the question is whether it is appropriate to continue that loading or, in the circumstances, to make some other provision such as payment direct to an appropriate superannuation fund for the benefit of a VMO.

Superannuation in recent times has received considerable attention by government and also by industrial tribunals in *National and State*

Wage Cases. In the *National Wage Case - April 1991* (*supra* at 178) the Australian Industrial Relations Commission said:

> Despite that view, the Commission is concerned about some of the problems which were raised in the June 1986 *National Wage* case decision. That concern is only increased by issues raised in the submissions of a number of the parties and interveners, including the Commonwealth Government, in these proceedings. Because of those concerns, we consider it essential that a concentrated attempt be made to deal with these issues at this stage of the development of award based superannuation; otherwise its further development may be flawed to the point of frustrating its contribution to the achievement of an adequate national retirement incomes system.
>
> Consequently:
>
> . we request the Commonwealth Government to convene a national conference on superannuation involving all relevant parties; and
>
> . we adjourn the hearing of this element of the unions' claims. It will be resumed on the application of any party to these proceedings.
>
> The conference, we expect, will review and clarify a number of vital issues about superannuation generally and, in particular, award based superannuation. It should consider, but not be restricted to:
>
> . non-compliance;
>
> . the desirability or undesirability of additional award based superannuation for employees already covered by non-award schemes;
>
> . extension of award based superannuation to all awards as appropriate and particularly in State jurisdictions;
>
> . flexibility in improving different aspects of award based superannuation;
>
> . the application of superannuation to casual, part-time and short-term employees; and
>
> . the role of the Commission in the long-term agenda for ensuring appropriate retirement incomes.

In the consequent *State Wage Case - May 1991* (*supra* at 413), the Industrial Commission concluded as to superannuation:

> We conclude that superannuation and retirement policies are subject matters with major implications for National policy. At this stage therefore we do not accept Mr Shaw's submission that superannuation should be dealt with in State terms.

> For these reasons we accept and confirm generally the expressed views of the Australian Commission when adjourning the superannuation claim. Should the Australian Government not convene the national superannuation conference as requested by the Australian Commission that Commission itself would materially assist if it convened such a conference.

An important development occurred with the enactment of the *Superannuation Guarantee (Administration) Act* 1992 (Cth.) as affecting superannuation arrangements between VMOs and the Department of Health. That Act commenced on 1 July 1992: s.2. As its long title stated, it was "(a)n Act relating to the establishment and administration of the Superannuation Guarantee Scheme, and for related purposes". Significantly, it was enacted subsequent to the decision in the *National Wage Case - April 1991* (supra) in which the Australian Commission adjourned the hearing of superannuation claims in order to enable "the achievement of an adequate national retirement incomes system". The Federal Treasurer, in his second reading speech in moving the adoption of the Bill (*Hansard*, 2 April 1992 at pp.1763,1764) said as to the background:

> When we came to office, 40 per cent of the work force had some superannuation cover; in 1991, the proportion was 72 per cent. On this basis alone, our reforms of superannuation are an achievement which the retirees of the future will value highly. Despite these reforms, there is an ongoing need to ensure that as many Australians as possible have access to superannuation. There is also a need to increase the average level of superannuation savings for each individual, if these savings are to provide an adequate level of retirement income. Consistent with these goals, the superannuation guarantee levy was announced in last year's budget.
>
> The superannuation guarantee levy represents another major step forward in the development of retirement incomes policy. It will lay the foundation for income security and higher standards of living in retirement for future generations of retirees. The superannuation guarantee levy provides:
>
> . a major extension of superannuation coverage;
>
> . an efficient method of encouraging employers to comply with their award obligations; and

. an orderly mechanism by which employer superannuation support can be increased over time, consistent with the economy's capacity to pay.

The levy will consolidate the reforms implemented since 1983, and will provide a coherent and equitable framework in which retirement incomes objectives can be progressed. It will ensure that, by the beginning of the next century, virtually all employees will be accumulating substantial superannuation savings to help fund their retirement income.

As to how the Superannuation Guarantee Scheme will work, the Treasurer said in his second reading speech (at pp.1764,1765):

The Bill, which applies from 1 July 1992, will encourage employers to provide a minimum level of superannuation support for employees. Where employers provide less than the minimum level of superannuation support, they will be liable for a superannuation guarantee charge. The superannuation guarantee charge-which will not be a deductible expense for employers- will be used to meet the superannuation contribution entitlement of the relevant employee and will be used, as I discuss later, to fund administration costs.

...

The level of superannuation support an employer is expected to provide will depend on the employer's annual payroll. For the 1992-93 year, employers with an annual payroll in excess of $500,000 will be expected to contribute 5 per cent of an employees' earnings base to a complying superannuation fund. This percentage will increase over the next nine years to 9 per cent. Employers with an annual payroll of $500,000 or less will be required to contribute 3 per cent, increasing on a slower transition schedule to 9 per cent,

An employee's earnings base will depend upon whether the employer was providing superannuation support for employees on 20 August 1991. Employers who, on that date, were contributing to a superannuation scheme which has an earnings base can continue to use that earnings base so long as it is not reduced. This will help minimise compliance costs. In any other case, the employer will be assessed against an earnings base that the employer is required to use under an industrial award or a base not less than ordinary time earnings.

Superannuation support must be provided through a complying superannuation fund in order to be counted towards the minimum level of superannuation support. The fund can be either a defined contribution fund or a defined benefit fund. In the case of a defined benefit fund, the employer will be required to obtain an actuarial certificate specifying the level of employer superannuation support implicit in the benefits available to employees in the fund. For all other funds, the employer's level of support will be based on the actual contributions made to the fund.

...

If an employer does not provide the minimum level of superannuation support, a charge will be imposed on the employer. The charge will be equal to the sum of:

. the total of the employer's individual superannuation guarantee shortfalls;

. an interest component; and

. an administration component.

As to award superannuation, the Treasurer said (at pp.1765,1766):

The Government has decided to support the inclusion in existing superannuation award provisions of the rates of contribution to superannuation funds required by the superannuation guarantee scheme as they become operative. The Government considers that, where there is no agreement between the parties to an existing award superannuation provision nominating a particular fund, the fund to which such additional award contributions are to be made should be determined by the relevant industrial tribunal looking to the best interests of the beneficiaries.

The superannuation guarantee scheme is designed to encourage employers to provide a minimum level of superannuation support. It is intended to improve the position of those employees who have inadequate superannuation coverage. It is not designed to provide a mechanism for a general increase in superannuation support for those employees who are already receiving in excess of the prescribed minimum level.

The Government expects that increases in the prescribed minimum level would not result in additional contributions in cases where employees were already providing superannuation support at or above that level. Of course, parties are free to negotiate levels of superannuation support above the minimum as part of enterprise agreement.

Many employers already provide such higher levels, often through a combination of contributions to industry funds and employer funds. In such cases, the Government expects negotiations between the parties on a case-by-case basis would determine the fund or funds to which superannuation guarantee/award contributions would be made. Any breakdown in negotiations should be referred to the relevant industrial tribunal.

The Superannuation Guarantee Scheme is clearly designed, as a matter of policy, to provide access to superannuation benefits as part of a national retirement income scheme. It is intended to provide a minimum level of superannuation support through a complying superannuation fund, but where an employer does not provide the level of superannuation

support then a charge will be imposed on the employer to bring the contribution up to the minimum level by investing the charge in a complying superannuation fund for the benefit of those employees in respect of whom the charge was paid. Employees will have a choice as to which fund those amounts go to.

The *Superannuation Guarantee (Administration) Act* binds the Crown in right of the State of New South Wales: s.3(1). A "complying superannuation fund" is a fund for the purposes of the Act if it is a complying superannuation fund for the purposes of Pt.IX of the *Income Tax Assessment Act* 1936 (Cth.): s.7. "Salary or wages" include the remuneration of a person who holds, or performs the duties of, an appointment, office or position under a law of a State: ss.11(1) and 12(9). "Employee" and "employer" have their ordinary meaning; however, for the purposes of the Act, that meaning is expanded to make a person who works under a contract that is wholly or principally for the labour of the person an employee of the other party to the contract: s.12(1),(3) and (9). The charge imposed on an employer's superannuation guarantee shortfall for a year is payable by the employer: s.16. The employer's charge payable as a superannuation contribution is a percentage of salary; where its national payroll exceeded $1.0 million for the base year of 1991-92 it will be 4 percent from 1 July 1992 to 31 December 1992, and 5 percent from 1 January 1993 increasing over the next nine years to 9 percent on 1 July 2002 and applicable at that rate for subsequent years: s.20. The superannuation guarantee charge in respect of the shortfall component is to be paid by the Commissioner of Taxation for the benefit of the employee to a complying superannuation fund nominated in accordance with the regulations by the employee: s.65(1). If an employee is under 55 years of age but has retired because of illness the Commissioner must pay the amount of the shortfall component to the employee: s.66. If the employee

has died, the Commissioner must pay the amount of the shortfall component to the legal personal representative of the employee: s.67. Amounts paid under ss.66 or 67 are not subject to taxation: s.68. That review of the scheme of the *Superannuation Guarantee (Administration) Act* is not intended to be exhaustive, but rather to highlight what I see to be the essential provisions for present purposes.

It would seem to me to be clear that the *Superannuation Guarantee (Administration) Act* would apply to the State of New South Wales in respect of the employment of staff specialists where the Crown provides less than the minimum level of superannuation support specified, in which case a superannuation guarantee charge will be payable to the Commissioner of Taxation to make up the shortfall to provide the staff specialist with the superannuation benefits prescribed. The question then is whether that Act applies to the Crown in respect of the engagement of VMOs as independent contractors under sessional contracts. The Minister and the AMA were at issue on that, with the Minister adopting the view the legislation was applicable to VMOs with effect as from 1 July 1992 and the AMA denying coverage over VMOs because they were not "employees", even within the expanded meaning of the term as defined in the legislation. Accordingly, on the AMA's submission, the *Superannuation Guarantee (Administration) Act* had no application and should be disregarded in considering superannuation loadings for VMOs; the 7.5 percent loading currently determined should therefore be continued in the new determination together with the additional consideration for superannuation in the hourly rates as earlier mentioned.

As support for the proposition that a VMO was not an "employee", Mr. *Sperling* referred to *Deputy Commissioner of Taxation v. Bolwell* ([1967] 1 A.T.R. 862) and to *World Book (Australia) Pty. Limited v. Commissioner of Taxation* ((1992) 27 N.S.W.L.R. 377). In *World Book*, the

Court of Appeal was required to construe the words "a contract that is wholly or principally for the labour of the person to whom the payments are made" as appearing in the definition of "salary or wages" in the *Income Tax Assessment Act* 1936 (Cth.), s.221A(1), being a similar expression to that appearing in s.12(3) of the *Superannuation Guarantee (Administration) Act*. The Court, applying the decision of the High Court in *Neale v. Atlas Products (Victoria) Pty. Limited* ((1955) 94 C.L.R. 419), drew a distinction between a contract for labour and a contract whereby the contractor had undertaken to produce a given result. Mr. *Sperling* submitted that a VMO under a sessional contract had agreed to achieve a particular result in the treatment of patients rather than a sessional contract being one for labour only so that the VMO was not an employee within the expanded meaning. The majority of *Clarke* and *Sheller* JJ.A. based the distinction on the proposition that if a contract permitted a given result by virtue of the labour of the independent contractor or the labour of others to whom he delegated the task then it would not be correct to describe the contract wholly or principally for the labour of the independent contractor. In the minority judgment, *Meagher* J.A. based his decision on a contract containing a power of delegation as not being a contract for labour, but suggested, as *obiter dictum*, that a patient's payments to his surgeon would not be under a contract wholly or principally for labour but under one for the surgeon to achieve a particular result.

I have given careful attention to the judgments of the Court of Appeal in *World Book*, but I have nonetheless reached the view that the sessional contract between a VMO and a hospital or an area health service is a contract that is wholly or principally for the labour of the VMO within the meaning of the *Superannuation Guarantee (Administration) Act*, s.12(3) so as to make the VMO an employee of the hospital or area health

service concerned for the purposes of that Act. Properly viewed, it is my opinion that a sessional contract does not constitute an agreement by the VMO to produce a given result, nor indeed any particular result at all, other than that he will treat and care for the public patients allocated to him in accordance with professional and ethical responsibilities, consistent with his clinical privileges and having in mind the facilities afforded by the public hospital. A public patient, it seems to me, whilst under the care of a VMO, is a patient of the hospital. Certainly, a sessional contract does not grant a power of delegation to a VMO. The view of *Meagher* J.A., as expressed in *World Book*, is distinguishable because, unlike the surgeon who received a payment from his patient, a VMO receives no such payment from a public patient but receives remuneration on a sessional basis from the hospital or area health service for the rendering of medical services pursuant to the sessional contract. Essentially then, I conclude that a sessional contract is one for the labour of the VMO. I accept the Minister's view that the *Superannuation Guarantee (Administration) Act* is applicable to VMOs, and I note the Department's current action in obtaining advice as to appropriate arrangements to implement compliance with that Act.

The result of that is to inject a most important consideration, which I ultimately find to be decisive, in deciding the issue as to the inclusion of a superannuation component in the remuneration for VMOs. Shortly stated, I have decided that no consideration for superannuation should be included in sessional contracts because to do so would result in double-counting, and, relevantly meeting the AMA's comparison with staff specialists, would place VMOs unfairly in a position of advantage.

As to the double-counting aspect, it seems to me that if a VMO were to receive a superannuation loading under a sessional contract then that payment would not be a superannuation contribution to a complying

superannuation fund, it being merely a payment to the VMO as compensation for superannuation which is able to be used as the VMO might see fit, with the consequence that there would be a "shortfall" under the *Superannuation Guarantee (Administration) Act*. The Crown, therefore, would still be required, in my view, to make the full amount of the superannuation guarantee charge to the Commissioner of Taxation to be dealt with for the benefit of the VMO on retirement, illness or death. I cannot see any different result were a VMO to himself pay the superannuation component direct into a complying superannuation fund, and, in any event, there is no guarantee or other sufficient provision suggested by the AMA that that would be done.

As to the comparison with staff specialists, Mr. *Sperling* provided detailed evidence from William M. Mercer Campbell Cook & Knight Pty. Limited, Consulting Actuaries, of the value to a staff specialist of superannuation benefits as supporting the amount of $18.00 per hour earlier referred to. However, that evidence took no account of the actual participation by staff specialists in available superannuation funds nor of the employer's actual contributions to those funds on behalf of staff specialists. Other evidence disclosed that very many staff specialists were not members of an available superannuation fund and of those who were members the majority elected to contribute no more than the superannuation guarantee charge under the *Superannuation Guarantee (Administration) Act*. A survey was conducted of staff specialists employed at Prince of Wales/Prince Henry Hospitals, Royal Prince Alfred Hospital and Royal North Shore Hospital in respect of their superannuation contribution levels; a total of 378 staff specialists were covered by the survey being approximately 40 percent of staff specialists employed in public hospitals. The average contribution which those surveyed elected to make to a superannuation fund was 4.74 percent of

salary and there were 114 of them who made no contribution to superannuation at all. That means that for those 114 the employer contributes under the new NSW Government Superannuation Fund, First State Super Scheme, an amount equivalent to that required under the *Superannuation Guarantee (Administration) Act* and for the remaining 264 staff specialists who make contributions the employer will be required to make additional contributions for very many of them to meet the requirements of the superannuation guarantee charge. On that evidence, I am unable to conclude that VMOs generally would be disadvantaged by comparison with staff specialists in terms of present practice.

I would have been otherwise inclined to include some component in VMOs' remuneration for superannuation, but not, I apprehend, as much as the present 7.5 percent because of the favourable comparison with staff specialists. Also, of course, the superannuation principle in the *State Wage Case - May 1991* requires the employer payments, to a maximum of 3 percent of ordinary time earnings, to be made to "approved superannuation schemes" so that, it seems to me, a serious impediment stands in the way of a continuing superannuation payment direct to a VMO as part of hourly remuneration. However, and in any event, the effect of the *Superannuation Guarantee (Administration) Act* and its consequences for State Government employment, including its application to VMOs, persuade me to the conclusion that the only reasonable course is to exclude superannuation as a direct payment to VMOs in a determination. I propose to do so.

Travelling expenses

In the 1976 sessional agreement, a provision was included entitling a VMO required to render services at a hospital or health facility other than the hospital at which he ordinarily rendered services to be reimbursed for the additional cost of travelling to that other hospital or

health facility where he used his private motor vehicle at rates applying in the public service. The provision continued unchanged in subsequent determinations and presently is in force. However, it was originally agreed at a time when there was no explicit allowance for background practice costs, and was continued notwithstanding the introduction of a background practice costs allowance by the 1978 determination. The parties here took the position initially that such a provision should be continued in a new determination, but, on it being pointed out that the cost of travel for VMOs between hospitals was a consideration in assessing background practice costs, they agreed the travelling allowance provision should not be included in the new determination. I agree.

Record of services

An issue of some importance is the record of services provided by VMOs under sessional contracts. In previous determinations it has not attracted the degree of attention given during the present proceedings, due, no doubt, to the large cost increases from the 1985 determination and the later structural changes to the public hospital system in terms of responsibility to provide the most efficient health service available consistent with scarce resources. Mr. Clout in his evidence referred to the inadequacies of the present system and of the disputes and difficulties which had occurred over the years. He said:

> As previously indicated, information in respect of the provision of services to hospital patients, is an important part of the total information which hospital managers need to have to enable them to take informed management decisions for which they have responsibility and for which they will be held accountable. The information is necessary so as to enable analysis of the cost and service outcomes of hospital services and to enable identification of practices and procedures which are in need of change so as to ensure the most appropriate use of resources without detrimentally affecting patient care. Practices of patient servicing which lead to what might be considered to be inappropriately long length of stay, for example, need to be able to be examined on a case by case basis to establish whether the view is able to be substantiated or whether the patient circumstances result in higher costs than normal.

Current information provided by VMOs on hospital patient services proved, make such examination extremely imprecise, which can lead to conclusions being incorrect.

The DOH proposal addresses the issue to a large degree and will be of great assistance to more informed decision making.

The provisions in the Department of Health's proposal are also necessary to provide an appropriate certification of the services performed by visiting medical officers when assessing payment claim forms.

The provisions in the existing Determination have been the subject of much disquiet by managers of health services for a number of years. Those managers are required to be accountable for the expenditure of public monies. In addition they are required to satisfy the audit requirements and the requirements of the Accounts and Audit Determination. This can only be done if there is an appropriate audit trail in respect of services provided as against claims submitted for payment. To my knowledge there is no other area of hospital expenditure for which there is no appropriate certification mechanism available.

In my experience as a Senior Industrial Officer responsible for visiting medical officer matters for some years I am aware that a number of hospitals have attempted to institute revised VMO claim forms so as to comply with the certification requirements and to ensure that the payments being made are correct.... Such attempts met with opposition from VMOs and the AMA and were ultimately either withdrawn or modified in a manner that is consistent with the provisions of the Macken Determination. It is essential that the provisions contained in the Department's proposal are achieved.

That part of Clause 19 contained in (ii) at paragraph C (iii) are also essential to ensure that hospital management is in a position to finalise its budget in a particular year and budget for the coming financial year in respect of VMO claims....

I have been involved in a number of disputes committees relating to the question of late submission of claim forms.... In a number of these cases the claims were submitted months, or years (in one case up to six years) after the services were provided. In almost all cases it has been the situation that if the services were provided then the payment claims had to be paid notwithstanding that they were submitted years afterwards. The impact of this is twofold. Firstly, the hospital is hit with a very large outstanding claim in a particular year when it has not budgeted nor been provided with funds for such a payment. In my personal experience this leads to a situation where the VMO budget in the particular year is either massively exceeded or the hospital has to curtail the essential medical services particularly services provided by visiting medical officers so as to ensure that the budget is not exceeded.

The Northern Sydney Area Health Service in particular has had difficulties with VMOs in its attempts to achieve a proper degree of

accountability for the expenditure of public monies for VMO activities. Dr. Spring, in a telling way in my view, said in his statement of evidence:

> There has, in my experience, between an unfortunate degree of acrimony in relation to the development of a proper degree of accountability for the expenditure of significant amounts of public funds.
>
> The desk audits conducted periodically throughout the Northern Sydney Area Health Service, but also more generally in the system, point to the desirability of a greater degree of information to facilitate monitoring and approvals.
>
> Attachments C trace correspondence over 4 years with both affected clinicians, the Royal North Shore Hospital management and the Australian Medical Association. Essentially, following the Macken judgment of 1985, the management tried to vary the claim form of the time - form C1.
>
> To do this they consulted a number of users and typical replies are enclosed (C4 and C5) from two clinicians. Despite their apparent agreement, the form (C7) was objected to and varied to remove the need to give patient details for routine work.
>
> The new form (Form C12) was then introduced and used until further complaints in 1989-90 even though the form had not been varied for 2 years. Even though the form has been used for two years unchanged there is a good degree of non-compliance with the form.
>
> Such non-compliance includes:
>
> - striking out areas and including a gross hours figure in the total.
> - non presentation of patient details.
> - non provision of leave etc.
>
> Some non-compliance can be expected due to haste or ignorance as to what is required, but a proportion is held to be due to the form not complying with the earlier Macken judgments.
>
> In 1990 - despite no modifications to the form, other than colour - the AMA objected to the form again (C14-19) on the grounds that it was not consistent with the Macken judgment of 1983 and further that the form was not part of an agreement with the AMA and the Department of Health.
>
> I am unable to ascertain where the form is in breach of the 1983 Macken judgment but nevertheless I believe that the form as presented in 1987 (C7), which included patient names for routine work is more consistent with 1991 standards for claiming on the basis of work performed.

Desk audits have at times revealed that Visiting Staff have not always held information sufficient to back up their claim forms.

Further difficulties occur when Visiting Medical Officers lodge claims that are many months old and occasionally years old. In those circumstances time can weaken the capacity to check that the services were delivered. 50% of the claims are late and 5-10% are over 3 months late. In addition claims that cross financial years cause difficulties in budgeting, even in an accrual environment, if the claim is not predicted. Appendix D1 includes a relatively recent claim, dating 5 years, received at the very end of the financial year and totalling approximately $150,000.

The evidence of Dr. Spring highlighted the differing attitude of VMOs to the keeping of records. One VMO asked to comment on the revised claim form prepared by Dr. Spring said - "The first impression is that the documentation required is almost equivalent to the Car Log Book for the Fringe Benefits Tax. While I realise that some degree of documentation is required by Medical Administration and Government bodies paying for the sessions, the tendency towards more detailed substantiation should be resisted for the sake of everyone's sanity." Another VMO, however, said that "(t)his form appears to be adequate for my needs ... the form appears to be simple and meet my needs for claiming." Those comments were made in August 1986 prior to the new claim form being finalised, but when it was distributed for use in December 1986 the AMA by letter dated 15 January 1987 objected to the form by observing - "Justice Macken in his Determinations of the past has been most emphatic that he would not accept a 'bundy' system requirement to be placed upon Visiting Medical Officers for the delivery of each and every service." Nevertheless, the letter continued to the effect that VMOs should be able to produce evidence for services rendered and that the maintenance of "records by Visiting Medical Officers on a private basis is prudent practice." As a general comment, I have viewed the claim form proposed by Dr. Spring at that time and I must say that, at least to me, its completion would not appear to be unduly burdensome, and, in any event, it merely called for details of services provided in a clear and logical

way and in respect of which the prudent VMO keeping a diary of his activities would have readily available.

Dr. Horvath too gave evidence of VMOs submitting claims for payment two and three years late, and commented that "(i)n a cash accounting system, this makes budgeting rather difficult."

Mr. Barker dealt with the deficiencies of the existing determination and proposed improvements to address accountability in respect of records and said:

> Clearly the Determination is deficient in that sound internal controls do not exist to provide an audit trail from the patients medical records to the V.M.O.'s monthly account to ensure that the claim is reasonable and that the service as claimed was actually provided.
>
> The Determination requires strengthening as follows:
>
> . Monthly accounts must be submitted to the contracting hospital within one calendar month. Accounts must be accompanied by a schedule in a format along the lines as proposed at Appendix A fully supporting the claim.
>
> . Where accounts are not submitted within 3 months (allows for 2 months grace) the contracting hospital shall not be liable to make payment.
>
> By way of explanation the above will:
>
> . place the onus fairly on V.M.O.'s to provide an account promptly in accordance with acceptable commercial time constraints. This will even out payments and reduce the incidence of arrear claims.
>
> . enable contracting hospitals to refuse payment where claims are not received in accordance with the prescribed time period.
>
> . reduce financial cash pressures on a hospital due to a large number of old previous years claims being received in the following year.
>
> . enable better and more even cash budgeting.
>
> . force a standard audit trail to be introduced by the introduction of a standard claim and supporting schedule(s) which will require insertion of
>
> - Date
> . Patient name

. Reason for visit
. Time seen
. Hours, minutes claimed
- On call hours
- Call back/public holidays claims

. provide a certificate that claims for sessional/call back and public holidays can be supported by entries on medical records.

. provide a certificate that claims for on-call are in accordance with the approved roster.

. by introducing a standard form improve the monitoring and control of V.M.O. hours and payments by the establishment of a data base at the local level and within the Department on an annual basis. This will then allow hospital administrators to monitor that overservicing and overclaiming is not present.

It would be expected that V.M.O.'s would be critical of the introduction of such a process, however the fact remains that they are contractors in a 3 way arrangement involving:

. the V.M.O. as the service provider

. the public patient as the recipient of the service

. the Department through the hospital as the payee for the delivery of the service.

In almost all areas of accounting whether government or private, a form of audit trail exists before payment to ensure the goods and/or services are provided. Under the existing Macken determination this trail is lacking thus creating a basic "loophole".

Against those difficulties and the need to improve accountability the present claims fall for consideration. The 1985 determination in cl.14, Record of Attendance contains the following features -

. To facilitate the calculation of the number of contracted hours per calendar month to be specified in a sessional contract a V.M.O. shall maintain a record of services provided indicating the date, commencing and finishing times, and the number of hours to the nearest quarter-hour of such elapsed time.

. To facilitate the making and verification of claims in respect of call-backs and public holidays a V.M.O. shall keep a record

showing the date, time of day, name of patient and nature of service rendered.

. The records so completed shall be submitted to the hospital concerned each calendar month by no later than the 15th day of the succeeding calendar month.

It will be clear that the existing determination imposes no requirement as to the name or medical record number of the public patient and nature of service (other than during a call-back and on a public holiday), the authority requesting a call-back, particulars of attendance in meeting teaching, training and committee requirements, and particulars of leave of absence. In light of the Minister's evidence, the absence of those details is seen to be a deficiency for the reasons stated, particularly the identification of a patient and the nature of the service provided. Another deficiency apparent in the form of the determination provision is the absence of uniformity in record keeping which, one could readily understand, would lead to inefficiency in processing claims. The remaining criticism of the existing provision concerned its failure to impose any sanction for the late lodgment of claims by VMOs.

The Minister's claim sought a provision to require a VMO to maintain a record, in the form prescribed by the hospital or area health service concerned, indicating specifically named particulars to meet the present deficiencies and to be submitted to the hospital or area health service for each calendar month no later than the twenty-eighth day of the succeeding calendar month. Also, in the event of non-compliance by the VMO with the requirements then the hospital or area health service was not to be obliged to make any payments unless special and extraordinary circumstances were shown by the VMO explaining such non-compliance. The AMA sought the replacement of the existing provision with one which contained the following features -

- The VMO to submit to the hospital or area health service concerned an account each calendar month.
- The aggregate time to the nearest quarter-hour spent in providing services for each day.
- The aggregate time to the nearest quarter-hour spent each day in attending committees and meetings, designating the committees and meetings attended.
- As to call-backs, the date, name of patient and description of services provided, the period during which the services were provided to the nearest quarter-hour, including travel and specifying the starting and finishing times.
- As to on-call, the period during which the VMO was rostered.
- The account to be submitted by the fifteenth day of the following month, in which case the hospital or area health service to pay the account by the end of the month.
- Where a VMO submitted a late account then it was to be paid by the hospital or area health service by the end of the month in which it was submitted, but if submitted after the fifteenth day of that month then by the end of the next ensuing month.
- Payment by the hospital or area health service of a VMO's account to be accompanied by a written statement setting out how the payment was made up, including hours and amount for ordinary hours, hours worked on a public holiday, on-call, call-backs at 10 percent loading, call-backs at 25 percent loading, and call-backs at 50 percent loading.

The significant point about the AMA's claim is that it is based upon aggregate times for the provision of services and no mention is made of the name of the patient nor the nature of the service provided. It resists too the Minister's proposal as to the consequence of a late claim for payment.

Mr. *Sperling* in his submissions frankly conceded - "We are willing to be reasonably accountable for what we do and what we are charging for. The ordinary way of being reasonably accountable for what you do and what you charge for is what you put into your account and we say what we propose is our clause to go into the account is sufficient for reasonable accountability.... but we do wish to stress if your Honour is persuaded by my learned friend that it is reasonably necessary that the visiting medical officer should keep some other record in addition to what appears in his account in order to provide reasonable accountability to the hospital, we will willingly accede to such a view...." As to a VMO being deprived of payment for failing to submit an account on time, other than where special and extraordinary circumstances explained the lateness, Mr. *Sperling* described that as "unprecedented and Draconian" and supported by evidence of only isolated occurrences of late claims; further, Mr. *Sperling* submitted that delay in payment was a sufficient sanction for a late claim and that the Minister's proposal was unfair, harsh or unconscionable, and against the public interest.

The evidence of the VMO witnesses was generally against maintaining the form of record sought by the Minister on the basis of the additional time involved. However, it became apparent that VMOs already keep for claim purposes a record in respect of their private patients as to name, medical record number and service provided. Dr. Stening gave the following evidence under cross-examination:

> Q. Do we understand your position? Are you opposed to providing to the public hospitals information on your claim form which is analogous to the information that you provide in relation to your private patients who claim?
> A. I am opposed to the double entry that is going to be required, the additional time that is going to be required in a situation where people are paid to do this work who can audit me. I mean, it is a matter of my week is crammed as it is. This is going to be a further imposition on time.

Q. Can we understand your position that because you feel that there is a capacity on the part of the public hospitals to audit your work --?
A. It is a statutory requirement of theirs, is it not?

Q. -- that you are opposed to being required to provide to hospitals the same detail in relation to public patients in a claim form as you provide for claim purposes in respect of private patients? Is that your position?
A. I do not quite understand about what I am required to supply in my private patients. I do not provide any information to the hospital about my private patients.

Q. For claim purposes in respect of your private patients you provide the name and the nature of the service to --?
A. My secretary who then generates an account.

Q. OK. Well, I am asking you whether you are opposed to having your secretary take the same step --?
A. And further subsidise the public system?

Q. -- in relation to public patients, the same information?
A. Would I be paid by the public hospital for doing this work? I mean, it is time-consuming work. That is my objection. It is the time consumption required. I have no objection to providing the information; but I do object to the time it will take to provide the information in a way that will be acceptable to the authorities. If they were to accept a print out of the raw data which they may find difficult to interpret I would have no difficulty with that.

Q. So, it is your position --?
A. I have a difficulty in spending more time than I am at present in filling out claim forms.

Q. And so the upshot of that is that you are opposed to the Minister's claim insofar as it may require you in submitting a claim form for public patients to provide the name and the nature of the service. Is that your position?
A. My position, I think, if I can paraphrase what you are saying --

Q. Yes?
A. -- is I do not object to being required to provide the information; but I do object to the time that it is going to take me to do it and the opportunity for mistake, because as the forms become more complex the opportunities for error are going to go muptiply. I think it is also reasonable to say that it will not absolve the hospital administration of the requirement to audit me and, in fact, it would increase their requirement to audit me because of the greater potential for error, inadvertant error, in completing these forms. Sometimes the error would be in my favour; sometimes it would be in their favour.

Barry John Springthorpe, a paediatrician VMO with appointments at Royal Newcastle Hospital, John Hunter Hospital, Belmont Hospital and Newcastle Mater Miseracordiae Hospital, gave the following evidence:

Q. You keep good and adequate records?
A. I do. I keep excellent records.

Q. Indeed, we see from your statement you actually identify the nature of service and the particular patient for the purpose of the claim forms in respect of public patients?
A. When I do a round of the hospital every day I dictate the round so I can go back six years hence and say I saw that patient at that particular time and what exactly the circumstances were.

Q. It follows from the way you keep your records you would be well and truly able to keep abreast of the amount of time you are spending in relation to public and private patients?
A. I have analysed it for the purpose of this exercise.

Q. You are required to submit claim forms in respect of private patients, setting out the nature of service and name of patient?
A. That's right.

Q. You follow the same course, although the form is different, in relation to your public patients, the name and nature of the service?
A. Yes, certainly.

Q. So you are able to maintain on an ongoing basis records which allow you to have an understanding of how much work you are doing for your public as opposed to your private patients?
A. It is not a major occupation of mine, but that is extractable from the records, yes.

There was a body of evidence too that a number of VMOs provide already, and without difficulty, the type of information sought by the Minister to be kept in records - see the evidence of Dr. Howsam, Dr. Springthorpe, Dr. Barnett, Dr. Hislop, Dr. King, Dr. Renshaw, Dr. Harris, Dr. Beatty, Dr. Oldfield and Dr. Kidson. But, of course, the qualification should be added of resistance to maintaining the record as sought by the Minister because of the additional time involved.

The evidence in support of the Minister's claim is, in my view, most persuasive. This aspect of the Minister's total case was directed very much to structural efficiency considerations and to providing knowledge in hospital administration for the better management and utilisation of VMOs' services. There is also the need for the maintenance of an adequate record for audit purposes. I think the Minister's claim is, therefore, reasonable and the determination will contain an appropriate

provision to that effect. The present determination requires a VMO to submit the records to the hospital each month by no later than the fifteenth day of the succeeding month, and I consider that provision should continue rather than adopting the Minister's proposal for submission of the records by the twenty-eighth day of the succeeding calendar month.

The AMA's claim for payment by the hospital or area health service of a VMO's account by the end of the month in which it is submitted is, it seems to me, too strict, and I think the position will be met by the determination providing that the record when submitted shall be accompanied by an account for payment on a thirty-day basis. Such a provision would not be inconsistent with usual commercial practice.

The AMA's claim for payment to a VMO to be accompanied by written notification of how the payment is made up seems to me to be quite reasonable as corresponding with the particulars maintained by the VMO on the record form. The determination will provide accordingly.

The remaining issue concerns the consequences of non-compliance by a VMO in submitting the record showing the required particulars by the due date. The sanction proposed by the Minister is that the hospital or area health service shall not be obliged to pay the VMO for the services rendered unless special and extraordinary circumstances are shown explaining such non-compliance. I have concluded that such a result is unfair on the VMO who, after all, has rendered services giving rise to a right to payment; a failure to comply with the determination for the lodgment of a claim for payment by a particular date does not, in my view, justify the loss of the right to payment nor should it require the VMO to make out special and extraordinary circumstances to obtain payment. The adequate sanction for the late submission by a VMO of a record and claim for payment would be the consequent delay in him receiving

payment from the hospital or area health service; where a VMO persistently submits a record and account for payment outside the time provided then that would be a clear breach of the sessional contract with the sanction which such persistent breaches might attract. I do not propose to make a determination in terms of the Minister's claim for non-compliance.

Confidentiality

The following clause was claimed by the AMA for inclusion in the determination regarding the publication of actual remuneration paid or payable to a VMO:

> 18. CONFIDENTIALITY
>
> The principal shall not publish or permit or enable to be published or made available for publication details of the actual remuneration paid or payable to the V.M.O. under the sessional contract unless:-
>
> (i) in the ordinary course of the principals operations to other persons and entities within the public hospital system including the Department of Health; or
>
> (ii) the V.M.O. first provides written consent to such publication; or
>
> (iii) such publication is required under compulsion of law.

In support of that claim, Mr. *Sperling* made the following submission:

> The last of the clauses requiring mention is cl 18, "Confidentiality," which provides for a prohibition against publication of details of actual remuneration - and then we have introduced provisos which we believe are adequate - publication within the public hospital system, including the department, in the ordinary course of operations is exempted, so too, with the consent of the visiting medical officer, and so too if required under compulsion of law.
>
> In support of this clause I would remind your Honour of the terms of Ex 172 and I hand up a copy. The first letter, dated 14 April, simply designates the topic out of which this matter arises. It is of no detailed relevance.

> On 15 May the head of the Department of Medicine at Auburn District Hospital wrote to the Administration of the Western Sydney Area Health Service complaining of the release of specific figures of incomes of positions with their names and without their consent, in particular, a publication of that material to members of a particular committee, stating that this was an unwarranted and serious breach of confidentiality.
>
> The reply, dated 2 June 1991, and written by the administrator to Dr Horvath, acknowledges receipt of the letter and then goes on to say, "The concerns raised in your letter ... acknowledged." He extends an apology for the publication and distribution. He says, "It was clearly not intended ... will occur again," and he further apologizes for what has occurred.
>
> Your Honour will recognize from that material that the matter is one of some sensitivity and further that your Honour would, we suggest, appreciate that people in independent practice do not expect that particulars of income will be made public.
>
> In recognition of that context, we would ask your Honour to promulgate this clause recognizing that the qualifications within the clause are sufficient to enable such publication as is necessary for the purpose of the operation of the public hospital system. We do say that a clause in those terms is consistent with practicality and it will contribute to harmony, without imposing any restriction. That is a practical downside.

The incident referred to by Mr. *Sperling* was isolated and there was no other evidence of any difficulties concerning the publication of VMOs' earnings from the public hospital system. A confidentiality provision has never been included in previous determinations, no doubt because it has not been an issue. Apparently there is an understanding between the parties that details of incomes earned by VMOs in the public hospital system will not be published with the name of the VMO concerned without his consent. Indeed, in the incident in question, the Deputy Chief Executive Officer of the Western Sydney Area Health Service apologised for the disclosure, albeit it was to an internal committee concerned with the cost of VMO payments for cardiology and cardiothoracic services. Mr. *Kenzie*, in resisting the AMA's claim, submitted the evidence did not demonstrate any need for a confidentiality clause, but, in any event, such a clause should not be included in terms of principle. Senior counsel emphasised that payments made to VMOs were from the public purse and

submitted it was generally accepted for amounts earned by public office holders to be available for public scrutiny; public confidence requires there to be no fetter on the ability to disclose matters related to the expenditure of public funds. Senior counsel added:

> Whilst it is true that financial information in some contracts of a commercial nature which the Government enters into with the private sector is kept confidential this is because of the commercial sensitivity of the particular information. The AMA has not submitted that the earnings of VMOs are in any way commercially sensitive, and indeed it is the Minister's view that such a submission could not be made out, bearing in mind that a standard rate for all VMOs under sessional contracts is fixed by a determination such as the one that will result from this Arbitration.
>
> Currently it is not a requirement that the earnings of VMOs be published in the Annual Reports of the respective hospitals or Area Health Services. Details of all consultants engaged during the year by each hospital or Area Health Service exceeding $30,000 in costs are required by the Department to be included in the Annual Report of the relevant hospital or Area. However VMOs have not been included within the term "consultant" for the purpose of the Annual Reports. As a result VMO earnings are not, as a matter of practice, published or otherwise generally made available to the public.

Having in mind the fixation by determination of rates of remuneration for VMOs under sessional contracts, it seems strange to me a confidentiality provision would be sought to prohibit the public disclosure of details of sessional payments to VMOs being payments made from the public purse. I do not share the sensitivity of VMOs in this respect. In addition, of course, other staff in the public hospital system have rates fixed by industrial awards so that their earnings are readily known. It was never explained to me why VMOs should be treated any differently as the holders of a public appointment; in a sense, VMOs are already advantaged compared to consultants whose earnings in excess of $30,000 are required to be included in the annual report of the relevant hospital or area health service.

Whilst I respect the present practice of keeping payments to VMOs in confidence, I am not prepared to recognise the practice in any way by a

provision in the determination. I consider a provision prohibiting disclosure of payments made to VMOs as being contrary to public policy. The claim is refused.

Suspension and termination of sessional contract

The existing determination provides for the suspension and termination of a sessional contract in cl.12, Duration of Sessional Contract. As to suspension, the hospital may suspend a VMO if it considers it necessary in the interest of the hospital by forthwith giving written notice of the reasons therefor and an opportunity for the VMO to present his case to the hospital. Apart from expiration of the sessional contract at the end of its period of duration, the determination provides for termination if the VMO ceases to be registered as a medical practitioner, on three months' notice given either by the hospital or the VMO, if the VMO becomes permanently mentally or physically incapable of performing his duties or if the VMO is dismissed in accordance with the provisions of the clause. Dismissal of a VMO may not occur unless he is first suspended or where the hospital considers the VMO to be guilty or serious and wilful misconduct after being given an opportunity to present his case to the hospital. In the event a VMO is suspended or dismissed, but there is no right of appeal under the *Public Hospitals Act*, then the VMO is entitled to lodge an appeal in relation to the suspension or dismissal or be dealt with in accordance with cl.13, Disputes which enables a committee to be convened or a legally qualified person appointed to deal with the issue. Nothing in the clause precludes a VMO from exercising any right of appeal available under the *Public Hospitals Act*; that reservation no doubt recognises the ability of a VMO who is suspended or terminated to appeal to the Minister against a suspension or termination and thereupon have a committee appointed to determine the appeal and to make such order as thought proper.

I did not perceive the parties to be wide apart on the issue of suspension and termination of a sessional contract, but some issues arose requiring resolution.

Suspension: Mr. *Sperling*, adopting the approach of simplicity and brevity where nice points will likely be taken if a VMO were to be suspended or terminated, outlined the AMA's claim as providing for *ad hoc* suspension in the event of a need for that arising. Suspension of a sessional contract by a hospital or an area health service to be permitted, subject to Pt.6B of the *Public Hospitals Act*, if the hospital or area health service considered a VMO may be guilty of serious and wilful misconduct or may be mentally or physically incapable of carrying out duties under the contract; notice of suspension to be in writing and the reasons given in writing within seven days. The suspended VMO to be given an opportunity to be heard by the hospital or area health service concerned, which, if satisfied the contract should be terminated, could then do so. A VMO dissatisfied with a suspension could initiate a dispute to be settled in accordance with the disputes procedure clause.

The Ministers' claim was based on the premise that the determination should bestow a right in a hospital or an area health service to suspend a VMO, being a right which was, although not expressly granted, assumed by the *Public Hospitals Act*, Pt.6B in granting a VMO the right of appeal to the Minister against the suspension of his appointment by a hospital board or an area health board. The existing determination grants a right of suspension, but not limited, as the AMA's claim intends, to serious and wilful misconduct or mental or physical incapacity. Further, and although the existing determination was in like terms, the AMA's claim for a hospital or an area health service to notify a suspended VMO in writing of its reasons and give an opportunity to be heard was resisted because Pt.6B itself required a board to give notice in

writing to a suspended VMO of its decision within seven days of the date of that decision; a VMO may then request the board, in writing, to notify the reasons for the suspension within fourteen days: s.33H(1). On an appeal against suspension, a VMO has a right to be heard: s.33M.

I am of the view, consistent with the existing determination, that a sessional contract should itself contain the clear right to suspension of the appointment of a VMO if such suspension is necessary in the interest of the hospital concerned, but subject to Pt.6B of *Public Hospitals Act* and to any applicable by-laws made by a hospital board or an area health board. That will directly bring into operation the provisions of s.33H as to the notice of a suspension to be in writing together with the reasons for it. The suspended VMO will have a full opportunity to be heard under s.33M on an appeal against suspension. I accept that the grounds for suspension contained in the AMA's claim as limited to serious and wilful misconduct and mental or physical incapacity would comprehend the usual reasons for suspension, but I accept also the Minister's position that a suspension may well be justified where the behaviour or competence of a VMO may not be in question but rather the need arises because of, for instance, the destruction of part of the hospital's facility thereby preventing the VMO from undertaking sessional work; the Minister's formulation of the ground for a suspension as being in the interest of the hospital concerned is therefore reasonable.

The determination will provide in terms of the Minister's claim, with the addition that suspension will be subject to Pt.6B of the *Public Hospitals Act*.

Termination: It is common ground there should be a mutual right to terminate a sessional contract on three months' notice in writing during its term and without cause, and it is agreed a sessional contract should terminate on a VMO ceasing to be registered as a medical practitioner. I

have dealt earlier with a sessional contract expiring at the end of its specified duration and with no entitlement for a further sessional contract to be made on such expiry of the existing contract. The determination will so provide.

The issues between the parties related to -

- The Minister's claim for a sessional contract to be terminated if a VMO becomes mentally or physically incapable of rendering services under the contract; the AMA's claim that termination may be effected by a hospital or area health service if a VMO becomes *permanently* mentally or physically incapable of so rendering services;
- The Minister's claim that termination should occur in the event of serious misconduct or other substantial breach, or repetitive breaches of the contract by the VMO; the AMA's claim that termination may occur where a VMO, having been given an opportunity to be heard after being suspended, has been found to the satisfaction of the hospital or area health service to be guilty of serious or wilful misconduct or is mentally or physically incapable of carrying out duties; and
- The Minister's claim that a sessional contract shall be terminated if the VMO's appointment is terminated by operation of any Act or regulation.

Having in mind my earlier conclusion that a sessional contract may be suspended by a hospital or an area health service in the interest of the hospital concerned, it seems to me if a VMO becomes mentally or physically incapable of rendering services then suspension, rather than termination, of a contract is the appropriate remedy until the VMO is able either to properly renew the rendering of services or is adjudged to be *permanently* incapable of doing so. It is only if and when the state of

"permanence" occurs that, in my view, termination becomes the appropriate remedy. The determination will so recognise the distinction.

Where a hospital or an area health service considers a VMO to be guilty of serious misconduct or other substantial breach, or repetitive breaches of the sessional contract, then, on its face, termination would seem to be justified. However, I am mindful of Mr. *Sperling's* submission that an element such as "repetitive breaches" would provide "a feast for lawyers". I have therefore hesitated in making a determination in such terms in lieu of what is the undoubted conduct, according to the authorities, justifying summary dismissal as being where the employee concerned has wilfully failed to obey the lawful and reasonable orders of the employer in such a way as to amount to an intention by the employee no longer to be bound by an essential condition of the contract of employment: see *Clouston & Co. Limited v. Corry* ([1906] A.C.122 at 129); *Laws v. London Chronicle (Indicator Newspapers) Limited* ([1959] 1 W.L.R. 698 at 700,701); *Jupiter General Insurance Co. Limited v. Ardeshir Bomanji Shroff* ([1937] 3 All E.R. 67 at 73,74); *Hackshall's Limited v. McDowell* ([1930] A.R.(N.S.W.) 620 at 629); *Adami v. Maison de Luxe Limited* ((1924) 35 C.L.R. 143 at 152-154); R. v. *The Darling Island Stevedoring and Lighterage Company Limited; ex parte Halliday and Sullivan* ((1938) 60 C.L.R. 601 at 621,622); *Lister v. Romford Ice and Cold Storage Co. Limited* ([1957] A.C. 555); *Australian Telecommunications Commission v. Hart* ([1982] 65 F.L.R. 41 at 47); and *In re Dispute - Dismissal of Union Delegates at Homebush Abbatoir* ([1966] A.R.(N.S.W.) 371 at 373,374). In that last-mentioned case, *Cook* J. summarised the law relating to acts of misconduct justifying instant dismissal by reference to various authorities, and concluded (*ibid* at 374):

> ... the question of whether the conduct of an employee amounts to misconduct justifying instant dismissal would generally depend

> upon whether or not the act complained of can properly be regarded as deliberate or wilful or of such a nature as to strike at an essential element in the contract of service, namely, obedience to the lawful commands of the employer and the right of the employer to enforce discipline.

The issue as to whether termination of a sessional contract should be according to "serious misconduct or other substantial breach, or other repetitive breaches of the contract" by the VMO, on the Minister's approach, or according to "serious and wilful misconduct", on the AMA's approach, should be resolved by avoiding problems of construction in the future by following what I understand to be the established approach for the termination of a contract of service; a contract for services being for the provision of work, in my view, should be similarly viewed. The determination will therefore provide for termination of a sessional contract in the event of the serious and wilful misconduct of a VMO.

The Minister's claim for termination of a sessional contract by the operation of any Act or regulation was not directly addressed by either the Minister or the AMA, other than Mr. *Kenzie* submitting that the proposed clause was "a suitable scheme and covers all appropriate contingencies". I was not directed to any Act or regulation which presently provided for a VMO's appointment under a sessional contract to be terminated and I rather suspect the claim was directed to possible legislation such as the closure of public hospitals and the re-location of health services and facilities from one public hospital to another. If a statute were to terminate a VMO's appointment then, it seems to me, the appointment would be terminated by force of the statute concerned and that would be a matter for the legislature. However, a difficulty may well arise if the determination did not contain such a facility for termination by reason of the *Public Hospitals Act*, s.29T and the *Area Health Services Act*, s.33 which give precedence to the provisions of a service contract, and hence a determination as to a sessional contract, over a provision of those Acts or

of a regulation or by-law made thereunder. So, if the determination were to permit termination of a sessional contract in certain specified circumstances only but not so as to comprehend those covered under an Act or regulation then, in my view, a conflict may well arise thereby frustrating the legislative intent. I think that to be undesirable. Of course, the legislature could meet the position by appropriate provision, but I do not think, on the arguments before me and the lack of active resistance by the AMA, the Minister's claim to be unreasonable. I will grant it.

Finally on this aspect, the Minister sought a provision that on termination of a sessional contract any amount due and payable to a VMO shall be paid at the time of such termination or as soon thereafter as reasonably practicable. That was not, of course, challenged by the AMA and I will include it in the determination.

As to both suspension and termination of a sessional contract, the AMA sought a provision that if the VMO concerned was dissatisfied with the decision of the hospital or area health service then that would constitute a dispute for the purposes of the dispute procedure clause. The Minister opposed that claim on the basis it was unnecessary in light of Pt.6B of the *Public Hospitals Act* which provided the foundation for the express exclusion from the dispute procedure clause proposed by both the AMA and the Minister of matters which could be dealt with under Pt.6B, namely the appointment, re-appointment, suspension or termination of appointment of a VMO as a visiting practitioner. There was, therefore, an internal inconsistency in the AMA's claim as between a challenged suspension or termination being dealt with as a dispute or pursuant to Pt.6B. I agree with the Minister's submission of apparent inconsistency, and, in the circumstances of the claims, I would conclude that disputes as to matters comprehended within Pt.6B should be dealt with thereunder

and not by a separate dispute procedure. The AMA's claim in that respect is declined.

Dispute settlement procedure

The existing determination in cl.13, Disputes contains a mechanism where parties to a sessional contract are unable to resolve any matter arising under that contract or in respect of its interpretation to have the issue settled by reference to a committee or to a legally qualified person for determination. The clause came under scrutiny by *Hodgson* J. in *Hyslop v. Liverpool Hospital* ([1987] 22 I.R. 52) where it was sought to be relied upon by the defendant in support of a stay of proceedings, in which the plaintiff sought orders from the Supreme Court in relation to the interpretation of the 1985 determination concerning the on-call allowance, until the dispute was dealt with in accordance with the dispute clause. In declining a stay, his Honour referred to the problems in implementing the procedure of cl.13 in the following way (*ibid* at 56):

> Under par (1) of cl 13 the reference was to a committee of two or four persons on which the association and corporation, that is, the second plaintiff and the second defendant, are equally represented. It makes no provision for the circumstance where one of those bodies nominates only one person to go on such a committee and the other body nominates two persons to go on a committee; in other words there is no procedure for resolving any dispute between those two bodies as to whether the committee should be of two or four persons. Further, there is no provision in cl 13 as to the procedure of the committee, the remuneration of the members of the committee, the way any evidence before the committees is to be adduced.
>
> Then there is some provision for resolution of the matter in par (iii) of cl 13 if a recommendation is not made within one month after referral. However, that provision does not provide for the procedure to be adopted by the persons to whom the matter may then be referred. It does not, for example, indicate whether their role is to review what has happened or embark on the matter de novo. The procedure allowed by (iii) is only one which *may* be adopted. A resolution under (iii) would require either agreement by the director of the Corporation and the president of the Association as to the dispute itself or as to the selection of a legally qualified person. There is no provision to deal with deadlock in either situation.

> Indeed in matters where, as in the present case, there is a dispute between the Association and the Corporation cl 13 would appear to be such that deadlock would be inevitable until the stage of reference to a legally qualified person referred to in par (iii)(b) is reached; and then deadlock would continue unless and until there can be agreement as to the legally qualified person to be selected.

A further difficulty with cl.13 was that it enabled two strangers to a sessional contract, namely the AMA and the Health Administration Corporation, rather than the parties themselves, namely the VMO and the hospital concerned, to refer a dispute to arbitration. In the result, his Honour held (*ibid* at 55,56) that cl.13 did not amount to an arbitration agreement within the meaning of s.53 of the *Commercial Arbitration Act* 1984 as being the provision dealing with the power of the Court to stay proceedings: see *Bacon v. Sunderland Corporation* ([1966] 2 Q.B. 56). The parties in the present proceedings have attended to those impediments and jointly proposed a dispute settlement clause, which, in my opinion of it, overcomes the identified difficulties.

However, three issues in the claimed disputes clause are not agreed and require resolution, that is -

(i) whether a *Scott v. Avery* clause should be included, as proposed by the Minister, to prevent the commencement of any proceedings at law or in equity in respect of any matter or thing of whatsoever nature arising under a sessional contract or in connection therewith unless and until an award has been made by an arbitrator;

(ii) whether a similar prohibition should be included, as proposed by the Minister, in the event the matter in dispute or difference relates to the appointment, re-appointment, suspension or termination of appointment of a VMO unless and until there has been a determination of an appeal pursuant to Pt.6B - Appeals of the *Public Hospitals Act* in

relation to such appointment, re-appointment, suspension or termination of appointment; and

(iii) whether the AMA, as sought by it, should be notified of a dispute arising between a VMO and the hospital or area health service concerned, together with a right in the AMA to appear before the arbitrator.

Scott v. Avery clause: The AMA submitted the inclusion of a *Scott v. Avery* provision was outside my jurisdiction as Arbitrator to make a determination because such a provision was not in itself a term and condition of work within the meaning of s.29M(1) of the *Public Hospitals Act*. If it were a term and condition of work it would, by the operation of s.29R of the *Public Hospitals Act*, become part of an arbitration agreement in the sessional contract so as to be rendered void by s.55 of the *Commercial Arbitration Act*; the power conferred by s.29M(1) would not enable the making of a term and condition of work that would be void. The submissions for the Minister asserted power under s.29M(1) to include a dispute resolution clause with a *Scott v. Avery* provision as a term and condition of work; s.55 of the *Commercial Arbitration Act* did not operate to dilute or otherwise derogate from s.29R of the *Public Hospitals Act* because the former section was a later general enactment which did not impliedly repeal the earlier specific provision : *Blackpool Corporation v. Starr Estate Co. Limited* ([1972] 1 A.C. 27 at 34). The maxim *generalia specialibus non derogant* operated to save the Minister's claim. In answer for the AMA, it was submitted the said maxim was the wrong test to apply as the *Public Hospitals Act* did not make specific provision in relation to the prescription of an arbitration clause but rather made general provision for the determination of terms and conditions of work in sessional contracts which might or might not prescribe an arbitration clause.

A general submission was put also for the Minister that the *Commercial Arbitration Act*, and specifically s.55 thereof, did not affect an arbitration conducted under Pt.5C of the *Public Hospitals Act* which constituted a comprehensive scheme for the determination of terms and conditions of work for VMOs under sessional contracts and was more in the nature of an industrial arbitration than a commercial arbitration; the arbitrator's determination, like an industrial award, was a form of delegated legislation by the operation of s.29R of the *Public Hospitals Act* whereas arbitration proceedings under the *Commercial Arbitration Act* relied in large part on the provisions of an arbitration agreement itself. The comprehensive nature of Pt.5C was said for the AMA not to be the true test in determining the validity of a *Scott v. Avery* clause, but even if it were the correct test it was not a comprehensive scheme because a determination may not include an arbitration clause; parties to sessional contracts were themselves able to include arbitration clauses in individual contracts which would operate in accordance with their terms in the absence of a determination under s.29M(1), and a standard sessional contract might well come into operation pursuant to s.29RB of the *Public Hospitals Act*. It was put for the AMA that the intention of the parliament when enacting s.55 of the *Commercial Arbitration Act* that it would strike down a *Scott v. Avery* clause in a privately agreed sessional contract but would not strike down such a clause determined under s.29M(1) by arbitration could not be the position.

I have no doubt that the dispute settlement clause as claimed is a term and condition of work within the meaning of s.29M(1) so as to enable a determination to be made in respect of it: see *Booth* (*supra* at 263) and *Westwood v. Lightly* ((1984) 53 A.L.R. 673 at 684). I include in that finding the Minister's claim for a *Scott v. Avery* provision as being part of a procedure for dispute resolution in a determination otherwise within

and not by a separate dispute procedure. The AMA's claim in that respect is declined.

Dispute settlement procedure

The existing determination in cl.13, Disputes contains a mechanism where parties to a sessional contract are unable to resolve any matter arising under that contract or in respect of its interpretation to have the issue settled by reference to a committee or to a legally qualified person for determination. The clause came under scrutiny by *Hodgson* J. in *Hyslop v. Liverpool Hospital* ([1987] 22 I.R. 52) where it was sought to be relied upon by the defendant in support of a stay of proceedings, in which the plaintiff sought orders from the Supreme Court in relation to the interpretation of the 1985 determination concerning the on-call allowance, until the dispute was dealt with in accordance with the dispute clause. In declining a stay, his Honour referred to the problems in implementing the procedure of cl.13 in the following way (*ibid* at 56):

> Under par (1) of cl 13 the reference was to a committee of two or four persons on which the association and corporation, that is, the second plaintiff and the second defendant, are equally represented. It makes no provision for the circumstance where one of those bodies nominates only one person to go on such a committee and the other body nominates two persons to go on a committee; in other words there is no procedure for resolving any dispute between those two bodies as to whether the committee should be of two or four persons. Further, there is no provision in cl 13 as to the procedure of the committee, the remuneration of the members of the committee, the way any evidence before the committees is to be adduced.
>
> Then there is some provision for resolution of the matter in par (iii) of cl 13 if a recommendation is not made within one month after referral. However, that provision does not provide for the procedure to be adopted by the persons to whom the matter may then be referred. It does not, for example, indicate whether their role is to review what has happened or embark on the matter de novo. The procedure allowed by (iii) is only one which *may* be adopted. A resolution under (iii) would require either agreement by the director of the Corporation and the president of the Association as to the dispute itself or as to the selection of a legally qualified person. There is no provision to deal with deadlock in either situation.

> Indeed in matters where, as in the present case, there is a dispute between the Association and the Corporation cl 13 would appear to be such that deadlock would be inevitable until the stage of reference to a legally qualified person referred to in par (iii)(b) is reached; and then deadlock would continue unless and until there can be agreement as to the legally qualified person to be selected.

A further difficulty with cl.13 was that it enabled two strangers to a sessional contract, namely the AMA and the Health Administration Corporation, rather than the parties themselves, namely the VMO and the hospital concerned, to refer a dispute to arbitration. In the result, his Honour held (*ibid* at 55,56) that cl.13 did not amount to an arbitration agreement within the meaning of s.53 of the *Commercial Arbitration Act* 1984 as being the provision dealing with the power of the Court to stay proceedings: see *Bacon v. Sunderland Corporation* ([1966] 2 Q.B. 56). The parties in the present proceedings have attended to those impediments and jointly proposed a dispute settlement clause, which, in my opinion of it, overcomes the identified difficulties.

However, three issues in the claimed disputes clause are not agreed and require resolution, that is -

(i) whether a *Scott v. Avery* clause should be included, as proposed by the Minister, to prevent the commencement of any proceedings at law or in equity in respect of any matter or thing of whatsoever nature arising under a sessional contract or in connection therewith unless and until an award has been made by an arbitrator;

(ii) whether a similar prohibition should be included, as proposed by the Minister, in the event the matter in dispute or difference relates to the appointment, re-appointment, suspension or termination of appointment of a VMO unless and until there has been a determination of an appeal pursuant to Pt.6B - Appeals of the *Public Hospitals Act* in

relation to such appointment, re-appointment, suspension or termination of appointment; and

(iii) whether the AMA, as sought by it, should be notified of a dispute arising between a VMO and the hospital or area health service concerned, together with a right in the AMA to appear before the arbitrator.

Scott v. Avery clause: The AMA submitted the inclusion of a *Scott v. Avery* provision was outside my jurisdiction as Arbitrator to make a determination because such a provision was not in itself a term and condition of work within the meaning of s.29M(1) of the *Public Hospitals Act*. If it were a term and condition of work it would, by the operation of s.29R of the *Public Hospitals Act*, become part of an arbitration agreement in the sessional contract so as to be rendered void by s.55 of the *Commercial Arbitration Act*; the power conferred by s.29M(1) would not enable the making of a term and condition of work that would be void. The submissions for the Minister asserted power under s.29M(1) to include a dispute resolution clause with a *Scott v. Avery* provision as a term and condition of work; s.55 of the *Commercial Arbitration Act* did not operate to dilute or otherwise derogate from s.29R of the *Public Hospitals Act* because the former section was a later general enactment which did not impliedly repeal the earlier specific provision : *Blackpool Corporation v. Starr Estate Co. Limited* ([1972] 1 A.C. 27 at 34). The maxim *generalia specialibus non derogant* operated to save the Minister's claim. In answer for the AMA, it was submitted the said maxim was the wrong test to apply as the *Public Hospitals Act* did not make specific provision in relation to the prescription of an arbitration clause but rather made general provision for the determination of terms and conditions of work in sessional contracts which might or might not prescribe an arbitration clause.

A general submission was put also for the Minister that the *Commercial Arbitration Act*, and specifically s.55 thereof, did not affect an arbitration conducted under Pt.5C of the *Public Hospitals Act* which constituted a comprehensive scheme for the determination of terms and conditions of work for VMOs under sessional contracts and was more in the nature of an industrial arbitration than a commercial arbitration; the arbitrator's determination, like an industrial award, was a form of delegated legislation by the operation of s.29R of the *Public Hospitals Act* whereas arbitration proceedings under the *Commercial Arbitration Act* relied in large part on the provisions of an arbitration agreement itself. The comprehensive nature of Pt.5C was said for the AMA not to be the true test in determining the validity of a *Scott v. Avery* clause, but even if it were the correct test it was not a comprehensive scheme because a determination may not include an arbitration clause; parties to sessional contracts were themselves able to include arbitration clauses in individual contracts which would operate in accordance with their terms in the absence of a determination under s.29M(1), and a standard sessional contract might well come into operation pursuant to s.29RB of the *Public Hospitals Act*. It was put for the AMA that the intention of the parliament when enacting s.55 of the *Commercial Arbitration Act* that it would strike down a *Scott v. Avery* clause in a privately agreed sessional contract but would not strike down such a clause determined under s.29M(1) by arbitration could not be the position.

I have no doubt that the dispute settlement clause as claimed is a term and condition of work within the meaning of s.29M(1) so as to enable a determination to be made in respect of it: see *Booth* (*supra* at 263) and *Westwood v. Lightly* ((1984) 53 A.L.R. 673 at 684). I include in that finding the Minister's claim for a *Scott v. Avery* provision as being part of a procedure for dispute resolution in a determination otherwise within

power as a term and condition of work; although not finally deciding, *Hodgson* J. in *Hyslop* (*supra* at 54) was inclined "to the view that a procedure for dispute resolution can be regarded as a term and condition of work and therefore ... within the jurisdiction of the arbitrator within s.29M." I find nothing to support the AMA's proposition that a *Scott v. Avery* provision as part of dispute resolution could not itself be a term and condition of work. The Minister's claim is, in my view, therefore within power.

The question then arises whether there is anything in the *Commercial Arbitration Act*, if it be applicable, to otherwise affect the exercise of that power by defeating it or, as a matter of discretion, warranting its exclusion. Mr. *Kenzie's* proposition as to the comprehensive nature of the scheme provided by Pt.5C of the *Public Hospitals Act* and the nature of the arbitration thereunder as being more in the nature of an industrial arbitration than a commercial arbitration, so as to render s.55 of the *Commercial Arbitration Act* ineffective, has much to commend it. A perusal of the terms of Pt.5C evinces, in my view, a clear statutory intent that it and it alone shall be the means by which the terms and conditions of work for VMOs shall be determined; and that is so even if the parties to the proceedings reach an agreement and which agreement may or may not be accepted by the arbitrator as being appropriate. As an arbitration concerned with terms and conditions of work, it reasonably follows that such an arbitration is akin to an industrial arbitration and a determination akin to an industrial award. Although Mr. *Kenzie's* general proposition is therefore made out, I think a distinction must be drawn between the dispute settlement procedure so determined and a provision within that procedure in the form of an arbitration agreement. In other words, it seems to me, and although as Arbitrator I may make a determination as to the terms and conditions of

work for VMOs under sessional contracts, that is the end of my function as Arbitrator; if a clause be inserted establishing a procedure for the resolution of any dispute or difference arising under a sessional contract then that is a separate matter in its actual operation to be dealt with otherwise according to law. Such a law is the *Commercial Arbitration Act*, as is the general common law in the resolution of a dispute between the parties to a sessional contract for, say, breach of contract. And, I would apprehend, in making a determination as to the terms and conditions of work for VMOs I would be necessarily limited by law from including certain provisions such as matters contrary to public policy or illegal. The *Commercial Arbitration Act*, therefore, requires consideration as to its impact on the *Scott v. Avery* clause as claimed by the Minister.

The *Commercial Arbitration Act* from its long title is "(a)n Act to make provision with respect to the arbitration of certain disputes ... and for other purposes". An "arbitration agreement" is defined by that Act as meaning "an agreement in writing to refer present or future disputes to arbitration": s.4(1). The Act applies "to an arbitration agreement (whether made before or after the commencement of this Act) and to an arbitration under such an agreement": s.3(2). Importantly, s.3(4) provides:

> (4)Subject to this section, this Act shall apply to arbitrations provided for in any other Act as if:
>
> (a)the Act were an arbitration agreement;
>
> (b)the arbitration were pursuant to an arbitration agreement; and
>
> (c)the parties to the dispute which, by virtue of the other Act, is referred to arbitration were the parties to the arbitration agreement,
>
> except in so far as the other Act otherwise indicates or requires.

Relevantly, the Act in ss.53 and 55 provides:

Power to stay court proceedings

53.(1)If a party to an arbitration agreement commences proceedings in a court against another party to the arbitration agreement in respect of a matter agreed to be referred to arbitration by the agreement, that other party may, subject to subsection (2), apply to that court to stay the proceedings, and that court, if satisfied:

(a)that there is no sufficient reason why the matter should not be referred to arbitration in accordance with the agreement; and

(b)that the applicant was at the time when the proceedings were commenced and still remains ready and willing to do all things necessary for the proper conduct of the arbitration,

may make an order staying the proceedings and may further give such directions with respect to the future conduct of the arbitration as it thinks fit.

(2)An application under subsection (1) shall not, except with the leave of the court in which the proceedings have been commenced, be made after the applicant has delivered pleadings or taken any other step in the proceedings other than the entry of an appearance.

(3)Notwithstanding any rule of law to the contrary, a party to an arbitration agreement shall not be entitled to recover damages in any court from another party to the agreement by reason that that other part takes proceedings in a court in respect of the matter agreed to be referred to arbitration by the arbitration agreement.

Effect of Scott v. Avery clauses

55.(1)Where it is provided (whether in an arbitration agreement or some other agreement, whether oral or written) that arbitration or an award pursuant to arbitration proceedings or the happening of some other event in or in relation to arbitration is a condition precedent to the bringing or maintenance of legal proceedings in respect of a matter or the establishing of a defence to legal proceedings brought in respect of a matter, that provision, notwithstanding that the condition contained in it has not been satisfied:

(a)shall not operate to prevent:

(i)legal proceedings being brought or maintained in respect of that matter; or

(ii)a defence being established to legal proceedings brought in respect of that matter; and

(b)shall, where no arbitration agreement relating to that matter is subsisting between the parties to the provision, be construed as an agreement to refer that matter to arbitration.

(2)Subsection (1) does not apply to an arbitration agreement unless all the parties to the agreement are domiciled or ordinarily resident in Australia at the time the arbitration agreement is entered into.

(3)Subsection (2) does not apply to an arbitration agreement that is treated as an arbitration agreement for the purposes of this Act by virtue only of the operation of section 3(4)(a).

The arbitration mechanism contained in Pt.5C of the *Public Hospitals Act*, in my view, and by reason of its nature as referred to above, would not be an arbitration covered by the *Commercial Arbitration Act*, s.3(4) because the *Public Hospitals Act*, again as I have found above, comprehensively deals with the determination of terms and condition of work for VMOs under sessional contracts so as to indicate or require the exclusion of the *Commercial Arbitration Act* from that procedure. I mention in addition, to support that finding, the provisions of the *Public Hospitals Act* as being inconsistent with or contrary to the *Commercial Arbitration Act*, namely Manner of exercise of arbitrator's functions (s.29N), Rights of appearance, administration of oaths, legal representation (s.29O), Conduct of proceedings and protection of arbitrator (s.29P), Notification of determination and finality thereof (s.29Q) and Appeals (s.29QA). However, and also as I indicated above, even though the arbitration I conduct under Pt.5C is not caught by the *Commercial Arbitration Act*, it seems to me by virtue of s.3(2) of that Act that it catches an arbitration agreement which I might make under s.29M(1) and which, by virtue of s.29R, is deemed to vary a sessional contract to include the terms of that arbitration agreement. Therefore, in my view, the dispute settlement clause proposed here by the parties is an arbitration agreement to which the *Commercial Arbitration Act* applies being an agreement in writing to refer disputes arising under a sessional contract or in connection therewith to arbitration. Having in mind the terms of s.55 as to the effect of *Scott v. Avery* clauses, the inevitable result is that the

Minister's claim for such a clause if granted would not operate to prevent legal proceedings being brought or maintained in respect of the matter in dispute nor would it operate to prevent a defence being established to legal proceedings brought in respect of that matter. Therefore, it seems to be of no utility at all for a *Scott v. Avery* clause to be inserted into sessional contracts. The Minister's claim is refused. Nevertheless, it should be pointed out that s.53 enables a party to a sessional contract seeking to invoke the arbitration mechanism provided by the dispute settlement clause to seek a stay of court proceedings commenced by the other party pending the conduct of the arbitration if the Supreme Court were to be satisfied as to the matters contained in pars.(a) and (b) of sub-s.(1) thereof. I consider, therefore, that a dispute settlement procedure in sessional contracts has relevant value even without a *Scott v. Avery* clause.

Part 6B appeals: The Minister's claim sought also for the dispute settlement clause to prevent legal proceedings as to a dispute concerning matters comprehended within Pt.6B of the *Public Hospitals Act*, namely appointment, re-appointment, suspension or termination of appointment of a VMO, unless and until the determination of the appeal provided thereunder. The right of appeal in Pt.6B and the procedure prescribed do not, in my view, constitute an arbitration agreement as that phrase is defined within the meaning of the *Commercial Arbitration Act* which would be necessary for that Act to apply by reason of s.3(2) thereof. And neither, in my view, are the appeal proceedings established by Pt.6B arbitrations provided for in the *Public Hospitals Act* so as to be an arbitration agreement within the *Commercial Arbitration Act* under s.3(4) thereof because the *Public Hospitals Act*, Pt.6B clearly indicates or requires by its terms that it is to be the sole means for the hearing and disposition of such appeals. In any event, an appeal by its very nature

could not be an arbitration of a dispute as comprehended by the *Commercial Arbitration Act*; where a VMO lodges an appeal against a relevant decision of a hospital board or an area health board then, it seems plain to me, the statute puts in place the appeal mechanism according to its terms without any agreement necessary on the part of the board concerned. It cannot be, therefore, any agreement at all and certainly not an arbitration agreement. Section 55, therefore, of the *Commercial Arbitration Act* does not operate to affect a consideration of the Minister's claim in this respect. It remains to consider whether the Minister's claim should otherwise be granted. I think not.

Whilst I accept that an appeal by a VMO would be a term and condition of work (see *Booth*, *supra* at 263), I would not as a matter of discretion grant the Minister's claim to prevent legal proceedings pending the determination of the appeal. Presumably, the Minister has in mind in making the claim not himself initiating legal proceedings in an appropriate court on the subject matter until the determination of the appeal so that the only conceivable plaintiff would be the VMO. It would be strange for a VMO to lodge an appeal and then initiate separate court proceedings, although it is possible that the appeal may well be filed as a protective measure to meet the one month's limitation period for the giving of a notice of appeal under s.33J(2) of the *Public Hospitals Act* at the same time as court proceedings are commenced. Even so, and although s.53 of the *Commercial Arbitration Act* would not operate as a power to stay court proceedings, I am disinclined, as a matter of discretion and for the same reasons as expressed above in relation to the *Scott v. Avery* clause, to grant this claim. It would still be open in any particular case where an appeal is filed by a VMO at the same time as he commences court proceedings for the board to seek a stay of those proceedings pending the appeal under Pt.6B according to ordinary legal principle of the

Supreme Court's inherent power and under s.61 of the *Supreme Court Act* 1970. Each case would have to be examined on its own particular facts and I think that to be the appropriate course. This part of the Minister's claim will also be refused.

Notification and appearance of AMA: The claim made as to the dispute settlement clause sought a provision for the VMO or hospital or area health service concerned to serve notice identifying all matters in dispute not only on the other party but on the AMA also; a notice was to be served on the AMA as to the requirement for the dispute to be referred to arbitration. Consequently, a provision was sought giving the AMA the right to appear before the arbitrator. The Minister opposed this claim.

Mr. *Sperling* supported it with the following general submission:

> It is also relevant that the AMA is recognised by the statute as having special expertise in this area by:
>
> (i) entitlement to appear without leave before the Arbitrator (s.29O(1)); and
>
> (ii) making recommendations to the Minister for the approval of conditions for inclusion in service contracts (s.29RB).
>
> It is submitted that the AMA has a bona fide interest in being notified of a dispute which arises under the Determination having regard to its obligations both in the Arbitration and in its role in recommending the conditions in service contracts. If there are disputes arising in relation to the conditions which have been determined then it is relevant for the AMA to be aware of such a situation for the purpose of making application under section 29M or assisting with an assessment of what conditions may be recommended to the Minister from time to time under section 29RB. Also, a particular dispute may have wider ramifications which should be drawn to the Arbitrator's attention.

The Minister's submission by Mr. *Kenzie* was as follows:

> The Minister submits that such provision should not be inserted in the dispute settlement clause. The AMA - as the evidence discloses - represents only a minority of Visiting Medical Officers in New South Wales. Its proposed clause requires notification to the AMA (and grants a right of appearance to the AMA) in relation to a matter covered by the disputes settlement clause regardless of whether the VMO in question is a member of the AMA or has any desire to have the AMA involved in his/her dispute at all. The

> clause is objectionable in that it permits the AMA to intrude into any dispute (whether or not it involves the AMA or a member thereof) regardless of the wishes of the parties to that dispute. Accordingly the clause has the potential to interfere with the prompt and speedy resolution of disputes.
>
> The Minister's draft clause would permit the AMA to appear as an agent in proceedings before an arbitrator if that was the wish of the VMO concerned. That is the legitimate extent of the interest of the AMA in such proceedings.

Mr. *Sperling* took issue, on the evidence, with the Minister's submission that the AMA represented only a minority of VMOs. The evidence concerned was that of Dr. Jensen, which, although he could not be precise, was to the effect that a high percentage of VMOs were members of the AMA. As to the Minister's submission that notification to the AMA would have the potential to interfere with the prompt and speedy resolution of disputes, Mr. *Sperling*, again on the evidence of Dr. Jensen, answered with the proposition that VMOs relied very much on the AMA for advice on sessional contracts. Mr. *Sperling* referred to the evidence of Dr. Stening to rebut Mr. *Kenzies's* submission that the claim could potentially interfere with the prompt and speedy resolution of disputes.

On a balance of the arguments put, and notwithstanding the evidence referred to by Mr. *Sperling*, I think it inappropriate in a sessional contract as between a VMO and a hospital or an area health service for the AMA to be notified of any dispute and of the reference to arbitration by the individual parties concerned. Accepting the majority of VMOs are members of the AMA, it may reasonably be presumed that a VMO member would seek advice and assistance from the AMA; but it must, in my view, be a matter for that VMO individually to decide to so approach the AMA and not as a requirement of the sessional contract. In any event, the clause proposed by the Minister allows the AMA to appear in an arbitration for its VMO member as agent by leave of the arbitrator. I have earlier referred to the impact of the *Commercial Arbitration Act* on

arbitration proceedings under the dispute settlement clause to the effect that the clause represented an arbitration agreement; that Act in its terms recognises the inter-parties nature of an arbitration so that I consider the dispute clause in the determination I make as flowing into a sessional contract should similarly establish rights and obligations as between the parties to the sessional contract and as not involving a third party, namely the AMA. Of course, and as Mr. *Sperling* emphasised, in an arbitration under Pt.5C of the *Public Hospitals Act* the AMA has a right to appear and be heard in the proceedings, but, in the view I take, once the determination is made that exhausts any rights in the AMA, apart from an appeal under s.29QA against the determination so made. I do not propose to interfere with a VMO's freedom of choice in this respect. I point out also that the *Commercial Arbitration Act*, s.20 in dealing with representation in arbitration proceedings limits it to representation of a party to an arbitration agreement and not to a third party.

I decline the AMA's claim for notification of a dispute arising under a sessional contract and to be able to appear as of right in arbitration proceedings.

Other issues: Although otherwise the respective claims of the parties were identical, there were two aspects not in common. First, the Minister, in addition to the persons agreed as being eligible to be an arbitrator, sought the eligibility of a person with not less than ten years' experience in medical or hospital administration. The AMA's claim did not include such a person. The parties did not expressly address this aspect, but no doubt such a person was considered by the Minister to be appropriate because of relevant knowledge and experience. However, I do not propose to include such a person as being eligible to be an arbitrator because, it seems to me, experience in medical or hospital administration may not necessarily be relevant experience in decision-making according to facts

and arguments presented in an arbitration which is essentially an arbitral process. I note, in any event, the agreement of the parties to include in the dispute settlement clause for an assessor to be appointed by each party to sit with the arbitrator in a consultative capacity and I think that that should meet the position.

The AMA, unlike the Minister, sought a provision granting the arbitrator power to make an award for costs of the arbitration. Sections 34,35 and 36 of the *Commercial Arbitration Act* deal in quite some detail with the question of costs. There is no need, therefore, for costs to be dealt with in the manner claimed and I propose to refrain from doing so.

Subject to the rulings made above, the determination I make will include a dispute settlement procedure in accordance with the joint claims.

Notices

The Minister sought the inclusion in the determination of a provision for the proper service of written notices required to be given by a sessional contract. The AMA took no issue with the claim. It seems to me to be not only a very desirable provision but also helpful in minimising disputes which may arise where written notice is to be given within a particular time. The claim will be granted.

The determination I propose to make will give effect to the terms and conditions of work as decided above.

CHAPTER 8 - HOURS OF SERVICE

The key feature of the Minister's proposed structural efficiency measures was the claim for a sessional contract to specify the agreed number of hours each week, fortnight or calendar month during which a VMO may be required to provide medical services (other than those pursuant to a call-back) at the hospital concerned in the care and treatment of public patients, including teaching, training and participation on committees (other than attendances at meetings of a medical staff council, grand rounds and continuing medical education programmes), and in respect of which specified hours the VMO would receive remuneration. The Minister's proposal was referred to in the proceedings as an "up-front hours contract". The claim conceded a condition that a hospital or an area health service was only to allocate work to a VMO which could reasonably be performed within the number of hours specified in the sessional contract. The claim made provision also for variation of the specified hours at any time by agreement between the VMO and the hospital or area health service concerned or on each anniversary date of the sessional contract following a review at least six weeks prior thereto on consideration of all relevant facts and circumstances. The medical services provided during an up-front hours contract were to be known as "core services".

The AMA resisted the claim most vigorously, and sought to maintain the present position whereby a VMO could elect to be paid for the actual number of hours of services provided or, after the first six months of the term of a sessional contract, according to an averaging system based on the average number of hours of service provided (excluding call-backs) during the first six months of the contractual period and re-calculated every six months thereafter.

The parties were thus fundamentally and conceptually opposed on this aspect, and it involved issues of jurisdiction and merit.

Jurisdiction

The AMA submitted there was no jurisdiction to make a determination for a VMO to be paid a rate per hour during a period irrespective of the hours actually worked. The submission was developed according to the definition of "sessional contract" in the *Public Hospitals Act*, s.29K, which type of contract limited the determination which could be made under s.29M(1) and under which remuneration was on the basis of "services performed over a specified period or specified periods". Mr. *Sperling's* succinct submission in denying jurisdiction was:

> A determination that the VMO is to be remunerated solely on the basis of hours agreed upon by the parties (so far as is presently relevant) is not remuneration on the basis of services performed over a specified period but irrespective of the services performed over the specified period, and indeed irrespective of whether any services are performed. The definition makes it clear that the contract envisaged is one in which the remuneration is related to what is done. The statement that it is not a fee for service contract makes it clear that the relationship is to be with the time taken by what is done rather than the end product of the service. Taking this together, it is clear that the definition clause would not apply to a contract in which the basis of remuneration was an agreed period of time irrespective of the services.

Mr. *Kenzie* upheld power to make an up-front hours contract in the form claimed by the Minister as being a term and condition of work in respect of the provision by VMOs of medical services; the hours claim required the VMO to provide a specified number of hours each week, fortnight or calendar month, as the case may be, for which hours the remuneration clause required the VMO to be paid by the hospital or area health service concerned. Senior counsel said:

> The fact that, in particular circumstances, payment may be forthcoming in respect of the stipulated hours of service notwithstanding that all those hours are not worked on particular occasions is irrelevant to the question of whether Clause 6 and 7 provide for terms or conditions of work. Similarly a clause that

> provided for a minimum payment for a call back regardless of length of time worked would be a term or condition of work.
>
> The AMA submits that jurisdiction to make an upfront hours provision is lacking because it is alleged that the promulgation of such a term would involve a *requirement* that the principal and VMO agree to something. That is, that it is not a term and condition of work but is a determination that the parties should themselves agree on a matter.
>
> The Minister submits that there is no substance in this contention at all. The Ministerial draft does not impose any form of requirement to agree on anything. All that it does is to provide for what is to happen when parties do agree to enter into a sessional contract.
>
> As to the suggestion that the clause is not within jurisdiction because it leaves matters for further agreement, it is submitted that there is nothing in this contention either. ...

Mr. *Kenzie* took issue with Mr. *Sperling's* reliance on the definition of "sessional contract" and put that it did not bestow jurisdiction but rather was a definition of the contract designed to facilitate the grant of jurisdiction otherwise found in s.29M(1) as to the terms and conditions of work.

I agree with Mr. *Sperling's* submission to the extent that the definition of "sessional contract" relevantly limits the jurisdiction to make a determination under s.29M(1) because it is plain any determination so made as to the terms and conditions of work, including the rates of remuneration, must be "in respect of medical services provided by visiting medical officers under sessional contracts". If a determination were made in terms contrary to a "sessional contract" then, it seems to me, it would not be a determination of the type contemplated by s.29M(1). However, I do not agree with the next step of Mr. *Sperling's* submission that the claim as to an up-front hours contract is not consistent with a sessional contract. Essentially, a sessional contract is one referable to remuneration for the performance of medical services over a specified time period as distinct from remuneration on a fee-for-service basis regardless of the time involved. The Minister's claim, in substance, seeks a

determination laying down a specified period or specified periods, according to the number of hours each week, fortnight or calendar month, during which a VMO may be required to provide services and for which specified period or specified periods remuneration is to be paid. If a particular VMO, otherwise ready, willing and able to provide services during the specified period or specified periods, does not for some reason, such as lack of patients or completion of tasks sooner than expected or power failures or unavailability of facilities or re-arranged hospital schedules, provide the services during the period specified in the sessional contract then, in my view, that does not detract from nor change the inherent nature of the sessional contract; rather it represents a contingency for which, on its occurrence, the VMO is to continue to be paid. Indeed, the claim by the AMA itself for the payment of remuneration to a VMO under a sessional contract where a hospital cancels an arranged period must be similarly based. Another example is the AMA's claim for a minimum payment during a call-back of one hour plus travelling time, notwithstanding the rendering of services for a shorter period of time. Jurisdiction was conceded as to those two claims and I see no conceptual distinction in the Minister's claim for an up-front hours contract.

Industrial awards generally provide for remuneration according to a particular period, be it an hour or a week or a month or a year, on the basis of a number of specified ordinary hours; such a prescription is not relevantly dissimilar from that proposed by the Minister here. By comparison, the minority of industrial awards provide for remuneration according to a piece work system which, perhaps, is not dissimilar to a VMO's fee-for-service contract. It might be mentioned too that industrial awards, like determinations over the years for VMOs, traditionally have provided for payment during periods when no actual work is performed,

namely annual leave, long service leave, sick leave and public holidays. The form of the up-front hours contract is unexceptional by comparison.

The AMA's claim for a determination, it must be remarked, seeks to approbate and reprobate by asserting jurisdiction to allow payment under it according to an averaging system based on the hours worked during the previous six months, even though during the period in question hours less than the average may be actually worked.

The present 1985 determination provides for payment according to a similar averaging system. There was the suggestion during argument, as earlier indicated, that it was made having in mind the former definition of "sessional contract" under which a VMO was "required to provide medical services ... during periods or sessions specified in the contract" so that up-front hours may have been accommodated, as distinct from the present definition of "sessional contract" as inserted in the *Public Hospitals Act* in 1988 which limited remuneration to "services performed over a specified period or specified periods". I have outlined above my construction of the present definition, and from that it may be concluded I think the distinction between the two definitions is a distinction without a presently relevant difference being merely the deletion of the word "sessions" so as to make a sessional contract referable solely to remuneration according to a specified period or specified periods.

I find the Minister's up-front hours claim to be within jurisdiction, as is the AMA's counter-claim for remunerated actual and average hours of service.

History of hours' prescriptions

I have earlier in these reasons detailed the provisions of previous determinations and their development. Although Mr. *Rogers* in 1976 recommended rates of remuneration based on the concept of a session of 3.5 hours, he was not required to consider the method by which sessional

time was to be determined. In the sessional agreement made following Mr. *Rogers'* recommendations, relevant provisions of which have been set out earlier, it is clear the sessional arrangement between a VMO and a hospital was based upon the provision of medical services for an agreed number of sessions and/or split sessions per week or fortnight, as appropriate, and for work performed during a session or a split session remuneration was to be at the normal sessional hourly rate but with a split session attracting a loading of 10 percent; the VMO or the hospital concerned at any time could seek alteration to the number of sessions or split sessions under the sessional arrangement. On reviewing those provisions, I then remarked they were not conceptually dissimilar from the Minister's present claim for an up-front hours contract. The 1978 and 1980 determinations made by *Macken* J. continued those sessional arrangements, including the requirement for agreement between the parties as to the number of sessions and/or split sessions during which services were to be rendered by a VMO.

The 1981 determination saw a major departure from the concept of sessions to an agreed set number of hours in each four-weekly period, with a minimum number of hours of one and a maximum of seventy. Ordinary remuneration was payable according to the "agreed hourly commitment in any four-weekly period" and for any "additional time involved" which was "required" by the hospital.

Importantly, the 1982 determination saw a major refinement as to the method of calculating the number of paid sessional hours. The changes, specified earlier in detail, formed the basis for the present prescription, but with a significant difference as to election by a VMO as to the basis for payment. The alterations provided for a sessional contract to be expressed in hours per calendar month, and an "unders and overs" system for payment was introduced whereby a VMO working less than the

specified hours continued to receive payment for the agreed hours but no additional payment was made if more hours were worked. The number of hours specified in a sessional contract was calculated as the average number per calendar month worked by the VMO, other than during on-call and call-back, in the immediately preceding six calendar months prior to the date of the determination; a sessional contract not operative during that six months' period was to contain hours of one per calendar month with remuneration for all services rendered in excess of that one hour; and hours were to be adjusted each six months' on the basis of the average hours during which services were provided in the immediately preceding six months' period. Those provisions are all contained in the existing determination.

The proceedings in 1983 saw interesting developments in that a major debate occurred around the computation of payments and contracted hours. In the 1982 proceedings the Health Administration Corporation had sought the adoption of the averaging concept, which *Macken* J. granted, whereas the AMA sought a return to the sessional arrangement of a session and/or a split session of 3.5 hours. In the 1983 proceedings it was the AMA which sought the preservation of the concept of average hours whilst the Corporation sought its abolition and replacement by a system of payment for hours actually worked each calendar month. His Honour adopted the alternative suggestion made by the Corporation to enable VMOs to elect between payment for actual time worked or average hours worked during the previous six months. And, so, the 1983 determination repeated the provisions of the 1982 determination but with the inclusion of the election provision. The 1985 determination continued that prescription, and added a provision whereby if a hospital cancelled a session without giving twenty-eight days' notice for anaesthetists and surgeons for operating theatre time and fourteen days'

notice for all other VMOs then there was an entitlement to payment for that cancelled time.

It will be apparent, from that review, the prescription for remunerated contract hours has been based upon an agreed number of hours specified in a sessional contract and in respect of which hours a VMO was paid even though less hours may have been worked; hours worked greater than those specified in the contract were paid if a VMO was required by the hospital to render services, but the 1982 determination excluded payment for such greater hours by introducing an "unders and overs" system where a sessional contract had been in force for a period of six calendar months immediately prior to the operative date of the determination, namely 15 December 1982. The contract hours specified were determined by the averaging system in that immediately prior six months' period and reviewed each six months when a new average was struck. Where a sessional contract had not been so in force the actual hours system operated based on a notional one hour, although after a period of six months the contract hours were adjusted according to the averaging system based on the number of hours worked during the immediately preceding six months' period. In my view, the system as it operated pre-1983 therefore had about it the essential features of the Minister's present claim. It was following the 1983 determination, by permitting VMOs to elect payment according to actual hours worked in terms of the Health Administration Corporation's submission, that the alleged problems occurred. Relevantly, in urging preservation of the "average hours" concept, senior counsel for the AMA submitted to *Macken* J. during the 1983 proceedings as follows:

> Now, if I can move from that issue to the matter of the basis upon which your Honour should fix the remuneration - cl.5 - and the averaging position. I would like to deal with the evidence about this if I can very briefly. It is suggested that a change is warranted on

> the evidence. Well, your Honour, I would submit that you would remain totally unconvinced that any change was warranted on the evidence. There is some suggestion at second or third or fourth hand from Mr. Taylor that there may be some doctors who would prefer to be paid on an hourly basis - that there were some 7 or 8 hospitals which he nominated where the hospitals would see that as appropriate. Now, 7 or 8 - a maximum of 10 out of between 60 and 70. If one is going to act on the basis of a bulk - we don't know - the question posed on 35 doctors at Blacktown Hospital to regulate the conditions of some 2,000 visiting medical officers then that would be a most flimsy basis upon which to act. We would submit that there is no evidence at all upon which you Honour could properly act. True your Honour is not bound by formal rules of evidence but your Honour is required to act judiciously and that evidence would form no basis at all for any inference as a matter of law, as a matter of law for this change which is suggested by the corporation - no inference of law can be drawn from this.

In short, the 1983 determination introduced the absolute discretion for a VMO to elect remuneration in accordance with actual hours worked or the averaging system, thus effectively removing, should a VMO so elect, the "unders and overs" system commenced by the 1982 determination and the prior condition for payment for hours worked greater than those specified in the contract to be "required" by the hospital concerned. It seems that the position of the Health Administration Corporation supporting remuneration according to actual hours worked was where a bill was before the Parliament requiring the arbitrator to determine payment for work done on an hourly basis and *Macken* J. was asked to anticipate legislation, but which, as it happened, was never enacted.

The AMA's support for contract hours to be determined by agreement as to a set number of hours may be illustrated by reference to submissions made by its senior counsel during the 1982 proceedings as follows:

> So that your Honour understands what we are doing, we have picked up a view expressed by Mr. Taylor in his evidence, where he said that he could see some merit in a system whereby, as he put it, there were no unders or overs. In other words, you specify a period and in advance, and the doctor is not entitled to extend his session; on the other hand, he is entitled to that figure. That has a great deal of attraction to the AMA because, while it may work to the financial detriment of a number of visiting medical officers, it is a more acceptable professional solution to the problem. It does not involve them in taking a stopwatch with them while they go to the

hospital. It means that, with the exception of call-backs out of hours, call-backs on call periods, they know what their commitment is and they attend the requirements of the hospital and the requirements of the patient. That is the thought that is behind it, it has only been produced quite recently.

HIS HONOUR: Would it abolish split sessions?

MR.. GYLES: No, it would not. It contemplates that the period may be taken up in any aggregation of time, whatsoever. It says, "Their commitment is so much time."

HIS HONOUR: What the Health Commission would do is work out what the likely times of a visiting medical officer was and offer them a sessional contract for less, knowing that they would get the time that they want and only pay for half of it or three-quarters of it.

MR.. GYLES: Yes, there are two things to it.

HIS HONOUR: It would be a much cheaper way of doing it.

MR.. GYLES: It may if there are two things to it. So far as the AMA is concerned, first of all this position is that the individual visiting medical officer should negotiate with the hospital, not with the Health Commission, on some completely standardised basis, in the belief that the hospital knows its requirements best and it will have a fair solution for the various visiting medical officers and fair response between visiting medical officers and others. If there is a breakdown it may be necessary to go to the AMA and the Health Commission or hospital to try and solve it. The primary thing is they do have faith in the visiting medical officers and the hospitals of arriving at a proper solution in what is after all, a professional problem.

That is the first safeguard they see. Secondly, they do see that it may be possible to arrive at a set of guidelines by negotiation with the Health Commission, which would assist all parties in attaining what is a proper means of doing it. We have given some thought to that and there are a lot of twists to that sort of exercise, which experience alone would throw up and it is something that would be needed to be sat down and thought about very carefully.

Bearing in mind that there is a dispute clause in the contract proposed by us, it seems to us that whilst there is certainly a risk that the Health Commission may take advantage of the position to offer visiting medical practitioners less than the appropriate period, we would be hopeful that between now and the next determination, the way it has been worked will be revealed and if there are problems, there would have been that period to work out perhaps guidelines as to the method to be used. So it is an endeavour to pick up what Mr. Taylor said, an endeavour to perhaps get such of the thought that has fallen on your Honour from time to time formally within the framework of the legislation.

That material is significant for the acceptance by the AMA, certainly at that time in November 1982, of the desirability and feasibility

of individual VMOs negotiating with the hospital concerned as to the number of contract hours; it was seen as a "safeguard". A not dissimilar theme, as set out above, was continued by the AMA in the 1983 proceedings. There was evidence before me which went to the satisfactory operation of the contract hours system pre-1983. For instance, Dr. Child said:

> Clause 6(h) was in existence before 1985 and, whilst a considerable number of VMOs had elected to be remunerated under the terms of this subclause before the December 1985 determination, and whilst more went over to Clause 6(h) following that determination, there are still VMOs working within the system on the basis of up-front hours commitments. This arrangement has continued to work satisfactorily. It is important to bear in mind that there is nothing novel about the concept of an up-front hours commitment. The only issue has been the degree to which it has been used in the recent past and should be used in the future.

Mr. Clout deposed the system "operated quite satisfactorily for many years prior to 1981"; John Thomas Taylor, Executive Officer and Director of Administration Services at Lidcombe Hospital, said as to the system's operation pre-1983:

> In addition, I can say that although such matters were more numerous than disputes concerning any other aspect of the Determination they were insignificant in total when one has regard to the total number of Visiting Medical Officers throughout the public hospital system. I could not quantify the number of such disputes except to say that they would not have averaged more than approximately one per month throughout 1982. The disputes in issue were invariably easily resolved between Dr. Cable and me, and he and I were invariably at a loss to understand why the parties concerned had been unable to reach agreement without our intervention.
>
> If there were a return to a system of payment based upon an "up-front" agreed number of hours, I would think that there is sufficient data available at this time, that was not available in 1982, to enable agreement to be reached between hospitals and Visiting Medical Officers. In the case of newly-appointed Visiting Medical Officers there should be sufficient historical data available in respect of other Visiting Medical Officers with similar anticipated workloads to enable agreement to be reached. Some form of provision for re-negotiation of hours would be required.
>
> The most unsatisfactory feature of the current system of paying for "actual hours" is that the hospital is unable to control the number of

hours worked by V.M.O.'s nor to verify that the number of hours claimed has actually been worked in the treatment of public patients exclusively. In practical terms hospitals have very little, if any, real control over V.M.O. expenditure.

There was evidence also from Dr. Horvath and Dr. Spring that up-front hours contracts have existed, even since the 1985 determination, at Royal Prince Alfred Hospital, Royal North Shore Hospital and in other hospitals in the Eastern Sydney Area Health Service, and that such contracts have been negotiated without difficulty and have worked most satisfactorily. Reference was made to arrangements for contract hours for VMOs in all other States, and specifically to the latest agreement in Tasmania following an arbitration. It should be pointed out that VMOs in other States are all part-time employees and not, like in NSW, independent contractors; nevertheless, the up-front hours contract is the form utilised there with an annual review of such hours.

The Minister, on a consideration of the prescription of hours in previous determinations, submitted his claim was not novel, and indeed such arrangements had been in force since 1976 affected only by the ability of a VMO to elect to be paid according to an actual hours system from 1983. The AMA took issue with the analysis made by the Minister of each of the prior determinations and submitted a VMO had never been subject to a condition under which he might provide services beyond an agreed commitment without remuneration for those hours. On my view of the previous determinations, that submission is simply not made out on the facts. It is plain that the 1982 determination, in its very terms, provided for an "unders and overs" system under which a VMO was remunerated for the hours specified in his contract and it was only where a contract had not been in force for six months prior to the operative date of the determination that actual hours were paid for, and even then only until the contract had continued for six months when the specified hours were fixed according to that six months' average. Of course, prior to 1982

the agreed number of hours specified in a sessional contract attracted remuneration even though a VMO in a particular period may have worked less than those hours, and additional hours were paid for only if the hospital "required" the VMO to work. I have earlier remarked on the conceptual, indeed perhaps also the prescriptive, similarity between those earlier systems and the Minister's present claim. It was only when the 1983 determination was made, as continued by the 1985 determination, that an individual VMO was given the discretion to elect under which system he wished to be remunerated, either the agreed hours fixed by the averaging system at half-yearly reviews on an "unders and overs" basis or the actual hours system. The system operating in all other States is support also for the lack of novelty of the Minister's claim and its practicability is supported also by that experience as well as by the evidence of Dr. Spring, Dr. Horvath, Dr. Child, Mr. Clout and Mr. Taylor. The submissions made for the AMA by its senior counsel in the 1982 and 1983 proceedings are, in my view, very telling as to the effectiveness of an up-front hours arrangement, and provide affirmation of the evidence before me called on behalf of the Minister as to the satisfactory nature of the prescription in determinations before 1983.

Of course, lack of novelty in itself may not justify the adoption of a provision in a determination, but it at least provides cogent material in a relevant context and on which the evidence in the present proceedings may be more comfortably accepted. It may be that a balance or compromise could be struck for the future by adopting the pre-1983 system, that is simply by deleting the VMO election provision. However, I have considered and rejected that approach as failing to decisively resolve the present gulf between the parties and as being inconsistent with structural efficiency considerations in the current setting, particularly the

need, as earlier discussed, to make the determination compatible with the present public hospital system and available resources.

The history of hours prescriptions in previous determinations and their operation, together with the prescriptions in other States for VMOs, positively favour the adoption of the Minister's up-front hours claim.

Grounds for up-front hours contract

Whilst the Minister amended his claim on some three occasions during the proceedings, the grounds stated for the initial claim nevertheless crystallise his case on this subject and I think it helpful to state them as follows:

1. This Clause provides Area Health Services or Hospitals with the means of balancing patient service requirements with the need to manage the payments to be made to Visiting Medical Officers - although the Clause itself does not provide for remuneration or the obligation to provide such remuneration, matters which are dealt with elsewhere in the Contract (see Clause 7).

2. Sub-clause (iii) provides a mechanism for review at yearly intervals and the proviso excluding agreements of one year or less is obviously appropriate.

3. Sub-clause (i) is a key provision providing an obligation on the part of the Visiting Medical Officer to provide the agreed number of hours of services per relevant period during each year of the Agreement. The sub-clause is a reflection of what has long been the basis of the determinations - namely that there be an upfront commitment to render services during an agreed number of hours. There is nothing novel in the provision which simply addresses the fact that the intention lying behind earlier arbitral determinations has seldom found reflection in enforceable agreements made with Visiting Medical Officers.

4. It is desirable that there be a comprehensive scheme addressing the whole question of the setting and variation of the hours that Visiting Medical Officers are to work under sessional contracts. It is desirable and in the public interest that contracting hospitals and authorities have as much certainty and flexibility as practicable for patient services and budgetary and administrative reasons. At the same time, it is desirable that there be adequate provision for reviewing the hours to be provided under sessional contract to take account of alteration in circumstances affecting either of the parties to an agreement.

5. The proposed Agreement is much more consistent with notions of structural efficiency than the AMA draft which provides either for averaging as the means of determining the upfront hours or obtaining variations thereto. On structural efficiency grounds there should be nothing to stand in the way of a hospital or area health board in making a determination of upfront hours on the basis of criteria available to it as to the number of hours required, both in the case of persons formerly contracted and those not formerly contracted.

6. The scheme of the Clause is that variations from the agreed number of hours of service (whether resulting from a smaller number of hours being worked or a greater number) are able to be accommodated, if not by agreement pursuant to Clause 6(i) and (ii), then pursuant to the mechanisms provided by Clause 6(iii) and/or by the compensation afforded by the 5% loading given for extended shifts.

7. The proposed Agreement does not contain many of the provisions found in Clause 6 of the AMA draft. It deletes Clauses 6(c) and (f) which provide respectively for averaging as a means of determining the upfront hours and for the establishment of a basis of entitlement to payment in the case where a contract has not been in existence for a former, relevant period.

8. Quite apart from the problems which might conceivably arise in relation to the interpretation of AMA Clause 6(f), it has been omitted from the proposed Agreement because it does not sit happily with the achievement of setting up front hours. On structural efficiency grounds alone there should be nothing to stand in the way of a Hospital or Area Health Board in making a determination on the basis of criteria available to it as to the number of hours required in the case of a person who has not formerly been contracted. In any event it is difficult to marry a clause such as existing Clause 6(f) with the concepts reflected in proposed Clause 6(iv) hereof.

9. This contract will not, however prevent a Hospital or Board having regard to the number of hours actually worked in the months preceding the offer of a contract in determining the hours relevant to the contract when made.

10. Neither does this proposed Contract include paragraph 6(g) of the AMA draft. The effect of the proposed Clause is to lengthen the period prior to which a review is to take place - namely from 6 - 10 1/2 months in each year of the contract. As far as AMA draft Clause 6(g) is concerned the question is dealt with in proposed Clause 6 (iii) hereof. Apart from a change in the review period it is sought to avoid the confinements of AMA Clause 6(g) which involve reliance on averaging alone as a basis for changes to the number of hours. Proposed Clause 6(iv) has greater flexibility than AMA draft Clause 6(g), a clause which is difficult to reconcile with structural efficiency principle notions. In any event the

concept of averaging as a basis of review is incorporated in the proposed Clause 6(iv)(c).

11. The other significant feature of the proposed Clause is that, unlike the AMA draft, it contains a mechanism for achieving a review. This again is consistent with structural efficiency considerations.

12. Consistent with the above considerations, AMA draft Clause 6(h) has been omitted. Since the significant increase in rates as a consequence of the 1985 determination, Clause 6(h) has provided the escape hatch from upfront hours based on the averaging concept as most Visiting Medical Officers have preferred in their "absolute discretion" to do, and be paid for, work that they have decided to perform.

13. Proposed Clause 6(ii) provides the real mechanism for the parties to come to grips with circumstances which change. It is backed up by the dispute settlement clause. The sub-clause is based on the concept that it is desirable to facilitate change by agreement where possible. Where the Hospital or Area Health Service is given power (in proposed Clause 6(iii)) to make a decision it is at the end of a defined period and then by reference to a process which involves consultation with the Visiting Medical Officer.

14. Apart from the fact that Clause 6(f) of the AMA draft does not sit happily with the proposed contract, it is unnecessary and potentially dangerous if Clause 6(h) of that draft is removed. There should be no incentive real or implied on the part of a Visiting Medical Officer to maximise the number of hours worked during the first six month period of any contract.

The particular vice arising from the insertion of the VMO election provision in the 1983 determination was stated in the general grounds in support of the Minister's proposed determination as follows:

3. Loss of control on the part of hospital administration as a result of the introduction of clause 6(h) in 1983 and the use of this provision by the majority of VMOs thereafter, especially following the decision in 1985, thus further reducing capacity to manage costs and undermining the formula for maintaining control otherwise found in the Determination.

It will be apparent from a perusal of those grounds that pre-eminent amongst them are structural efficiency considerations and the concept of a VMO and the hospital concerned negotiating an agreed number of hours of services appropriate to all relevant circumstances. The safeguard of a regular review mechanism with compensation in the

hourly sessional rate of a 5 percent loading for extended shifts, where hours may be worked in excess of the number agreed pending review, are also given prominence.

Grounds against up-front hours contract

In responding to the Minister's general ground for removal of the alleged vice caused by the VMO election provision inserted in 1983, the AMA denied the Minister's claim was in accord with earlier determinations and asserted that the "benefit of the Minister's new proposal requires examination and has to be weighed against its detriments." Specifically as to the Minister's whole claim as to up-front hours, the AMA pleaded:

(1) For the reasons given earlier, the arbitrator has no power to direct that there be a fixed hours contract.

(2) The proposed clause limits to the number of hours specified for a period the right and obligation of the VMO to treat public patients. Accordingly, when the specified hours run out the VMO's right and obligation to treat public patients cease, including the treatment of patients under a course of treatment, patients seen by the VMO and awaiting surgery, patients seen by the VMO before admission to the hospital and admitted under his care, patients referred by other medical staff within the hospital, patients allocated to the VMO by roster, etc. These will include cases where the VMO is the only medical practitioner on the hospital's staff with the qualifications to treat the particular case.

(3) It is unacceptable that a VMO should not be entitled to discharge his professional obligations to continue the treatment of patients under his care and to treat patients who are referred to him by other members of the medical staff of the hospital or allocated to him by the administration of the hospital in the expectation that he will treat them.

(4) Only the VMO would know when his time had run out, but the system of allocation and referral of patients and the expectation that the VMO is available would continue as if he still had the right and obligation to treat. The Department's proposal would create chaos in the public hospitals if implemented.

(5) The right and obligation to participate in teaching, peer review etc pursuant to Clause 5 (ii) and (iii) would similarly cease when time ran out, with similarly intolerable consequences.

(6) The listed considerations for annual review are of no consequence because they need only be adDr.essed by the hospital administration. The weight to be given to them is discretionary. For practical purpose there is a unilateral right in the hospital to vary the hours annually as it may think appropriate.

(7) The provisions for review (Grounds 2, 6 and 11) are unilateral in the absence of agreement. A failure to agree attracts the Dispute Settlement clause (Ground 13) but the clause (which the Minister seeks to retain contrary to the AMA's claim) is unworkable. More importantly, nothing pre-empts the hospital's reserve power to over-ride any resolved difference under para (iii) by making a unilateral determination under para (iv).

(8) The appeal to "structural efficiency" (Ground 5) remains to be explained.

(9) The AMA draft which continues the existing arrangements, providing for remuneration in accordance with work done (whether directly or by averaging), is said not to serve "structural efficiency" (Ground 5). Again, that remains to be explained.

(10) Deletion of other provisions from the existing determination, appearing as Clause 6 of the AMA draft, (Grounds 7, 8, 10 and 14) is proposed without justification or by further appeal to "structural efficiency".

(11) Ground 12 misconceives the operation of Clause 6 (h) of the existing determination as enabling a VMO to set in advance the work he is to be paid for doing.

(12) 1985 marked the end of a period of grave distrust and disharmony. Under the operation of Clause 6 as presently framed there has been industrial peace for 6 years, increase in productivity, marked advances in the sophistication of services provided, commitment by VMOs to patient care in the face of bed closures and cut backs, and loyalty of VMOs to the hospitals they serve. No instances of abuse are cited. As a concept, payment for work done should be retained.

The focus of the AMA will be seen to be on difficulties caused to a VMO in the discharge of his professional and ethical responsibilities to patients should the specified contract hours run-out, and an alleged entitlement in a VMO to continue the treatment of patients under care and to treat other patients referred regardless of the hours involved; interference with the special position of the individual VMO in allocating and referring patients would lead, it was said, to chaos in the public

hospital system. The annual review mechanism was said to be of no consequence because, in the absence of agreement, the hospital administration could unilaterally determine the hours. It was further asserted in respect of the review mechanism that although a failure to agree attracted the dispute settlement procedure the clause was unworkable. Emphasis was placed on the settlement of the 1985 doctors' dispute as marking the end of grave distrust and disharmony, and the consequent period of industrial peace should not be disrupted. Accordingly, the concept of payment for work done should be retained as effected by the AMA's claim.

Earlier findings

After reviewing the historical background and context in which the present claims fell for consideration, together with the basis of approach, I made findings above which are relevant to a consideration of the Minister's up-front hours claim. For convenience, I repeat them below -

- VMOs include very many practitioners with undoubted commitment to and co-operation with the public hospital system.
- That commitment and co-operation are by no means universal, and sufficient numbers of VMOs are not participating with the majority of their colleagues in ensuring structural efficiencies consistent with available resources.
- The modern practice of medicine and the proper functioning of the public hospital system require direct attention to resource allocation and management to an hitherto unprecedented degree.
- The various changes to the public hospital system have been designed to ensure comprehensive control over the system,

including by the participation of VMOs in a consultative capacity; the various structural efficiency measures sought by the Minister in a determination are intended to facilitate that process.

- The present context of the public hospital system, and the way in which it has developed in the last decade or so and having in mind its needs in the foreseeable future, firmly make out the Minister's case for the implementation of structural efficiency measures and for a determination affecting VMOs under sessional contracts to recognise that by appropriate provisions.
- The Minister's various structural efficiency measures, although non-costed, were admitted as being a significant contribution to the containment of VMO costs in practice and as directly improving productivity and efficiency overall in the public hospital system.
- The nature of the claims made and the circumstances in which they arise require processing in accordance with the *State Wage Case - May 1991* as a special case thereby enabling the monitoring of costs in an economic environment requiring increased efficiency and productivity.

In my view, those findings provide the proper setting for consideration of the present claims as to the hours during which remunerated services are to be provided by VMOs.

Deficiencies in present actual hours system

The AMA broadly supported the provisions of the present determination as being both reasonable and workable, thereby denying the deficiencies in the present system as identified by the Minister. Those deficiencies were expounded at length by Mr. *Kenzie* by reference to a

large amount of the evidence called during the proceedings. It is impracticable, and I think unnecessary, to recite all of the submissions made. The importance of the issue, however, requires an attempt to state what I see to be the major deficiencies identified by reference to the supporting evidence, as follows -

(1) The actual hours system was introduced prior to the 1985 doctors' dispute when the level of trust and co-operation existing generally as between VMOs and health system administrators was high. Peer pressure was available and effective to control unwarranted VMO activity. In addition, the rates of pay for sessional work were significantly lower than they are now.

(2) The circumstances existing at the time the actual hours system was introduced no longer exist.

In her statement of evidence, Dr. Horvath relevantly observed:

> The change from sessions to "actual hours" or piece-work payment, may well have suited the smaller hospitals where the VMO truly "visited" intermittently during the week, but it did not in any way reflect the manner of work in the major hospitals. Once the option was given to the VMO to be paid for "actual Hours" (as opposed to an up-front hours commitment) the majority of the VMOs progressively took advantage of this option. The opportunity for negotiated sessions was thus greatly diminished. It became very easy for the arrangements to change at the whim of the VMO - without reference to hospital management - and still be reflected in payment. In effect, the independent contractor could determine the time, place, type and volume of services. The contracting authority could only determine how and when to pay. The control mechanisms then had to reside in constant attention to service access points - theatre time, outpatients department sessions, bed availability and on-call rostering. Peer pressure was then relied upon to minimise any "time" abuse. However, with the New South Wales doctors' dispute and the general "anti-Government" feeling amongst VMOs, this peer pressure has proved (especially in recent times) much more difficult to harness. Furthermore, in my experience the existing control mechanisms have often proved to be ineffective or inappropriate in various circumstances where the contracting authority has simply

wanted to achieve (for a variety of reasons) more control over the number of hours of work actually being provided by a VMO (or by VMOs) to public patients. Restricting admissions is a pretty blunt tool in an era where the health care system is trying to adDr.ess issues of fairness and distributive justice in instituting ethical resources allocation.

Whilst I did not support the introduction of the actual hours option in the early 80s for the reasons that I have outlined above, it was obviously regarded as an acceptable option by some managers in some hospitals. However, it must be realised that the option was introduced in the pre-doctors' dispute era when there was still a considerable level of trust and co-operation between VMOs and the contracting authorities and where reasonableness and flexibility on both sides meant that the actual hours approach was feasible and workable. Unfortunately, the industrial environment in the 1990s (i.e. even 5 years after the doctors' dispute) is certainly not as harmonious as it was in the early 80s and co-operation and flexibility are terms which can no longer be as appropriately applied to describe the relationship and arrangements between contracting authorities and the VMOs. Obviously, those relationships have not been enhanced or assisted by the economic constraints under which the public hospital system operates. In other words even if an actual hours option was seen as appropriate and workable in some hospitals during some part of the 1980s, I certainly see it as neither workable nor appropriate given the realities of the public hospital system in the 1990s.

Looked at from the viewpoint of the non-medical administrator, Mr. Clout said:

The Department's proposal to introduce into the contract an arrangement of up front hours is not new as it existed prior to 1981 arbitration. In today's economic situation it is absolutely essential that Area Health Services and hospitals can plan for and control the budgets they are provided with ...

As Senior Industrial Officer responsible for visiting medical officer matters in the period from 1986 through to 1988 I am aware of many circumstances where hospitals were unable to budget for or plan in a manner that enabled them to control visiting medical officer costs. The main reason for this relates to the fact in the health system that it is exceedingly difficult for managers to dictate the level and extent of services provided by practitioners. The main complaint is that the health system is a doctor-driven system but the outcome on the cost side has to be the responsibility of the managers. Under the current arrangement it is generally difficult to achieve a mechanism by which hospital management sits down with visiting practitioners and agrees in advance to the level of service that will be provided within the funds available to pay for that level of service delivery. Typically the approach taken by VMOs is we know what services must be provided and it is the job of management to obtain the funds necessary to cover the associated costs.

Often the VMOs approach is "we have been inadequately funded by the AHS or Government so more funds should be made available".

(3) The system of payment for actual hours fortified and perpetuated the post-1985 doctors' dispute trend to non-participation in hospital management and clinical planning decisions on the part of VMOs. In that respect, I quoted earlier in these reasons an extract from the evidence of Dr. Horvath as to the "us and them" mentality of VMOs as a group; the identified deficiency was said by her to result from the fact that "VMOs are very much free to run their own race with scant regard for the impact of their chosen work levels and patterns on the hospital's clinical budget and on the efficiency of the health services being administered by that hospital."

(4) The system encourages VMOs to proceed or add tasks without regard to the impact thereof on hospital budgets and without discussing the matter with hospital management. The earlier evidence referred to from Dr. Horvath dealt with this aspect. Also, Dr. Hyslop in cross-examination said:

Q. You would hope, would you not, there would be consultation between visiting medical officers and the administration with a view to reaching as much agreement as possible about how the hospital resources should be allocated?
A. I would like to see that happen. Certainly it does not seem to be happening at the moment.

Q. I think you advanced to his Honour something like a sledgehammer to crack a nut argument. You do accept at the moment there is nothing like that happening and decisions at the moment are being made essentially by the visiting practitioners as to the level of activity that will be engaged in relation to the patients that they have admitted to the public hospitals?
A. No, a lot of our levels of activity is governed by the amount of theatre time available and the amount of beds. I will grant you there are certainly people who I alluded to before who will generate a lot of activity for their own reason they might have for it.

Q. Is your approach doctor, although you would accept fixed hours contracts might assist in relation to that sort of problem you do advance a sledgehammer to crack a nut argument and you say it is not necessary to go that far to resolve that sort of problem, is that your position?
A. Yes, that I feel this problem can be addressed in other ways and should be.

(5) A major vice of the actual hours system was the introduction in 1983 of the VMO election provision which, on Mr. Clout's evidence, had the following adverse consequence:

The 1983 introduction of 6(h) (the VMO election provision) imposed a proposition that took away from the hospital manager any ability to have any say directly, into the number of sessional hours that would be worked and paid for by the visiting medical officer. The averaging of the hours worked over the preceding 6 months did not in reality continue to occur. Rather most VMOs moved to a situation where their contract specified one hour and they were then paid for the number of hours service that they provided. This factor coupled with the fact that the required attendance records did not enable the manager to accurately determine the number of hours of service actually provided to the hospital patients, meant that the visiting medical officer determined to a very large degree the hours that he could claim for payment. The VMO also gained control of the level of services that was provided to hospital patients. The manager was left with the problem of having to balance the budget but had to enter into a circuitous route to regulate, plan and manage the level of services provided. For surgery, this was not too difficult because the manager could limit the availability of operating theatre time, which indirectly affected, to some extent, the number of patients being serviced by visiting medical officers. It did not however, enable the manager to identify or predetermine the number of hours services provided by each surgeon to a particular patient subsequent to the operation.
In the non procedural areas, the ability of the manager to predetermine the amount of service and thereby the cost of providing those services to patients, was very much more limited.
This issue has led in a number of cases in a number of financial years to visiting medical officer budgets for Area Health Services or hospitals being blown out towards the end of the financial year. In my experience hospital managers argue that they could not be held accountable for such budget blow-outs as they had no effective means of controlling the VMOs actual activity as the VMO could choose at their absolute discretion to have one hour inserted into the contract and then be paid for the number of hours actually provided. ... In result the Department regularly (at least to my knowledge prior to 1988/89) had to bail hospitals out towards the end of the financial year in terms of their VMO budget over-runs.

(6) The present system of actual hours, even if negotiations occur, does not necessarily reflect the hours claimed by VMOs because those hours claimed can continue to rise despite the negotiations and without any involvement of hospital management. In other words, the system provides no link between the obligation of the hospital to pay for work and compliance with any agreement or understanding as to the activities to be undertaken.

Dr. Horvath illustrated the problem this way:

> Q. What was to stop you from negotiating with the particular VMO at the inception of his contract on the basis that, for example, you only wanted him at the hospital on a Monday and a Thursday and at no other times?
> A. There is nothing to stop you negotiating that but there is everything to stop you from having that as the final arbitration as it were. That is your visiting medical staff, indeed all your senior staff are really very powerful people in a hospital setting, they have access to treat their patients, they need that access if the patient needs them. They need to come back. If I say I really only want you there on Wednesday mornings and they have an in-patient who is sick there is no way that they won't come and look after that patient and no way I would expect that, but if they also choose to start seeing patients in a side room off the ward and checking their dressings or if they choose to extend their theatre time and get everyone to start a little earlier these sorts of things are easier to do when you are the captain of the ship. For that to go back and be reflected in payment and that to be the first time there is a general awareness this is going on, I think is inappropriate, I think those things should be part of negotiation but why spend the time doing it if you don't have to.
>
> ...
>
> Q. For all ambulatory patients but it would still be open to the hospital in relation to ambulatory patients to specify that certain procedures were not to be undertaken or a limited number of certain amounts of procedures were to be carried out at the hospital?
> A. Yes, that is the whole issue of having people subject to the clinical policies of the institution and I agree with you in that. What I disagree with you in is that if individuals on the visiting staff decide to do additional procedures on a patient or spend additional time with that patient or bring some more patients to the ward to see them, they then can present us with an account for payment which we are obliged to settle.

(7) The present system of actual hours is open to abuse. Illustrations of this were given by Mr. Taylor as to the practice of VMOs claiming for the whole day notwithstanding the existence of a mix of public and private patients; by Dr. Horvath as to anaesthetists calling on patients in wards to see if their services regarding pain management were needed; by Dr. Spring as to attendance by VMOs on call-back only on a Sunday; and by Dr. Hyslop as to VMOs conducting unnecessary "surgical extravaganzas". Reference has been made earlier too to the submission by the Association of Medical Superintendents of New South Wales and the Australian Capital Territory as to the lack of real authority of hospital administrators in general and medical superintendents in particular over the actions and behaviour of VMOs in public hospitals. Dr. Horvath gave evidence as to many examples of areas of discretion residing in a VMO but which resulted in activities for which the hospital had to pay regardless of whether it wanted the activities or not.

(8) Excesses of actual hours cannot be satisfactorily controlled by "blunt instruments" such as hospital closures, ward closures, admission policies and the like. Both Dr. Child and Dr. Horvath dealt with this aspect in evidence as to the unsatisfactory use of them as an alternative, and a substantial number of VMOs also gave evidence against the use of such instruments.

The above identified deficiencies were said by Mr. *Kenzie* to permit VMOs to be paid for every hour worked, even though within the confines of clinical privileges, but regardless of whether it was consistent with hospital goals and budget limitations - such a system must be completely

unacceptable given the clear need for proper commercial arrangements with VMOs and the achievement of structural efficiency. Mr. *Kenzie* put the position as highly as this - "The fact that the AMA sees this situation as acceptable, whereas the Department of Health sees a continuation of this situation as totally unacceptable, is at the heart of these proceedings especially in relation to the issue of the up-front hours claim."

The deficiencies so identified were not rebutted nor qualified in any way by evidence led for the AMA. In a consideration of the overall working relationship between VMOs and hospitals within the public hospital system, I must say that even if part of such evidence were the fact the situation would be cause for serious concern, but I have no reason to doubt the essential thrust of the totality of that evidence. I accept it. The conclusion must be, therefore, that the present system of actual hours is so deficient and contrary to the legitimate aims and purposes of the public hospital system as to require its abolition. The question then arises whether the Minister's up-front hours claim is an appropriate replacement.

Justification for up-front hours contract

This aspect of the case was the subject of comprehensive and detailed attention by counsel for the parties, and again it is only practicable here to highlight the points made.

Benefits: The central submission made by Mr. *Kenzie* was that whilst there was a present capacity to set a general framework for the delivery of health services at public hospitals, by means of the preparation and administration of budgets, admission policies and the like, and although there was a range of blunt instruments which could be used in the event of a budget excess by means of hospital, ward or bed closures, restrictions on theatre time, rationalisation of on-call rosters and the like, the evidence was that those measures were insufficient to control the level of hospital

activity generated by VMOs. Those measures, whilst capable of addressing hospital activity in part in the sense of the numbers of patients in hospitals, did not impact upon hospital activity in the sense of the nature or extent of the treatment given to patients by VMOs; nor did they impact upon other hospital activities engaged in by VMOs such as teaching, research and committee work. It was the level of hospital activity which was of relevant importance and that was impacted by the number of patients, nature and extent of services provided to those patients by VMOs and tasks or services undertaken by VMOs in other activities such as teaching and committee work. All of the activities generated significant costs for the hospital. The difficulty in controlling hospital activity, and hence the ability to manage costs, under the present actual hours system and in which the use of blunt instruments rather than a direct control on VMOs hours was the only means available, was the subject of evidence given by Dr. Horvath under cross-examination as follows:

> Q. So far as the kind of work is concerned, all of that can be undertaken as readily in connection with a contract providing for payment of fixed hours as in relation to a contract providing for payment of actual hours, can't it?
> A. I think, as I have indicated before, the negotiations don't have a back door about the present arrangement, about free floating hours. You must remember that only a proportion of patients go to theatres. There are many more who are dealt with as out patients, who are dealt with on the wards, and that situation is not controlled by an up front negotiation if people can simply claim for it.
>
> Q. I am not asking you at the moment about the quantum of work, I am only asking you about the kind of work and I am suggesting to you that the kind of work can be as readily controlled in a contract which provides for payment for actual hours as it can be controlled in a contract which provides for fixed hours, am I not correct?
> A. You are correct in what you are trying to put to me but I disagree with that. I believe it is, and I am aware of circumstances in which staff have undertaken things beyond the agreement and, as I indicated, some might have done procedures or attended a clinic in addition to other staff who are at a clinic or gone on a ward round in addition to other staff and have paid for all those really different types of work beyond that which I might have negotiated

as an agreement for payment and do more for hospital patients. It goes beyond the nature of the work that was agreed. So that at the present time I cannot agree with you, that all that is as controlled, controlled as distinct from negotiated, under the present arrangement.

The evidence on behalf of both the Minister and the AMA was common to the effect there was a preference for co-operation in limiting hospital activity rather than the use of blunt instruments - the evidence of Dr. Jensen, Dr. Burkhart, Dr. Harris, Dr. Barnett, and Dr. Buhagiar was to that effect. Even so, under the present actual hours system the evidence of a number of the VMO witnesses was that they retained the capacity to bring direct pressure on hospitals for the admission of patients; Dr. Stening, for instance, gave the following evidence:

Q. When you book a patient into hospital, do you select the date or does the hospital select the date?
A. It is a bit of to-ing and fro-ing. Usually I select the date because I have a better idea of when I am available. When I say "available" I have an idea ahead of time when I have fully booked an operating session. There is no point in booking someone for an over-booked operating session because he won't get his operation.

Q. Now, on the day do all of the patients you have booked into the hospital necessarily get to be admitted?
A. No. It varies greatly. If I apply pressure to the hospital then for several months I will get most of my patients in. If I stop applying pressure then the number falls off. There was a period at the beginning of this year at St George Hospital where for four weeks I had only managed to get one elective case into the hospital. I applied pressure and in the last few weeks they have all been getting in.

Q. What sort of pressure?
A. I embarrass the administration by bringing this point up.

Dr. Trew in his evidence acknowledged a VMO had a measure of influence in the admission of a patient to a particular hospital if that patient attended the VMO's rooms and the admission was initiated from there. Alexander George McDonald Harris, an anaesthetist at Albury Hospital, Tumbarumba Hospital, Holbrook Hospital and Culcairn Hospital, gave the following significant evidence as to the negotiation and co-operation between a VMO and a hospital in the functioning of an up-

front hours contract in terms of its benefits compared to the present system:

> Q. You have told us that you are not really in favour of the use of blunt instrument closure or restriction of service because of its impact on your income. Would that be fair enough?
> A. I would like to put the patients first and say that I don't like to see them denied the services and I don't like to see me and my partners thrown out of work either.
>
> Q. What about the proposal that the strain be relieved or the problems be resolved by the hospital taking charge of the reallocation of patients in making decisions as to whether there would be continuity of treatment as between the particular doctor and the public patient. Are you in favour of that as an approach?
> A. No, I am not because I feel that the hospital administrators are not appropriately trained to carry out that role.
>
> Q. Neither are you in favour of an approach which will avoid the hospital being presented with a bill at the end of the period of activity by a number of VMOs. Is that right?
> A. I am willing to sit down and discuss that with them as we do.
>
> Q. You would say that there would be an element of unpredictability from the activity of yourself and your partners?
> A. Yes, and I do not think that the fixed hours contract would be any better off over time than the current system.
>
> Q. You see no alternative to the continuation of the situation in which hospital administrators are presented with accounts of uncertain amounts from time to time by VMOs. Is that right?
> A. Yes but averaged over a year they are fairly predictable, I think.

The evidence too of Dr. Harris, in my view, starkly raised the issue which the Minister's up-front hours claim seeks to address, namely its use as a management tool in the allocation of hospital resources by managing hospital activity in the number of patients and their allocation to a particular VMO rather than the use of blunt instruments. The rejection by Dr. Harris of the Minster's approach to the problem for hospital administrators to be involved because they were not appropriately trained to carry out the role conflicts with the evidence given by Dr. Child, Dr. Horvath, Dr. Spring, Mr. Taylor and Mr. Clout; by perpetuating the former system whereby VMOs effectively controlled hospital activity and presented accounts for payment by the hospital after the services were

rendered is to overlook the deficiencies in the present system which the evidence disclosed, which I have accepted as requiring attention, and it denies also the perceived benefits in an up-front hours contract, after negotiation between a VMO and hospital administration as the informed and responsible parties concerned. In light of the deficiencies found in the present system, I think it to be no answer to merely assert, as did Dr. Harris, that there was no alternative to the continuation of the present situation. In times of economic strictness to meet scarce resources it seems to me plain that advance negotiation between informed parties of the services to be rendered over a particular period has much to commend it. In any event, it is also good management practice at any time for a principal to be aware of the services for which payment eventually is to be made. The Minister's claim has that singular benefit.

I was impressed by the following submission made by Mr. *Kenzie* for the Minister:

> Whilst the Minister does not seek to directly interfere with the exercise of many of those discretions (especially those directly pertaining to the way in which the Doctor treats the patient) the Minister submits that it is in the public interest that there be a system which will maximise the chance that those discretions will be exercised responsibly, mindful of the economic consequences and the limited financial resources available and in the interests of the efficient operation of the public hospital system. This has nothing to do with interfering with the individual doctor/patient relationship but everything to do with the development of a more responsible view about clinical needs and clinical priorities.
>
> ...
>
> The Minister sees the up-front hours prescription as providing at the very least, clear encouragement to VMOs to think hard about clinical needs/priorities. It is not practicable for the hospital to determine on a day by day basis whether there truly was a clinical need or justification for a particular VMO to do a particular thing or task, eg. to add himself to a ward round or a procedure in the theatre. It is not possible to challenge or control the exercise of his discretion in any one of the many areas where it exists. ... Far less is it practicable or possible to control such discretions continually exercisable and exercised by not one but a large number of VMOs operating in a range of specialities and areas, across the public hospital system.

> VMOs are rightly and necessarily left with those discretions. But a system which provides for an entitlement to payment regardless of the manner in which each of such discretions is exercised is quite intolerable given budgetary constraints and certainly indefensible on grounds of efficiency.
>
> The hospital system can no longer afford VMOs to have a concept of clinical need that does not involve acute consciousness of considerations of costs and efficiency.
>
> ...
>
> The aim of the Minister's claim in relation to up-front hours is to set reasonable boundaries that will encourage, and if need be force, VMOs to closely consider whether there is a need for a particular activity (whether it be clinical or otherwise) and whether that need should be fulfilled in priority to other needs (whether clinical or otherwise).

By reference to the evidence, Mr. *Kenzie* identified a number of benefits alleged to flow from an up-front hours contract, which, in summary, were as follows -

- VMOs, through negotiations with hospital management, will be encouraged to have regard to the cost impact of their activities, and through discussions with management and other VMOs matters not presently dealt with will be considered, thus ensuring a forward-looking system rather than the present retrospective consideration.
- The allocation and re-allocation of resources in a period of budgetary restraint will be facilitated by VMOs being encouraged to rank activities according to precedence.
- VMOs will be encouraged to more readily comply with hospital policies, protocols and the like by having a reference point against which to measure activities.
- VMO resistance to change in the hospital system will be overcome by the up-front hours mechanism accommodating changes in the amount and type of activities through

discussion, thus relieving the alternative blunt instrument approach.

- VMOs generally preferred consultation and agreement rather than the application of blunt instruments.
- The up-front hours contract is consistent with the legislative scheme established by the *Public Hospitals Act*, s.27A and the *Area Health Services Act*, ss.19(c) and 20(1)(e), (f) as to the duties of a hospital board and an area health board in achieving and maintaining adequate standards of patient care and services provided and the efficient and economic operation of the hospital; the legislation requires a matching of services with the available resources and requires planning for the future development of health services.
- Various structural efficiencies will be achieved.
- The up-front hours system worked satisfactorily under determinations prior to 1983, and since that determination it has worked satisfactorily at Royal North Shore Hospital.
- VMOs as a group will be re-involved in the public hospital system in relation to issues of administration and resource allocation.
- Improved industrial relationships between VMOs and hospital managements will occur by reason of the co-operative basis of the up-front hours system.
- Health administrators will be assisted with restructuring and re-organisation of hospitals and area health services by, for example, the knowledge that key VMOs will provide particular services for an agreed number of hours so that the necessary staff support and facility allocations may be planned.

- A better mechanism will exist for the avoidance or minimisation of budget excesses.
- Disputes as to time claimed by VMOs under the actual hours system will be minimised.
- The up-front hours mechanism provides more opportunities for adjusting the needs of hospitals than do the blunt instruments presently available.

The benefits of an up-front hours contract as above identified represent, in my assessment, real and substantial improvements in the provision and use of services by VMOs. The benefits take on added importance in justifying an up-front hours contract by reason of their structural efficiency aspects, and so the thrust of the principles of wage fixation according to the *State Wage Case* would be met.

Practicability: The operation in practice of an up-front hours contract has as its core the ability of the parties to reach agreement as to an appropriate number of hours during which a VMO is to render paid medical services during the term of the contract, subject to variation by agreement at any time and subject also to annual reviews. The ability to reach agreement was, as will later appear, challenged by the AMA which seriously questioned the lack of *bona fides* on the part of hospital management in the negotiations, particularly at an annual review. However, and as earlier stated, the AMA in the 1982 and 1983 proceedings adopted the position that agreement was practicable, and, indeed, as the AMA's senior counsel said in the 1982 proceedings - "That has a great deal of attraction to the AMA because ... it is a more acceptable professional solution to the problem. It does not involve them in taking a stopwatch with them while they go to the hospital. It means that, with the exception of call-backs out of hours, call-backs on call periods, they know what their commitment is and they attend the requirements of the

hospital and the requirements of the patient." The unanimous opposition of the VMOs in the present proceedings to an up-front hours contract seemed, in my assessment of it, to stem from the repercussion of the 1984-85 doctors' dispute when feelings ran high and distrust arose. One is reminded of Dr. Horvath's comment in that respect of an "us and them" mentality emerging; but one is reminded also of the intention of the up-front hours system to again involve VMOs in the decision-making process by negotiation and consultation with hospital management. Nevertheless, the problem was put by Dr. Jensen in this way:

> Q. I would like to ask you about the form of contract that is proposed by the Minister.
>
> If you assume that the salient features of that contract are that at the commencement of the contract there would be a discussion and then a particular number of hours would be specified in the VMO's contract, as being the hours he would be remunerated for, that annually that would be reviewed by the hospital administration who, having taken into account the VMO's view, would have the authority at its discretion to vary those hours of work and, if the VMO is dissatisfied with the outcome of the annual review, the question could be referred to a disputes committee or an arbitrator.
>
> Assume if you would in the interim it would be open to either side to approach the other for an adjustment in the remunerated hours, if there were agreement, that would be done but, if there was not agreement, then again that would be a matter that would be capable of being arbitrated.
>
> Please further assume that the doctor would be paid for those remunerated hours specified in the contract, irrespective of whether he worked those hours - less or more - what would your reaction be to a contract of that kind?
> A. Well, I've already indicated in my statement that I have great difficulty with that type of contract. I have difficulty with signing a contract at the outset that leaves me in a difficult situation at the end of a period of time - say six or twelve months, or whatever - where the administration has the power to alter that, where the comeback is a dispute settling mechanism.
>
> I find that a very difficult concept. We have already demonstrated - I presume the Minister's reason for doing that is he wishes to have control of the budgets and so on. We have certainly demonstrated that is no problem. There's no problem in controlling admissions to the hospital, there's no problem in controlling surgical lists and so on; so, that is - you don't need that sort of thing, even though our institute structure - even without the sophisticated arrangements

that they are proposing - the hospital administration does not need this sort of contract to control budgets.

On the other hand, we're asked to sign a contract where, at the end of a period of time, we have to give recourse to a number of factors in those five or six items listed that potentially leaves power totally in the hands of the administrators to change that, and the mechanism they have to resolve any problems is the dispute mechanism. Somebody who is advising or assisting the AMA - there's millions of dollars being spent in this courtcase, both by our side and the Government and the Health Department, to arrive at a contract that at the end of the day would force each individual VMO - or 2550 VMOs or 2700 VMOs to then undergo a further series of discussions, some of them, I am absolutely certain, would not be favourable to administrators, despite whatever assumptions and assurances you might give me, we have this untenable situation, and I do not see the need for it. It has been amply demonstrated that the system is now working extremely well.

The doctors' dispute is in the past. Its aftermath cannot, in the view I take, continue to be used to repress desirable and legitimate reforms consistent with the needs of the public hospital system as it has evolved, and particularly the need for it to operate efficiently in the present economic climate with scarce resources. An up-front hours system was found to be practicable pre-1985, and to me rational and responsible thinking would suggest it again would be practicable of operation. Certainly, in my view, reliance on a perceived lack of *bona fides* very much stemming from the doctors' dispute is no reason to reject the proposed up-front hours system with its many tangible benefits, not the least of which is to again necessarily bring VMOs and hospital managements together in a consultative process.

There is no evidence which would lead me to doubt the *bona fides* of hospital managements in the administration of an up-front hours system. In fact, the evidence of Dr. Child, Dr. Horvath, Dr. Spring, Mr. Taylor and Mr. Clout is very much to the contrary. I propose to presume all parties to contract negotiations would be genuine in their endeavours as professionals committed to the successful operation of the system.

Reasonableness: The basic fairness of the proposed system is in the requirement for the hours to be as agreed between the VMO and the

relevant hospital or area health service, and that requirement for agreement exists where it is desired the contract be varied at any time during its term. Given the ability for agreement to be reached, no issue can be taken, it seems to me, with the fairness of the proposal.

At the time of each annual review the proposal requires the VMO and the relevant hospital or area health service to consult as to the number of hours to be specified for the following year, but if agreement is not reached then the proposal contemplates the hospital or area health service concerned deciding the number of hours having regard to specified criteria. The criteria range from the needs and resources of the hospital considering the views of the VMO, and through to the actual hours of service provided during the preceding year, including the nature of the VMO's appointment, experience, knowledge and ability and any other relevant fact or circumstance. The hospital or area health service thus has imposed upon it the requirement to consider relevant matters; that seems to me to be fair to the VMO. In any event, it must be undoubted that a principal engaging an independent contractor has the right to decide when and for what period the contractor is to provide services; that is unexceptional.

A further aspect of the proposal is the obligation imposed on a hospital or an area health service to only allocate work which the VMO can reasonably perform within the agreed number of hours. That, in my view, is fair.

Extended sessions loading: An aspect of unfairness alleged by the AMA was that a VMO would simply continue treating patients, notwithstanding he had reached or exceeded the number of hours for which payment was to be made, having in mind his professional and ethical responsibilities to care for patients and even though it was not proposed the contract should expressly impose the obligation to do so. The

Minister met that situation by conceding what was referred to as an extended sessions loading in the amount of 5 percent of the hourly rate to be paid for each agreed hour specified in the contract, and during call-backs, whether or not the VMO provided services beyond the agreed hours. Thus, for twenty hours of services provided a VMO would receive payment for twenty-one hours.

It should be mentioned that the present determination contains, as did earlier determinations from 1981, a loading for split sessions of 5 percent of the hourly rate and the Minister on this occasion sought the removal of that loading. That issue will be considered later as part of the remuneration claims, but its connection with the extended sessions loading cannot be overlooked. Effectively, and as was submitted for the Minister, the extended sessions loading was considered an appropriate replacement for the split sessions loading. In the particulars supplied in explanation of the claim the Minister stated:

> The concept of split sessions is anachronistic, and has been so since the concept of contracted hours changed from the traditional 3 and 1/2 hour sessions to any number of hours over and above the base of 1 hour, in the 1981 case. The Department has re-designated that part of the loading, ie., from "split" to "extended", as it is believed that it more aptly describes the actual situation where, for instance, a VMO (say a surgeon) is working a public hospital list anticipated to take 4 hours but it takes 5 hours, either because of the addition of patients or the list takes longer than anticipated.

As to the payment for additional time worked, the AMA sought further particulars from the Minister and the following question and answer emerged:

> AMA question: Is it contemplated that if a VMO is required to work an additional hour following say four (4) hours of contracted time, the only remuneration for the additional hour would be covered by the five percent (5%) "extended sessions" loading?
>
> We consider that the Department's position would be clarified by a definition of "extended sessions".
>
> Could you supply a definition please?

Minister's answer: The Department certainly does contemplate that "the only remuneration for the additional hour would be covered by the five percent (5%) 'extended session' loading". It must be appreciated that the extended session loading forms part of the hourly rate of pay for each and every contractually agreed hour of work. Those hours are loaded so as to (more than) adequately allow for the contingency/possibility that in certain circumstances the VMO *may* be required to work longer in the hospital on a particular visit than he/she had planned to which *may* also mean (but not necessarily so) that more than the agreed number of hours will be worked in a particular week/fortnight/calendar month. It should also be noted that the 5% extended session loading will be paid for each agreed hour of service even when no 'extended' hours are worked and even when less than the agreed number of hours is actually worked in a given period. Finally, as was stressed in our earlier response ... the provisions of clause 6(ii) to (iv) are designed to properly accommodate, *inter alia*, 'extended' hours (i.e. over and above the agreed hours) becomes something more than a rarely occurring aberration.

Whilst this definition will need refinement it is intended that "Extended session" will mean that extra period of time that a VMO is required to spend rendering services to hospital patients, that extends the length of a particular visit/attendance and may result in more that the agreed number of hours being worked by the VMO in the agreed period.

It seems to me in an up-front hours contract, with payment for a fixed number of hours regardless of the actual hours worked in the agreed period, a loading in the amount of 5 percent to compensate for those occasions when a VMO may work more hours than those specified is not unreasonable, particularly having in mind on some occasions less hours may be worked than those specified but for which the specified hours will still be paid, including, of course, the 5 percent loading in the hourly rate. I accept the reasonableness of the 5 percent extended sessions loading. Whether that means the 5 percent split sessions loading should be deleted will be a matter for consideration later, but I observe at this stage that a loading to compensate for split sessions seems, at least on its face, to be out of harmony with an up-front hours system and possibly even redundant following the change in the 1981 determination from a sessional to an hourly basis.

Safeguards: Apart from the fairness of the up-front hours concept, the Minister's claim included what were safeguards from the point of view of the VMO. Those safeguards included a provision preventing the allocation of more work to a VMO than could reasonably be performed in the agreed hours, a capacity for the hours to be varied at any time by agreement, referral of any dispute for settlement to the dispute's mechanism and an annual review of the specified hours. Those safeguards, under the proposal, would have contractual recognition, and, in my view, they represent adequate protection for a VMO in the operation of an up-front hours contract where for some reason he may work consistently longer hours than those for which he was paid. Equally, of course, a hospital or an area health service, because a VMO may consistently work fewer hours than those specified in the contract could move to seek a variation to more accurately reflect the reality. Either way, I accept the Minister's proposal as containing adequate safeguards to make an up-front hours contract viable.

Resistance to up-front hours contract

The AMA was robust in its opposition to the Minister's claim in this respect. All of the VMOs who gave evidence included in their prepared statements a section in consistent terms expressing opposition to the up-front hours concept. A typical statement was that of Dr. Jensen, as follows:

> **Fixed Hours**
>
> 41. I consider that I ought to be paid for the work that I do and not paid when I do not provide services. In this regard the current system under which I am paid, namely for actual work done, seems to me to be the fairest and most appropriate.
>
> 42. I understand that the Department considers that hospitals can only accurately budget in respect of services provided by visiting medical officers if they have fixed contracts. In my opinion there is no need for these contracts as the data

currently available to hospitals should enable them to budget appropriately.

43. I am also concerned by the proposal that at the end of each year or possibly some earlier period I will have to negotiate with the Hospital concerning the amount of hours to be remunerated under my contract. The budgetary restrictions that apply to hospital administrators would place enormous pressure on them to negotiate fixed contracts whereby VMOs would not be paid for all the hours that they did. If this occurred to me I would have to re-consider my position at the Hospital.

44. Furthermore, I consider that any proposal for imposing a system of fixed hours under which payment for VMOs' services is limited to their fixed hours with the expectation that they will continue to provide services after their fixed hours expire, is likely to have a serious effect on the morale of VMOs and is inimical to the future of the public hospital system.

Dr. Trew put his position thus:

Upfront Hours

24. I understand that the Minister is making a claim to have a contract put in place in which there will be a fixed number of hours for which the visiting medical officer will be paid irrespective of the number of hours he works. I also understand that the hospital will be entitled to adjust those hours on an annual basis whether or not I agree to such adjustment.

25. In my role as Divisional head and in allocating budgets I have in mind that I want value for the money I am allocating. To have such a contract in place is not going to be helpful to control the budget because the work that needs to be completed will be completed in any event, whether the practitioner is paid for the hours or not. I have been able to make an assessment of the requirements of the Division for the following year from the records available in the hospital and make adjustments without imposing such a system.

26. It seems to me that to give one party to the contract an entitlement to vary it in such a way without agreement is unfair. I believe it will do little to enhance the relationship between the VMO and the hospital. I would be concerned that the imposition of such a system as the only available option for the provision of medical services by VMOs would be detrimental to the relationship that has been built up in the manner I have outlined in paragraph 21 above.

Dr. Trew, as Head of the Division of Medicine at St. George Hospital, said he invited the VMOs to group meetings on a regular basis to discuss in an open fashion the particular practices of each of them. That

certainly moves some way towards one of the intentions of the Minister's up-front hours claim by encouraging greater involvement of VMOs in the hospital system, but it does not, as the Minister's claim envisages, involve consultations between a VMO and the hospital administration.

Both Dr. Jensen and Dr. Trew denied budgetary assistance from the up-front hours system, essentially on the basis hospitals had the data available from previous years to enable budgets to be set for future years. That may well be so, but it seems to me the formulation of budgets by merely accepting previous budgets and actual experience is not management but simply record keeping; it would certainly not involve consideration of the re-allocation of scarce resources and would perpetuate any previous inefficiencies. That cannot be a proper system, and those types of matters were the very problems which the Minister's claim sought to meet. Also, it would represent, in my view, non-compliance by a hospital and an area health service with the statutory duties cast on them for the efficient and economic operation of hospitals under their control.

The difficulties which were seen to arise from a fixed hours contract were dealt with by Dr. Hyslop in the following way:

Fixed Hours

41. As stated above I am paid on the basis of actual hours worked which I believe is the fairest system. The concept of fixed hours, at least to me, suggests that a uniformity of time or something approaching it, will be spent in relation to an operating list. In my experience major cases are more likely to be longer than shorter than anticipated, especially if one is teaching a Registrar. Minor cases may have anaesthetic problems which then take longer, or may be extremely simple and be accomplished sooner than anticipated.

42. I believe that if the hours attracting payment were fixed, productivity may be impaired as surgeons would be encouraged not to book too many patients (for fear of going over their fixed hours) and to pace themselves in order to utilise all time allocated under the fixed contract.

43. Fixed hours contracts do not appear to satisfactorily comprehend fluctuations in the volume of patients attending

a clinic supervised by a particular VMO, for example in my case, the increase in patients in the antenatal clinics on a Tuesday which result from a public holiday on the preceding Monday. Other factors which can influence the amount of VMO time required in the antenatal clinic are as follows:-

- The number of patients who turn up;
- The number of residents/registrars who turn up and when they turn up;
- Any interruptions caused by, for example, residents/registrars having to leave;
- The number of patients seen by the VMO at the request of the midwives conducting their own antenatal clinic for low risk patients.

The service to patients in the antenatal clinic may be considerably reduced if the VMO consultant is limited to a fixed time. It appears to me infinitely more efficient for the VMO's hours to be flexible so that he is providing the service when it is required.

44. In relation to ward rounds, they can vary from me having no patients to see, to sometimes 45 minutes per round depending upon any problems which may be encountered in the antenatal, post-natal and gynaecological areas.

45. I understand that it is proposed by the Department that the VMO will negotiate with the hospital in relation to the appropriate number of hours to be fixed in the contract which will attract remuneration. It occurs to me that the Hospital may see fixed hours negotiations as presenting an opportunity to limit the post operative time spent by a VMO surgeon to a nominal amount, perhaps on the basis that post operative care could adequately be continued by resident staff in the interests of "efficiency". However, such action may result in two undesirable consequences:-

- First a longer stay for the patient - The experienced specialist (unlike resident staff) can pick, treat and often prevent complications and thereby shorten hospital stays; and

- The ethical and legal obligations of the VMO require him or her to, once management of the patient has been accepted, continue to be directly responsible for the management of the patient until the patient is discharged subject only to the parameters of their expertise and competence. Any move to compromise that role presents an ethical difficulty for the VMO.

46. I also believe that the hospitals will see in these negotiations an opportunity for limiting the VMO surgeon to payment for time actually spent operating, thereby leaving the VMO unremunerated in respect of the enormous amount of time he is required to spend waiting around public hospitals during the inefficient changeover of cases.

47. I understand that the Department of Health claims that fixed hours contracts are necessary to enable them to budget effectively. I believe that sufficient information is already available for the hospital to budget in relation to the VMO line without the need for fixed hours contracts e.g.:-

- adequate data in respect of claims made by VMOs over the years;
- projected increases in CPI;
- records of increased patient usage and projections of future usage;
- data in relation to the increased proportion of hospital patients.

The clinical considerations referred to by Dr. Hyslop as influencing the variable amount of time required to be spent by a VMO do not, in my view, act against the up-front hours concept because, and as the evidence disclosed, VMOs are well able from experience to quite accurately assess the amount of time spent by them on average in rendering services to public patients. The averaging mechanism, of course, is a key part of the Minister's up-front hours claim and is one of the specific factors to be taken into account at the annual reviews. I therefore conclude there to be no clinical impediment to the Minister's claim.

An interesting reference was made by Dr. Pennington to the operation of fixed hours contracts in the United Kingdom. He said in his statement:

Upfront Hours

26. I am absolutely opposed to a fixed hours contract. I believe that I should be paid for the work that I do. Hospital work is unpredictable in terms of time required, except for the routine part of one's day such as ward rounds and outpatient's sessions. Operating sessions are very unpredictable, particularly where operations are thought to be straightforward but subsequently turn out not to be so. This is especially true in trauma cases and urgent work of any kind is by its nature completely unpredictable.

27. I consider it unfair to be required to provide treatment to patients beyond the time stipulated in a fixed contract. The hospital would simply exploit the natural tendency of doctors to feel sorry for the sick and sacrifice themselves and their families. In the current financial atmosphere the hospital's imperative is cost containment.

28. To offer no financial incentive to treat patients will discourage the conscientious and harden the lazy and cynical. This is supported by my experience in the UK where doctors are paid the same remuneration irrespective of how much work is done. Any case that was not "life threatening" was put off until a later date and it was common to have elective surgical waiting lists of longer than 10 years. With notable exceptions, many of the doctors in the United Kingdom became lazy and unwilling to provide more than a basic service.

The overseas experience was not developed at all in the evidence, but the asserted consequences of it as stated by Dr. Pennington should not pass without comment. To liken the Minister's claim to "no financial incentive to treat patients" is to misconceive the claim; the alleged consequences of the claim to "discourage the conscientious and harden the lazy and cynical" is to pre-judge the system to an extreme degree. I have earlier reasoned the deficiencies in the present system and the justification for up-front hours contracts. The perceived benefits and fairness, including the safeguards, of the proposed system lead me against the consequences stated by Dr. Pennington. In addition, of course, the proposed extended sessions loading of 5 percent must be taken into account in assessing reasonable compensation. I must say Dr. Pennington's conclusion that "many of the doctors in the United Kingdom became lazy and unwilling to provide more than a basic service", if translated to New South Wales, would be cause for considerable alarm and hesitation in introducing an up-front hours system. However, I am not prepared, on the evidence, to accept that that would be the probable consequence in this State. It is true, as noted earlier, there are differing attitudes amongst VMOs, but I am only able to presume that a medical practitioner who accepts a VMO appointment will discharge his responsibilities in an ethical and professional manner; if he were not to do so, then, it seems to me, the responsibility of hospital management would be to deal with that VMO and act appropriately in relation to the continuation of his sessional contract. Further, Dr. Pennington's remarks

overlook what would appear to be the successful operation of not dissimilar hours prescriptions in determinations up to 1981 and of the AMA's expressed favourable attitude towards such type of contract in the 1982 and 1983 proceedings. The essential element in the formulation of an hours provision would seem, on the AMA's part, to be the ultimate safeguard whereby a VMO has been able since the 1983 determination to elect at his absolute discretion to be remunerated on an actual hours basis. Having in mind the evidence as to the wide variation in the attitudes and behaviour of VMOs in the performance of their sessional contracts, I am not prepared to make a determination continuing a provision giving VMOs such unilateral discretion on an important issue with structural efficiency implications for the proper functioning of the public hospital system. On the other hand, the Minister's claim, in my view, seeks to involve VMOs in a consultative process to assess an appropriate number of contract hours and with a mechanism for review. It is only where agreement cannot be reached at a review that a hospital or an area health service may decide the hours according to specified criteria, and , of course, if that decision be unacceptable, a particular VMO may terminate the contract. The Minister's proposal in that situation envisages a notice period of six weeks in lieu of the general period of three months. Although that notice period of six weeks may, in the circumstances, be a little long, it nevertheless provides a resolution where agreement cannot be reached.

Specific aspects of the Minister's claim were addressed by the AMA and those matters are dealt with below.

Uniqueness or novelty: The AMA denied the Minister's suggestion that the proposed up-front hours contract was not novel as being consistent with previous determinations from 1976 to at least that in 1981. The AMA submitted that in none of the earlier determinations could it be said

a VMO was subject to a term and condition of work under which he was to provide services beyond an agreed commitment and not be paid for those hours. Also, it was put that there had never been a time when a system had been accepted which permitted unilateral variation of the agreement during its currency. The agreed hours contracts presently in force at Royal North Shore Hospital were said, on their true construction, not to be up-front hours contracts as VMOs had the option of being paid on an actual hours basis.

I have earlier examined the history of hours prescriptions and, whilst they were not precisely in terms of the Minister's present claim, the conceptual similarities are significant. I do not repeat the conclusions made already by me in this respect as they are sufficiently detailed above; suffice it to say those conclusions are against the AMA's submission that the Minister's present claim is so unique or novel as to be unsupported. Where the claim departs from earlier fixations is the VMOs' unilateral right to determine their own hours and be paid on an actual hours basis; again, as I have said, a discretion of that type should not be continued in a new determination.

Ethical considerations: The AMA relied on the evidence of the various VMO witnesses to the effect that ethically they regarded themselves as obliged to be the advocate for individual patients in obtaining whatever treatment they could for them and would continue treating patients according to clinical need even though hours under a fixed hours contract may be exceeded. This ethical question, and the apparent dilemma it posed, has been the subject of earlier consideration by me by reference, in particular, to the evidence given by Dr. Horvath. I need only affirm my acceptance of her approach to the problem, which has the necessary conclusion that I do not see the Minister's up-front hours claim, if granted, as posing any real ethical difficulty for VMOs.

The Minister's claim does not, in my reading of it, purport to remove the VMO's right, indeed duty, to treat public patients and to provide the other specified services once the agreed hours have been reached. So, and consistent with ethical considerations, a VMO would be able, and in my view expected, to continue the particular service which he was providing; from a practical point of view, in the next monthly period his hours may be less than those specified in the contract. In any event, the extended sessions loading would appropriately meet that situation. Further, over the whole contract period, or a substantial part thereof, the hours may reasonably be expected to balance. It therefore follows, as I would reason, that the question of a VMO regularly working longer than the hours for which he was paid would be more imaginary than real, and particularly where the Minister's proposal contains a review mechanism.

Criticism of the "blunt instrument": Reference has been made earlier to the Minister's preference in the management of hospital activity, and hence costs, for VMOs' remunerated hours to be ascertained and known in advance by means of the up-front hours system rather than recourse to what were referred to as "blunt instruments", such as hospital closures, ward closures and restrictions on theatre time. The AMA challenged the Minister's reliance on that preference as a "bizarre comparison (which) must be rejected as misleading and inappropriate". The up-front hours system, said the AMA, was in reality a blunt instrument, masquerading as a sharp instrument, because it involved a unilateral decision-making process in favour of hospital management; therefore, it was no real alternative at all.

I must say I did not understand the Minister's case to be that the up-front hours claim was put forward as an alternative to or a substitute for what were otherwise described as the "blunt instruments". Shortly stated, I understood the Minister's submission on this aspect to be that the

up-front hours system would facilitate consultation between VMOs and hospital management so as to re-involve VMOs in the process of control over hospital activity so that the use of the blunt instruments would be minimised. Seen in that way, the up-front hours system would represent a very real benefit and improvement to the present position.

Alleged problem of increased VMO costs: The Minister's reliance on payments to VMOs being in excess of budget so as to justify the adoption of an up-front hours contract to more readily control hospital activity generated by VMOs was said by the AMA to be based on a "paucity of material" so that there was no "genuine problem about controlling VMO expenditure". Much of the proceedings was concerned with a detailed examination of VMO expenditure, and the reasons therefor, after the introduction of global budgeting in 1988, and, in particular, the actual expenditure against budget for the years 1990-91 and 1991-92. Whilst it was conceded by the AMA that in the year 1990-91 VMO expenditure exceeded budget by 3.2 percent ($6.7 million) and in the year 1991-92 the excess was 3.9 percent ($8.1 million), the total circumstances disclosed on the part of the Department of Health an intentional tolerance of such excesses in the context of accommodating an increase in services within balanced global budgets. For instance, as to the year 1990-91, it was pointed out there had been an increase in patient admissions, and hence in activity, which was accommodated in hospitals' global budgets and an increase in salaried staff to handle that increased activity; the excess of VMO expenditure over budget was, therefore, to be expected with increased activity levels. For the year 1991-92 a similar pattern emerged, but was exacerbated by the fact the VMO budget over-run of 3.9 percent arose in the context of the 1991-92 VMO budget being set below that for the year 1990-91 and where patient admissions in 1991-92 increased by 4.8 percent. It followed, said the AMA, that with VMO expenditure being

fairly static at 3.1 percent over the previous year's expenditure it was hardly suggestive of such expenditure being out of control as put for the Minister. My attention was directed to "scant evidence of concern on the part of the financial arms of the Health Department and of the areas and regions about VMO expenditure."

I should observe both Mr. *Sperling* and Mr. *Kenzie* attended carefully to the detailed financial evidence on this aspect to make out their respective cases. I have found that material helpful, but in the view I have formed I find it unnecessary to conduct here an appraisal of it. It is sufficient, I think, for the purpose of assessing whether VMO expenditure is a continuing problem in the control of hospital costs so as to support the adoption of an up-front hours contract as a control facility, to recall the evidence of Mr. Barker. The specific evidence I have in mind in that respect was detailed earlier, to the effect that VMO expenditure increased from around $50 million for the year 1984-85 to $200 million for the year 1988-89; VMO expenditure is approximately 6 percent of the total health budget which itself represents around 28 percent of the State's budget. I have in mind also the evidence of Mr. Barker as to the economic consequences of the granting of the AMA's present claims. It would be quite irresponsible, as I approach the problem, to not give decisive weight to those facts as favouring the acceptance of the facility of an up-front hours contract as the means for controlling VMO expenditure as a significant cost component in the public hospital system.

The assertion by the AMA that the Department has intentionally tolerated increased VMO expenditure is not an inference I draw from the evidence. Indeed, the facts disclose to the contrary, as shown by Mr. Barker's evidence of tightening budgetary control, Mr. Clout's evidence of negotiations between the Department and the AMA over a number of years prior to the present proceedings, the request on 24 October 1988 by

the Minister for the Public Accounts Committee to inquire into payments to VMOs, and the very basis on which the Minister's present claims have been advanced.

Lack of need for up-front hours approach: The AMA took issue with the Minister's submissions as to the deficiencies in the present actual hours system and so denied any need for a change to an up-front hours approach. Two limbs of the Minister's argument in this respect were attacked by the AMA, namely that VMOs' clinical activities are not presently amenable to control, and, secondly, that VMOs are prone to abuses. As to the control question, Mr. *Sperling* in written submissions put it as follows:

> The Minister claims that VMOs are powerful people and can't be controlled by what he persists in describing as "blunt instruments". ... Quite apart from the totally misleading picture of VMOs this presents, the evidence simply does not support the proposition.
>
> It has been demonstrated in the AMA's final submissions and in its reply submissions on the normal hourly rate that it is VMOs who are:-
>
> . Assisting the management with management of departments, institutes and hospitals.
>
> . Assisting the management with budgetting.
>
> . Developing *with* management appropriate peer review and quality assurance programmes.
>
> . Developing networking of services with management.
>
> . Making contributions to state wide programmes together with management for the better delivery of health services. ...
>
> These are just a few examples of such commitment and demonstrated co-operation with management throughout New South Wales.
>
> This is hardly indicative of a group that is out of control and in need of pummelling with anything, let alone with the Minister's new "blunt instrument", his Upfront Hours Contract.
>
> ...
>
> The evidence of the visiting medical officers in this case demonstrates that each group have been acutely aware of the

budget and the need to provide services within that budget. It is simply to deny the fact to say that the VMO is out of control.

As to the abuses question, Mr. *Sperling* said in the written submissions:

> In support of this proposition the Minister ... is critical of the *present* system because it is open ended and provides obvious *opportunity* for abuse. He goes further however and says that *abuses are present* within the system. From these examples he moves to an upfront hours system to cure these defects.

Mr. *Sperling* then referred to and explained the particular examples relied upon by the Minister to show opportunities for abuse of the present system by VMOs.

The response by Mr. *Kenzie* on those submissions included the following points:

> In particular it is wrong to suggest that the Minister's case as to the need for the upfront hours contract is simply based on the need to control VMOs clinical activities and on evidence as to abuse. The Minister's case is that the upfront hours prescription is a *much more efficient prescription* than the one which exists at present. It is also contended that it is a *much better management tool* than the determination which exists at present. As a part of the Minister's case it is said (as is recognised) that VMO clinical activities are not presently able to be controlled to a sufficient extent.
>
> ...
>
> In addition the Minister says that the Arbitrator will not be assisted by emotive phrases such as "out of control and in need of pummelling". The issue is whether the current system is the most suitable and efficient and fair system.
>
> ...
>
> It is more accurate to suggest that the upfront hours system will assist in minimising the opportunity for abuse. The Minister says that such an approach is consistent with considerations of efficiency generally.
>
> ...
>
> However the Minister submits that considerations of efficiency, particularly when large sums of money are involved on an ongoing and regular basis, dictate that every effort should be made to come forward with a system which is efficient and minimises the opportunity for abuse.
>
> ...

> The Minister's position, on the other hand, is to include within the concept of "abuses" inefficient and slack practices which cost the public hospital system more unjustifiably. For example, a VMO may attach himself to a ward round without considering that the value in so doing is not reflected in the charge to the public purse incurred thereby - or not consistent with the priorities of the public hospital concerned. This would be an "abuse", but clearly not fraud.
>
> The Minister's case is, and always has been, that such abuses (as generally understood) will be minimised under the Minister's scheme because, pursuant to the reassessment of "clinical need" and re-prioritization of activity which is contemplated, there will be less scope for slack and inefficient use of paid time.

I do not see it as necessary in considering the up-front hours claim to make findings on whether the evidence established VMOs as a group were "out of control and in need of pummelling"; that rhetoric by the AMA was irrelevant as a misunderstanding of the way in which the Minister's case was put, as shown in the above extracts from Mr. *Kenzie's* submissions. Also, it was no part of the Minister's case that the claim would cure defects but rather would assist to minimise the opportunity for abuse; a system which is shown to be efficient and capable of minimising opportunity for abuse must be commended.

Colin MacArthur, General Manager of the Liverpool Health Service in the South Western Sydney Area Health Service, commented on the Minister's up-front hours claim as follows:

> The degree to which the introduction of Clause 6 (h) has caused loss of control of VMO payments has varied from hospital to hospital. In general, I have not experienced such loss of control, but that is probably because I have worked in hospitals with controlled VMO establishments in Areas of population and service growth. I accept that control has been more difficult in teaching hospitals with less well controlled VMO establishment numbers, particularly in Areas where Public Health spending has been relatively static. I support the principle of "up-front" contracts as the only way to provide appropriate controls in all hospitals. Although I do not fully support Dr. Horvath's view (at page 12) that there are no discernible advantages to the public hospital system of the actual hours approach to VMO remuneration, I consider that the proposed up-front contractual approach is workable and will have considerable benefits to the public hospital system as a whole. I support the view expressed by both Drs. Horvath and Spring that such an approach would enable hospital management more effectively to manage and budget for VMO costs, whether this is

conducted within clinical units (in many teaching hospitals) or by the central hospital administration (more usual in district and base hospitals).

I regard Dr. MacArthur's view as a balanced approach to the problem and supportive of the way in which Mr. *Kenzie* put the case.

The Association of Medical Superintendents, as earlier referred to, in its submission to the enquiry conducted by the Public Accounts Committee emphasised the need for sufficient accountability of VMO activity. Further, the submission to that same enquiry by the New South Wales Branch of the Australian Hospital Association commented "that Visiting Medical Officers' services have implications beyond just the one line item in the Health Department allocation. Examples of this include the costs associated with Visiting Medical Officer services, e.g. operations, prosthesis, length of stay, drug costs, introduction of technology, nursing dependency levels, etc." In a situation where VMO activity has direct and indirect effects on overall hospital activity with its consequent costs, it seems, at least to me, to be unarguable that a system which better manages such activity should be implemented. As I have earlier found, the up-front hours system is appropriate for such purpose so that, and contrary to the AMA's approach, I accept the need for its implementation in sessional contracts.

Effects of performance contracts: The fact senior health executives of hospitals and area health services and regional directors of health operate under "performance contracts", whereby there is a contractual requirement for them to achieve budget or face the prospect of dismissal, was relied upon by the AMA for the proposition that administrators would be obliged to look for opportunities to reduce costs and so would be duty bound to negotiate a contract with a VMO at the lowest number of hours possible. I perceived the implication in such circumstances that the *bona*

fides of administrators under performance contracts in negotiating an up-front hours contract with a VMO may be open to question.

I place no credence on this argument in resisting the Minister's claim. As I commented earlier, there is no evidence which suggests administrators would act other than *bona fide* in negotiations with VMOs, and there must be a presumption that the negotiations will be entered into genuinely by all parties. Of course, it is to be recognised hospital administrators have the duty to match resources with services to be provided by VMOs and to do so consistent with budgetary constraints - in the present economic climate of scarce resources such an approach seems to me to be understandable.

Undesirable and unfair consequences: Mr. *Sperling* helpfully provided an outline of the evidence called by the AMA in relation to the Minister's up-front hours claim, and, by reference to that outline, senior counsel summarised the main points. I have perused that material and have endeavoured to deal earlier with what I consider to be the essential features of it. However, specifically as to the consequences of the operation of an up-front hours system, it is convenient to state the points made by Mr. *Sperling* as follows -

- The power of unilateral variation by the hospital on annual review is unfair.
- The contract provides in effect for a salary, that is a payment fixed by the hospital, but with the right to vary the salary.
- The balance of power between the hospital and the individual VMO is distinctly in favour of the hospital.
- Most VMOs do not acquire negotiating skills and are not good businessmen.

- Because the contract is unnecessary, VMOs "smell a rat", that is they suspect an ulterior motive, namely an outcome of less remuneration per hour of work.
- The expectation is that hospitals would set hours at less than the work load, particularly on annual reviews, under the influence of budgetary considerations.
- VMOs would end up doing a significant amount of work for nothing. They would be part-time honoraries.
- Dealings with hospital administrators over other matters in the past have been such as to give no confidence administrators will be fair and reasonable on this occasion, or that they will administer the contract with commonsense.
- The extent of the bargaining procedure at the commencement of the triennium and then annually with 3,000 VMOs State-wide, each on an individual basis, all having to be processed at about the same time, should not be under-estimated. Under the pressure of getting through this administrative workload, there is a poor prospect it would be done with proper attention to individual cases, let alone that it would be accompanied by in-depth discussions about hospital resources, the philosophy of prioritisation, the likely future activity of the VMO, his efficiency relative to others, etc.
- Administrators are by nature inflexible. The prospect of securing *ad hoc* variations to contracts due to unforeseen developments is slow.
- It is fairer to pay for what is done.
- VMOs would be uncomfortable about taking money for time which was not worked.

- The contract raises a conflict between private interest and professional duty, which would be uncomfortable.
- That conflict would be resolved in favour of professional duty at a sacrifice of private interest, which would be irksome.
- Relationships between VMOs and administrators would be detrimentally affected by such negotiations, because the negotiations involve how many hours should be paid having regard to the VMO's efficiency and the use of his time, that is they question the VMO's competency to work efficiently and impose a sanction for inefficiency as judged by the administration.
- Morale would be adversely affected by imposing a form of contract on VMOs they do not want.
- The contract is primed for confrontation at its inception, on annual review and whenever a disparity arose between the hours fixed and the workload.
- The form of contract would send a message to VMOs that they cannot be trusted to avoid unnecessary activity and that they will over-service dishonestly unless restrained in some way.
- VMOs would resent having to spend time and energy negotiating with administrators about how they were to be paid, knowing it would not affect how much work they were going to do.
- VMOs would see the contract as an attempt to cast the VMO in the role of gate-keeper, that is the one to tell the patient he would have to wait for treatment and how long he would have to wait.

. The contract would be open to abuse in the hands of hospital administrators. A personality clash with a particular administrator might lead to a VMO being discriminated against in terms of hours.

Those matters, and although some of them have been dealt with earlier, may conveniently be grouped in the category of alleged undesirable and unfair consequences were the Minister's up-front hours claim to be adopted. It is simply impracticable to deal with each of those matters separately in turn by reference to the large volume of evidence called, but my general conclusion is they tend to exaggerate and speculate what the consequences may be. It seems to me many of the points rely on mistrust of hospital administrations, suspicions and concern at over-regulation.

Those reactions and views formed by VMOs are unfortunate, and, I think, probably have their origins in the 1984-85 doctors' dispute. Perhaps it may be timely to again observe that that dispute ended eight years ago and there have been many developments in the public hospital system since, which, in the context of the present economic climate, require a system with appropriate controls and regulatory mechanisms - so much is called for in the public interest.

Findings

The conclusions I have reached lead me to find that the Minister has made out a compelling case for the adoption of the up-front hours contract for VMOs. I am comfortably satisfied the present system is deficient in many respects and the up-front hours system is justified in terms of its benefits, practicability and fairness; it has built-in and appropriate safeguards for VMOs, together with compensation in the form of an extended sessions loading. The claim will be granted and a determination made accordingly.

In formulating a determination, the only differences which will be made to the Minister's proposal relate to terminology and drafting matters. The claim refers to the hours being referable to "core services", being the medical services (other than those provided pursuant to a call-back) as dealt with earlier in the contract for services. Having in mind my earlier findings in that respect, it seems to me preferable to refer to the hours specified in a sessional contract, other than those pursuant to a call-back or an on-call roster, as "ordinary hours" for which a VMO shall be paid an ordinary hourly rate of remuneration. The expression "ordinary hours" is a well understood expression in industrial terms and should, in the drafting scheme I have in mind, better fit the prescription for background practice costs allowance, amounts payable for on-call and call-back, and payment for services rendered on a public holiday where required by the relevant public hospital or area health service.

I think it reasonable to include in the new determination, as does the present determination, a provision for a sessional contract to specify not less than one ordinary hour per week, fortnight or calendar month, as the case may be.

As to the annual review of the number of ordinary hours of services specified in a sessional contract, I propose to make explicit reference to the possibility of agreement being reached between the parties, in which case the sessional contract shall be varied accordingly. In the event agreement is not reached, I think it fair for the VMO to be able to terminate the sessional contract by four weeks' notice in writing rather than the six weeks' notice proposed by the Minister.

CHAPTER 9 - REMUNERATION FOR SERVICES

The major issue arising in the proceedings and to which much attention was directed was the amount of remuneration which should be paid to VMOs rendering services under sessional contracts. I may immediately say one could not help but be impressed by the nature of the work performed by VMOs and the high degree of knowledge and skill required to carry it out. I adopt the conclusion reached by Mr. *Rogers* in 1976, namely that VMOs include practitioners whose reputation and skill ranked them in the most pre-eminent in the field, not only in Australia but in the world. As did Mr. *Rogers*, I accept also on the evidence the high quality of the professional skill and ability of VMOs, the exceptional stresses and strains imposed on them in making decisions affecting the very life of patients, the impact on them of the great strides made in medical and general scientific knowledge and their burden in keeping abreast with all new techniques and developments. In the context of that view, it becomes necessary to assess remuneration rates for VMOs in accordance with principle and all relevant circumstances, including those matters which s.29N(2) of the *Public Hospitals Act* requires me to have regard.

Relevant findings

Earlier in these reasons in dealing with the context, basis of approach and previous determinations I made a number of findings. The major findings with direct relevance to rates of remuneration may be stated as -

- VMOs, from general practitioner to senior specialist level, include medical practitioners with undoubted commitment to and co-operation with the public hospital system as it has been evolving.

- That commitment and co-operation are by no means universal, and sufficient numbers of VMOs are not participating with the majority of their colleagues in ensuring structural efficiencies consistent with available resources.
- The various changes to the public hospital system have been designed to ensure comprehensive control over the system, including by the participation of VMOs in a consultative capacity.
- The present context of the public hospital system, and the way in which it has developed in the last decade or so and having in mind its needs in the foreseeable future, firmly make out the Minister's case for the implementation of structural efficiency measures and for a determination affecting VMOs under sessional contracts to recognise that by appropriate provisions.
- The consequence of the present economic situation is that for the AMA's claims to be granted in whole or in substantial part would require a most decisive and compelling case to be made out. In the balance would be the benefits of the implementation of the Minister's various structural efficiency measures as being a significant contribution to the containment of VMO costs in practice and as directly improving productivity and efficiency overall in the public hospital system.
- The principles of wage fixation as formulated in the *State Wage Case - May 1991* are appropriate to take into account in assessing rates of remuneration for VMOs as independent contractors.

- The specific principles are those relating to structural efficiency and work value changes, but the nature of the claims and the circumstances in which they arise require processing as a special case.
- Consistent with the purpose and intent of the principles, a policy of restraint should be adopted in fixing rates of remuneration, particularly having in mind the economic consequences.
- Sessional rates fixed by the 1985 determination were assessed erroneously as income maintenance to compensate for the "Medicare effect" and as relief against the former "Robin Hood principle" but which only survived as a component in the private fee structure. The 1985 approach was, therefore, fundamentally flawed.
- The failure to apply, or even consider, the principles of wage fixation further compounded the error in the 1985 approach, as did the apparent absence in the decision-making process of the economic consequences of any determination.
- The resultant rates of sessional remuneration fixed in 1985 represented significant and inordinately high increases unsupported by proper principle.
- The provision of the 1985 determination as to the automatic adjustment of remuneration rates following increases in the basic wage, as interpreted in *Hyslop (No.2)*, compounded the excessive increases in the sessional rates and is contrary to industrial equity, merit and principle.
- It is unsafe and inappropriate to use the 1985 determination as a base on which to make a new determination. The appropriate determination for use as a basic reference is that

made in 1982, as adjusted and up-dated by that made in 1983. As part of a total review, the 1976 private arbitration and recommendations remain foundational and to which particular weight should be given.

The respective claims

The parties were wide apart in the claims made for appropriate rates of remuneration. It is necessary to state the different approaches.

AMA's approach: The normal hourly rates claimed by the AMA, including the 49.3 percent loading but excluding the background practice costs allowance, were:

Classification	Existing Normal Hourly Rate	Claimed Normal Hourly Rate	Increase	
	$	$	$	%
General practitioner - less than 5 years	63.00	89.10	26.10	41.4
5 to less than 10 years	71.00	99.00	28.00	39.4
10 years or FRACGP	88.50	123.75	35.25	39.8
Specialist	102.50	143.55	41.05	40.1
Senior specialist	110.50	155.10	44.60	40.4

Mr. *Sperling* introduced his final submissions on remuneration by the following comment:

> By way of preface could I remind your Honour yet again of the terms of the section under which you honour will make this determination, and that is section 29M, which I imagine your Honour now knows by heart. Could I emphasise what we would wish to emphasise - namely, that in subsection (1) the Arbitrator is to act judicially and be governed by equity and good conscience without regard to technicalities and legal forms; and in subsection (2) that in making the determination the Arbitrator shall have regard to three matters - economic consequences, most recent determination under section 57 and principles of wage fixation.
>
> The overriding consideration, we would suggest, is one of fairness; and we will be putting a submission to supplement what we said in opening about the proper role of wage fixing principles. May I say at this stage that in exercising a determination on the ground of fairness we have proposed a number of different ways of looking at

the problem which are encapsulated in our three exercises, and in what really is a fourth exercise which was the tender of evidence relating to the rates charged by other professional people; but the best evidence for the assessment of a fair and reasonable rate of remuneration is the evidence that your Honour has heard from the witness box.

Your Honour has had the evidence from a large number of visiting medical officers drawn from a variety of specialties and a variety of locations and a variety of kinds of hospital. Your Honour has the evidence of the services that they provide, the length and intensity of their training, particularly for specialist qualifications, but even for general practice - the length and intensity of the training would be known to be at the higher end of professional qualifications generally.

Your Honour has heard of the need for updating skills which visiting medical officers must undertake at their own expense. Your Honour has heard of the rigour of peer review and quality assurance which visiting medical officers undertake to ensure the maintenance of their standards. Your Honour has heard what the commitments to on call roster and call backs involve. Your Honour has the contribution which visiting medical officers make to hospital management and administration, including planning. Your Honour has the pressures arising from budgetary constraints which now impinge so heavily on their professional lives.

Your Honour has heard from a number of hospital administrators. Your Honour has heard of a number of hospital administrators. They obviously vary greatly in quality and attitude; but it is significant that in many of them there is a negative attitude towards visiting medical officers over a range of matters, and that is an important aspect of the environment in which visiting medical officers provide their services; and lastly your Honour has heard of the risks and stresses of being in private practice, particularly with the threat of hospitals changing roles or closing down altogether. Your Honour will set fair and reasonable rates for the services provided, having regard to such considerations.

The essential approach of the AMA to the assessment of remuneration was the concept of fairness according to the evidence given by the VMO witnesses as to the length and intensity of their training, the need to up-date skills, the rigour of peer review and quality assurance to maintain standards, commitment to on-call and call-back, contribution to hospital management and administration, and the pressures arising from budgetary restraints; the negative attitude of very many hospital administrators added to the pressures. Also, VMOs are subject to the risks and stresses of being in private practice, and faced with the threat of the changing role of hospitals and the closure of hospitals. Mr. *Sperling*

submitted fairness in the assessment of remuneration could be considered by reference to four exercises undertaken by the AMA. The exercises were based upon the senior specialist classification and it was said new rates of remuneration for the other classifications could be calculated so as to maintain existing relativities with the senior specialist. It was stressed by Mr. *Sperling* the exercises were a guide only as a means to an end and not an end in themselves; the exercises were never intended as being a path to follow closed-in by mathematical formulae.

First, a calculation was made increasing the existing normal hourly rate for a senior specialist by taking into account an increase of 20 percent for work value changes since 1985 and *State Wage Case* increases since 5 February 1988 (the date VMOs' rates were last adjusted). This exercise resulted in a normal hourly rate for a senior specialist of $159.41. The exercise proceeded on the basis *Macken* J. was correct in the 1985 assessment, and the calculation sought an up-dating of his Honour's assessment based on movements in wage levels in the community by *State Wage Cases* and by recognising changes in work value.

Second, Mr. *Sperling* presented an exercise, again proceeding on the correctness of the 1985 rates, calculating an increase in the senior specialist's normal hourly rate which would correspond with increases since 1 January 1986 in the senior staff specialist's remuneration package (including salary, allowances and the value of conference travel benefits, but not including the special allowance). The exercise was performed by reference to Schemes A, B, and C staff specialists, but not Scheme D. By applying the resultant increases for the Schemes A, B and C senior staff specialist, the respective hourly rates for a VMO senior specialist would be $153.60, $154.77 and $152.14.

The third exercise disregarded the 1985 rates and calculated a normal hourly rate by reference to the current senior staff specialist's

remuneration package (including salary, allowances and the value of conference travel benefits, but not including the special allowance). Again, the exercise was performed by reference to Schemes A, B and C. Having calculated the senior staff specialist's total remuneration package, the exercise then reduced the annual amount to an hourly rate (on the basis of 38 hours per week for 52 weeks per annum) and added 50 percent for associated time, 10 percent as a part-time loading and 49.3 percent as a loading for superannuation, split sessions and leave. The resultant hourly rates for the VMO senior specialist according to the comparison with Schemes A, B and C would be respectively $147.91, $193.43 and $224.28.

The fourth exercise was a survey conducted by the AMA into hourly rates charged by other professionals in New South Wales, namely arbitrators, architects, Queen's counsel, general practitioners, quantity surveyors, services engineers, solicitors, solicitors in Commonwealth Attorney-General's Department, structural engineers, and structural and chartered civil engineers. The rates disclosed a wide range, being from $140.00 per hour for a general practitioner to $180.00 for an architect to $277.00 for a solicitor to $300.00 for a Queen's counsel to $400.00 per hour for an arbitrator being a retired judicial officer. In addition, Mr. *Sperling* elicited evidence from Stephen John Teulan, Chartered Accountant and Partner of Deloitte Ross Tohmatsu and called by the Minister in relation to the background practice costs claim, to the effect that a partner in his firm charged clients an hourly rate between $180.00 and $325.00.

In view of my findings in relation to the 1985 determination, I propose to disregard the AMA's first and second exercises, thus leaving for consideration the third and fourth exercises as a guide to support the AMA's claim.

Minister's approach: Mr. *Kenzie* submitted that the AMA's exercises could not be relied upon as any "guide" in the context of setting appropriate rates for VMOs in 1992 as rates had to be assessed in accordance with accepted principles. By reason of the Minister's submissions as earlier mentioned, but like the AMA by reference to the rate for a senior specialist, the preferred approach to the assessment of proper total hourly rates commenced with the base rate for a senior specialist resulting from the 1983 determination adjusted by increases from the *State Wage Cases* in November 1985, July 1986, March 1987 and February 1988 (but excluding the decision in *Hyslop (No.2)* and using ordinary industrial principle for the basic wage adjustment) to which was added some escalation for work value, structural efficiency and special case considerations. To the resultant rate a loading of 18.04 percent was added to account for leave of 13.04 percent and 5 percent as an extended sessions component. Thus, the whole of the increases from the 1985 determination, being what was called therein the "Medicare effect", were disregarded, as was the effect of the interpretation of the basic wage adjustment provision by the Court of Appeal in *Hyslop (No.2)*.

The Minister's claim did not specify a particular amount claimed for remuneration, but, according to the above calculation, stated as the preferred approach a range of rates depending upon the amount assessed by me as Arbitrator for work value, structural efficiency and special case considerations of increases of nil, 6 percent, 10 percent, 15 percent and a maximum of 20 percent.

Set out below is the rate for a senior specialist which would result from the Minister's approach thus stated:

Base Rate	Special Case Increase	New Base Rate	18.04% Loading	Preferred Normal Rate Range
$	%	$	$	$
34.33	0	34.33	6.19	40.52
34.33	6	36.39	6.56	42.95
34.33	10	37.76	6.81	44.07
34.33	15	39.48	7.12	46.60
34.33	20	41.20	7.43	48.63

A similar exercise could be performed for the remaining classifications of VMO, but the results would maintain existing relativities and so the illustration for a senior specialist is sufficient to identify the Minister's approach. Mr. *Kenzie* made available other calculations using options, although not accepted by the Minister, such as by accepting the effect of *Hyslop (No.2)* but excluding the "Medicare effect", including the "Medicare effect" but excluding the effect of *Hyslop (No.2)*, applying the 18.04 percent loading to the base rate and then applying the "Medicare effect" and/or *Hyslop (No.2)*, and so on. However, I do not see the need to particularise those further examples.

It will be immediately apparent, comparing the Minister's preferred approach to the AMA's claim, that for a senior specialist the difference between the parties in the hourly rate was to the order of $110.00; thus, the Minister sought an hourly rate of about $65.00 less than the current rate and the AMA sought an hourly rate of about $45.00 more than the current rate. The difference is accounted for by the fundamentally different approaches in terms of principle as to the use of the 1985 determination, comparisons with staff specialists, reduction in the 49.3 percent loading to 18.04 percent and increases from *State Wage Cases* after February 1988.

In understanding the Minister's preferred position, I think it to be important to refer to the submissions of Mr. *Kenzie* as to the context in which it was offered. Senior counsel stated in a written submission as follows:

> These submissions made it clear that the fixation of an appropriate rate would depend upon the building of a rate *based on proper principles*. These principles involved the conclusion that the level of the rate fixed would be necessarily affected by the extent of structural change incorporated into the determination as a result of this arbitration. In circumstances where the AMA denied the relevance of the wage fixing principles (and the structural efficiency principle in particular), together with the need for structural change, the Minister contends that it will be necessary for structural change to be arbitrated onto the AMA. This submission is consistent with the approach in the TAFE case referred to in the Minister's submission on the wage fixing principles.
>
> It is in this sense that the Minister's preferred position ... is to be understood. The Minister contends that a work value/SEP increase of less than 15% is justified in the case of specialists (and less of an increase is justified for GPs) but then only in circumstances where substantial structural change is affected as a result of the arbitration.
>
> If such changes are not imposed the Arbitrator would not accept the submission that structural efficiency increases are available to VMOs because of the evidence of the participation of some VMOs in a number of efficiency type programs. Such evidence is not sufficient to warrant across the board increases based on structural efficiency. In any event, it is to be noted that the contributions to efficiencies relied upon by the AMA have precious little to do with the form of determination pursuant to which the VMOs are remunerated. The authorities make it clear that the modernisation of the relevant prescription is a foundational aspect of structural efficiency.
>
> ...
>
> Rather, what the AMA proceeded to do (and was in fact forced to do) was to accept that *another basis* would have to be found to justify the claim as prosecuted. This basis was said to be the improvements in the package available to Staff Specialists since 1986 - principally by reference to changes to the entitlements of Staff Specialists in relation to private practice earnings. Again the AMA has done no more than fix upon the simplistic proposition that private practice earnings are "earned" for work done *in the public hospitals* and ignore the Minister's submissions that:-
>
> (a) demonstrate that the entitlement to earn private practice income is, in truth, based upon a contractual license granted by the public hospital; and

(b) show that the public hospital is nothing more than an agent in respect to billing and collection.

The AMA's submission simply ignores (as irrelevant) the fact that the money from which private practice earnings are drawn *is not the public hospital's money in any sense*. The public hospitals are only entitled to retain a portion of such money by virtue of their agreement with the relevant Staff Specialists.

The AMA appears to be advancing its submissions on the basis that, because a proper application of correct principles does not yield a result satisfactory to it, then some other avenue *must* be found. At the end of the day the AMA has not sought to defend its claim on the basis of an argument that an application of *proper* principle *can* yield the result claimed at all and has accordingly been forced to resort to relying heavily on changes in the value of Staff Specialists' private practice arrangements (an exercise which was initially advanced to the arbitrator as "a guide" and not an end in itself) to justify the increases sought for VMOs in these proceedings.

The Minister urges the Arbitrator to reject the inclusion of Staff Specialist's private practice earnings in any VMO/Staff Specialist comparison for reasons advanced elsewhere. The Minister then asks the Arbitrator to consider the impact of the rejection of the AMA's argument in this respect on the AMA's claimed rate increase. This will inevitably bring one back to a consideration of the various options contained in the options document.

...

The AMA then went on to *re-characterise* the Minister's position in relation to the appropriate rates as being based either on the figures put forward in Table 1 of page 2 of the options document or on maintenance of the existing rate. Reliance was placed on Transcript 6005.8. *But this is a completely incorrect characterisation of the Minister's position.* The Minister has stated, as unequivocally as possible, that his position is that *the rate must be based upon proper principles* and that this will *necessarily* drive the rate backwards (subject only to the Arbitrator's view of the merits of the AMA's claim for increases. *For example,* the Arbitrator may conclude that whilst some of the Minister's submissions justify reducing the rates by say 10% that the AMA's claim justifies a 10% increase on those reduced rates). At no stage did the Minister *advocate* the maintenance of the existing rate (as did the DRS) either on the basis of *"fairness"* or on any other basis.

All that the Minister submitted was that *IF the Arbitrator* formed the view that the outcome of the Minister's approach was industrially unrealistic because of the impact of the submissions in driving back the existing rate to levels significantly lower than those that have stood for 7 years, then the only option would be to adopt the DRS position. This is to do no more than state the logical position. But it does not mean that the Minister was, or is, advocating such a step. The AMA has quite wrongly attempted to re-characterise the Minister's submissions in this regard.

...

> The AMA wrongly categorised the Minister's reference to the existing rate as an *alternative* submission. It was no such thing. Indeed it is illuminating that, faced with the options document - and the realities thrown up therein - the AMA has wrongly sought to re-characterise the Minister's submission with respect to the existing rate in an attempt to provide a foundation (*and the only foundation*) for attacking the Minister's options document.

The Minister tendered two helpful documents. The first set out movements in staff specialists' salaries from those in March 1977 to the current rates in September 1991; that document is reproduced as Appendix "N" hereto. The second document traced the history of rates of remuneration for VMOs from the first arbitration in September 1976 to the latest determination in December 1985, including *State Wage Case* adjustments to the rates up to February 1988 to give the current amounts; that document is reproduced as Appendix "O" hereto. The parties generally accepted the accuracy of those two documents, although the AMA raised some minor matters of no present significance, and I must say I have found them of considerable assistance in reviewing the respective submissions as part of my present task.

DRS's approach: The logic implicit in the Minister's approach was accepted as reasonable by the DRS so that the AMA's claim should be rejected on the grounds of its economic consequences, rates for VMOs in other States and general wage fixing principles. Submissions were made that a determination of remuneration should take into account award salaries for staff specialists and career medical officers. Generally, the DRS supported the Minister's case, but submitted a determination should be made freezing remuneration at current levels. In summary, the DRS's written submission outlined its aims as follows:

> The Society has two aims. The first is to advocate on behalf of patients to ensure that no group in the community receives a lower standard of medical care simply because they do not have money. The second aim is to represent the interests of the membership.
>
> It is our view that the community is not fairly served by the AMA claim for a 58 to 67.6 per cent pay rise depending on the

classification nor is the profession best served by the Minister's claim for, at worst, a fifty per cent reduction in the current hourly rate. The Society therefore desires an outcome such that the rate be frozen at $135.50 per hour for Senior Specialist VMOs.

More junior contractors are currently paid $127.50 for Specialist, $108.50 for General Practitioner of greater than 10 years experience, $91.00 for General Practitioners of 5 to 10 years experience and $83.00 for General Practitioners of less than 5 years experience. The Society desires that these rates too be frozen.

The Society recognises that the Minister's draft determination, should it be adopted, effectively reduces the current rate of remuneration for VMOs by about one half if background practice costs are not taken into account. We consider that such a claim is industrially unreal. The Society therefore seeks a determination which leaves the current VMO rate as it is until such time as staff specialist Awards "catch up". The AMAs draft determination will be shown to be inappropriate in various respects in the Society's view.

Previous fixations of remuneration

From the review of earlier determinations, as I have already found, Mr. *Rogers* in 1976 assessed remuneration by reference to the equivalent work performed by staff specialists who he placed in the very first rank of practitioners in the State in their particular discipline. The conclusions reached by him have been summarised above and I do not repeat them, except to emphasise that in making a comparison between VMOs and staff specialists it was found realistic to make the comparison on the basis that in addition to the award salary a full-time staff specialist received an allowance of 16 percent (now 20 percent), either from private practice carried on during hospital hours or directly from the hospital in lieu of private practice. Mr. *Rogers* noted too the average hours worked per week by staff specialists was fifty-five, and, although subject to on-call and call-back, no additional remuneration of any kind beyond the base salary was provided. In the result, Mr. *Rogers* fixed annual base rates for VMOs which converted to normal sessional hourly rates of $14.54 and $15.99 respectively for a fifth year specialist and a senior specialist; it is interesting, as I set out earlier, to compare the corresponding hourly rates for a staff specialist (fifth year) and a senior staff specialist of respectively

$9.66 and $10.62. In both cases, the VMOs' rates were 150.5 percent of the staff specialists' rates. Of course, at that time, the rates for VMOs were not loaded for public holidays, leave or superannuation, such matters being separately accounted for; the rates, however, included an element for practice costs. The other significant point about the 1976 arbitration was the approach by Mr. *Rogers* fixing remuneration considered to be fair and excluding any consideration for the "Robin Hood principle". Therefore, the remuneration determined in those foundational proceedings may be accepted as a proper level at the time and not depressed.

The 1978 review by *Macken* J. accepted the approach of Mr. *Rogers* and his Honour adjusted rates by *State Wage Case* increases and included an automatic adjustment provision to reflect future increases from *State Wage Cases*. In the 1980 determination, *Macken* J. again adjusted remuneration by *State Wage Cases*. The 1981 determination made by *Macken* J. was significant in that remuneration was expressed as a "rolled-up" sum comprising a base rate, superannuation loading, private practice loading, split session loading and a leave loading. The amount thus obtained was known as the normal hourly rate. His Honour adjusted the base hourly rate in accordance with community wage movements.

The 1982 proceedings involved an extensive review by *Macken* J. of the approach to the fixation of remuneration by reference to the 1976 arbitration. I have earlier set out in some detail the approach eventually followed by his Honour in determining an increase of 20 percent on work value grounds, but of which 6 percent was deferred because of economic constraints. Significantly, his Honour said in the reasons (at p.23) "that, apart from work value considerations, V.M.Os are entitled to a salary increase based on their loss of relativity with the industrial community generally, and with staff specialists in particular." His Honour then

identified the general community wage movements as requiring an increase for VMOs of 14 percent and the work value component, which was deferred, of 6 percent. That 14 percent increase took into account the comparison with rates for staff specialists. His Honour accepted as correct the 1976 fixation and determined remuneration appropriate in the 1982 context, rejecting levels equivalent to those fixed for the treatment of a doctor's private patients because private fees contained an amount to cover the previous honorary work in treating public patients; thus, his Honour continued the fixation of rates for VMOs at "fair" levels and without any discounting for the "Robin Hood principle". The 1982 determination commenced on 15 December 1982 so that, it seems to me, the appropriate date from which future changes in work should be measured would be 15 December 1982.

The deferred work value increase of 6 percent from 1982 was granted by the 1983 determination together with an increase of 4.3 percent from a *State Wage Case*. No further work value consideration was given in fixing remuneration for VMOs, and, I think it fair to say, the 1985 determination did not attend to such a question, being concerned, as I have earlier found, with compensation for the so-called "Medicare effect". The 1985 assessment of remuneration, by a retrospective consideration of it, has been found to be flawed, and, therefore, unsafe to use as a starting point for the present assessment.

The result of that review, in the opinion I have formed, must be that the appropriate rates on which to base the present review are those fixed by the 1983 determination with the date from which work value change should be measured, that is the datum point, being 15 December 1982. Further, in fixing remuneration for VMOs it is most relevant to take into account salary rates for staff specialists as that comparison was a feature of the 1976 arbitration and of subsequent determinations up to and

including that in 1983. That that comparison has been utilised before is unexceptional in view of the finding in 1976, and accepted in the present proceedings, of the commensurate nature of the work as between staff specialists and VMOs. That approach gives the following base rates for VMO specialists from the 1983 determination, excluding the background practice costs allowance and the 49.3 percent loading, by comparison with rates for staff specialists, as follows:

Classification	VMO	Staff Specialist*
	$	$
Specialist	27.21	18.12
Senior specialist	29.89	19.88

* (These rates based on annual salaries reduced to an hourly rate for 55 hours per week).

Interestingly, the above two rates for VMOs each represented about 150.25 percent of the rate for the corresponding classification of staff specialist; that relationship was consistent with the 150.5 percent as assessed by Mr. *Rogers* in 1976 in a similar exercise as referred to earlier. One should immediately caution that such exercises do not provide a mathematical escape for arbitrators, but they do provide guidelines over a period of time against which other relevant factors which occur from time-to-time may be brought into account. It should also be remarked that the higher base rates for VMOs by comparison with staff specialists, and even though being compensation in both cases for a labour or work element, are clearly reflective of status as an independent contractor thereby representing compensation for the usual risks of conducting a business on a commercial basis - including such matters as practice costs, continuing self-education and training, maintenance of knowledge with changing technology, administrative time, capital risks, insurance, employment of

staff, return on investment, general business expenses and so on; associated "labour" type benefits, such as superannuation and leave, were provided separately in the 49.3 percent loading, thus having a separate equivalence with employees. It will be apparent many of the matters I have identified will arise for consideration later as part of the assessment of a background practice costs allowance, but it is helpful at this time to mention them in the setting that practice costs were included in the base rates fixed by Mr. *Rogers* in 1976. When *Macken* J. provided for those costs to be reimbursed to a VMO as a separate amount his Honour did so "in a small sum and, thus, recognise the principle that the public purse should bear such background private practice costs" because there was "no reason why (VMOs) should bear *additional* private practice costs as a result of their accepting sessional contracts" (see 1978 reasons at p.18).

Principles of wage fixation

I have found the appropriate principles to take into account are those formulated in the *State Wage Case - May 1991*, and, as to remuneration rates, the principles are those relating to structural efficiency and work value changes. The nature and circumstances of the claims require their processing in accordance with the wage adjustments principle as a special case. The application of the principles of wage fixation to the present case was considered above, and I accepted the thrust of the submissions made by Mr. *Kenzie* as reproduced in Appendix "L" to these reasons. Nevertheless, the circumstances of this case require attention as to how and to what extent the particular principles may be applied. I turn to those questions, bearing in mind the terms of the paid rates awards principle, namely - "Subject to special cases paid rates awards will be adjusted in accordance with the structural efficiency and wage adjustments principles of this decision".

Structural efficiency: There can be no doubt, in my view, that the centre-piece of the principles of wage fixation is the structural efficiency principle. The key principle in the system of wage fixation formulated in the *National Wage Case March 1987* ([1987] 17 I.R. 65) was the restructuring and efficiency principle which was based upon co-operation between the workforce and management to increase the prospect of meaningful and satisfying work and the fuller realisation of human potential. However, in the *National Wage Case - August 1988* ([1988] 25 I.R. 170), as adopted in the *State Wage Case August 1988* ([1988] 26 I.R. 24), the former Australian Conciliation and Arbitration Commission noted that, and despite the success achieved by that principle in its terms and as understood and accepted by many parties, because of the general approach to its application and usefulness it was found desirable to discontinue it in favour of a new system. The Australian Commission said in that respect (*ibid* at 174):

> We consider it essential, however, that any new wage system introduced should build on the steps already taken to encourage greater productivity and efficiency. Attention must now be directed toward the more fundamental, institutionalised elements that operate to reduce the potential for increased productivity and efficiency.

And so the present system was born. In reviewing the role played by structural efficiency concepts as part of the principles, the Industrial Commission in Court Session in the *State Wage Case August 1989* ([1989] 30 I.R. 107 at 112) observed "that, in accordance with the principle, structural efficiency exercises should incorporate all past work value considerations". That was really a repetition of what the Australian Commission said in the *National Wage Case March 1987* ([1987] 17 I.R. 65 at 80) as to the relationship between the restructuring and efficiency principle and the work value principle to the effect "that there will be

some overlap between these two principles but whichever is used in particular cases, there should be no double-counting".

The present structural efficiency principle states:

STRUCTURAL EFFICIENCY

Consistent with the ongoing implementation of the structural efficiency principle determined in the *State Wage Case* decision of 4 October 1989, any party to a minimum rates award or a paid rates award seeking the increases in wages or salaries allowable under the *State Wage Case* decision of 29 May 1991 is required to satisfy the Commission:

(a) that the parties to the award have examined or are examining both award and non-award matters to test whether work classifications and basic work patterns and arrangements are appropriate - the examination to include specific consideration of:

(i)the contract of employment including the employment of casual, part-time, temporary, fixed term and seasonal employees,

(ii)the arrangement of working hours,

(iii)scope and incidence of the award;

(b) that the parties to the award have a genuine commitment to the insertion of facilitative provisions in relevant clauses of the award and have taken or are taking action to do so;

(c) that the award requires enterprises to establish a consultative mechanism and procedures appropriate to their size, structure and needs for consultation and negotiation on matters affecting their efficiency and productivity;

(d) that the award, in order to ensure increased efficiency and productivity at the enterprise level, while not limiting the rights of either an employer or union to arbitration, provides a process whereby consideration can be given to changes in award provisions; any agreement reached under this process would have to be formally ratified by the Commission and any disputed areas should be subject to conciliation and/or arbitration;

(e) that there is a provision in the award to the effect that an employer may direct an employee to carry out such duties as are within the limits of the employee's skill, competence and training;

(f) that the parties to the award have implemented, substantially, the structural efficiency principle determined in the 4 October 1989 *State Wage Case* decision and have applied or are applying consequential award reforms to the workplace.

In the present case, as earlier noted, the AMA's position was that the principles of wage fixation were largely inapplicable, but, to the extent they were applicable, even in spirit, they had been complied with by VMOs. Specifically, Mr. *Sperling* put that the concept of the structural efficiency principle was inapplicable so that reliance had to be placed upon the work value changes principle and the since rescinded anomalies principle. Mr. *Kenzie* for the Minister, as earlier stated, denied compliance by VMOs with the principles at all. It is true, as senior counsel emphasised, there is really no consensus between the Minister and the AMA on behalf of VMOs for the implementation of the various structural efficiency measures proposed in the Minister's claim. Indeed, the measures were all vigorously opposed, such as the up-front hours concept, form of sessional contract, specification of clinical privileges, statement of a VMO's responsibilities, review of hours during which services are to be rendered and the maintenance of a record of services provided. Of course, those measures have been considered by me already in this arbitration, and, largely and in their essential aspects, have been accepted as detailed earlier in the contract for services, terms and conditions of work and hours of service. The result is that VMOs cannot be denied appropriate consideration in terms of remuneration, by a special case or otherwise, because structural efficiency is imposed by arbitration rather than on a consensual basis. That approach is consistent with that adopted by the Industrial Commission in Court Session, in a not dissimilar situation, in *Re Crown Employees (Teachers and Related Employees - Technical and Further Education Teaching Service) Salaries*

and Conditions Award (C.I.C.S. - 89/566, 89/1619 & 90/515 - 7 August 1991) and in which the Court Session observed (*ibid* at 38,39):

> Ordinarily, these increases would be presented to the Commission on a consensual basis in the terms of an agreement between the parties on new salary levels. In turn, the Commission would consider whether the additional salaries so agreed met the standards of restructuring and efficiency required by the wage fixation principles.
>
> Where there is no agreement or insufficient agreement to determine a special case on a consensual basis, the Commission will arbitrate on salary rates. In a proportionate way, it follows that issues going to structural changes, increased efficiency and cost effectiveness are to be similarly arbitrated.

The specific measures which must be satisfied to meet the structural efficiency principle are those contained in it at pars.(a) - (f), and in identifying the nature of those matters in the *State Wage Case-May 1991*, the Court Session said (*supra* at 415):

> Reference to that principle shows that the matters with which the Australian Commission was then concerned were the positive co-operation of parties to an award in a fundamental review of that award and the implementation by them of measures to improve the efficiency of industry and provide workers with access to more varied, fulfilling and better paid jobs.
>
> The principle specified particular measures to be considered, including the establishment of skill-related career paths, the elimination of impediments to multi-skilling, the broadening of the range of tasks which a worker may be required to perform, the creation of appropriate relativities between categories of workers within the award and at enterprise level, and ensuring that work patterns and arrangements enhance flexibility and efficiency.

Curtis John Berry, Human Resources Director of the Department of Health, gave evidence in respect of structural efficiency proposals in the health system. In his statement of evidence, Mr. Berry said:

> In my view, the matters raised by the Department during the period 1986-1990 related to structural efficiency. I can specifically comment on the negotiation processes following my appointment to the Department of Health in June of 1990, as I have been directly and continually involved in the process.
>
> The discussions and negotiations with the AMA about a new set of remuneration and conditions for VMOs commenced not long after

the 1985 Determination was made by Justice Macken. However, detailed specific negotiations between the parties became intensive in the two years leading up to November, 1990 when the AMA disclosed its intention to formally seek a new Determination.

The negotiation process was certainly viewed as being a structural efficiency related exercise by the Department, notwithstanding that the arrangements being addressed were for independent contractors and not salaried staff covered by awards of the then New South Wales Industrial Commission.

As indicated above, there was a period of discussion and negotiations between the Department and the AMA seeking to agree to a new set of terms and conditions and remuneration arrangements for VMO's. On reviewing Exhibit 70, I note that it identifies that:-

"Negotiations between the DOH and the AMA on:-

- Modes of remuneration
- Payments of old or late VMO claims
- Attempts to change on-call rosters
- Attempts to change VMO claim forms
- Application re flat dollar amounts
- Re State Wage Increases
- Correct application of the on-call allowance during normal sessional hours and call-back
- Payment of the background practice costs during call-back
- Appropriate form of remuneration of some VMOs in country hospitals
- Certain patients VMO claim forms
- Alteration of the Public Hospitals Act in respect of Sections relating to VMOs
- Disputes committee on on-call payments"

took place between December, 1986 and February/March 1989.

In my view, the majority of the items identified above by Mr. Berry as relating to structural efficiency are matters directly the subject of these proceedings for a new determination. In his oral evidence he related the various items in the Minister's claim to the structural efficiency principle, and I think it helpful to quote some extracts, as follows:

So, for example, if I take out the May 1991 State Wage Case decision at p 130 where the principle is outlined in some detail and the issues that need to be satisfied by the Commission for the granting of rises are outlined, I would say the following things: for example, in relation to up-front hours. If I quote directly from the Commission's decision it says at point (a) on that page, it says "That the parties to the award have examined or are examining both award and non-award matters to test whether work classifications and basic work patterns and arrangements are appropriate.

The examination to include specific consideration of (i), the contract of employment including the employment of casual, part-time, temporary, fixed term and seasonal employees. (ii), the arrangements of working hours and (iii) scope and incidence of the award". Now on reading those things and considering up-front hours as a concept I see that there are a number of points there which are particularly relevant. First of all, basic work patterns and arrangements are they appropriate? Well parts of our claim is that up-front hours would be a better way to organize things. (ii) the arrangement of working hours, now I see that as a very key component of our case and up-front hours is a mechanism to address that.

We will contend that in the overall sense the up-front hours will improve the efficiency in terms of resource, utilisation and a number of witnesses have given evidence to that effect.

It also puts a greater emphasis on economic considerations balanced against clinical issues and I think that that is not inconsistent with where point (a) of the principle is driving, that these things should be addressed. It is quite clear that in saying that the contract of employment needs to be looked at and negotiated or addressed, that there is an element of boundaries having to be clearly established and I think we are trying to do that with what we put forward.

We would also say that the up-front hours has that impact of improving efficiency which is an overall Structural Efficiency simply by having questions of certainty of costs from our side, or total budget outcomes, being much more capable of being clearly identified at an early time rather than the current situation where it is quite difficult to do that; and many hospital administrators have commented on that over time to me.

The up-front hours context and its relation to SEP will also ensure that we can improve the planning of how services are different because we will have more information on which to do that because we will have actually spoken to the VMOs very directly about issues.

So there is a context in which up-front hours aims to achieve certain things and those things are to do with efficient use of resources. There is a capacity for negotiation between the VMO and the hospital about what is appropriate hours to be worked. There are questions about efficiency and effectiveness in terms of use of resources. There is opportunity to improve planning. There are levels of certainty in relation to costs and there is I suppose from the VMOs side of it a greater degree of certainty about their income outcomes for participating in the health system because if we have negotiated up front hours with them they know what the outcome will be. So there is a higher degree of certainty for them as well.

So the overall concept of up-front hours in my view is absolutely relevant to point (a). in that May 1991 decision. And its effect is as outlined in those other points.

If I could then move to some other points that bear on the up-front hours context but they are not at point (a). they are at point c. of p 130.

It says that the award requires enterprises to establish a consultative mechanism and procedure appropriate to their size, structure and needs for consultation and negotiating on matters affecting their efficiency and productivity.

What we would say is that up-front hours has very much that impact because it puts a requirement both on the system and on the individual VMO to actually talk about matters that are relevant to the provision of services into the public health system. And that is not something which is entirely clear in the current arrangements and so whether one would normally sort of say that one on one discussions and negotiations are a consultative mechanism for the purposes of a contract such as VMOs I would say they very much - what we would say is that it is an appropriate structure to have individuals negotiating on that question involving the VMO and the hospital directly.

I would also say that up-front hours exercise and that consultative process is also likely to lead to much more sensible planning in terms of less recourse to what have been variously described as blunt instruments such as hospital wards, bed closures et cetera or theatre time restrictions than is currently the case, because the planning focus that can be achieved for up-front hours will be quite important in that regard.

Mr. Berry similarly dealt with the relationship to structural efficiency in the health system of clinical privileges, the comprehensive nature of a sessional contract, a dispute settlement procedure, preparation of on-call rosters, review of call-back arrangements and proper record-keeping. I accept the cogency of Mr. Berry's identification of those subject matters with structural efficiency in the engagement of VMOs.

The evidence of Ms. Crawshaw, Legal Director of the Department, as to recent reforms to the public hospital system was considered earlier as part of the historical background and context in which the present claims arise, and she highlighted the particular statutory changes made in the last decade as affecting the public hospital system, and, I would add, as affecting VMOs in terms of consultation and increased involvement. Similarly, Mr. Barker, as Executive Director - Finance and Administration of the Department, related the legislative changes concerning financial management and accountability of public hospitals to the involvement of

VMOs. The area of concern which I have, however, and as I have particularised earlier, relates to the differing attitudes of VMOs to change and to my finding that commitment and co-operation by them was by no means universal with sufficient numbers not participating with the majority of their colleagues in ensuring structural efficiencies consistent with available resources. Although, as found on the evidence, very many VMOs have undoubted commitment to and co-operation with the public hospital system as it has been evolving, that negative attitude must be a counter-balance in assessing remuneration on structural efficiency grounds. Even so, I am prepared, having in mind what I perceive to be the favourable attitude of the majority of VMOs to change and my decision to make a determination incorporating the Minister's structural efficiency measures by arbitration, to give only minor weight to those negative elements. The view I take is that the making of a determination consistent with the structural efficiency claims will provide the framework and basis for the better functioning of the public hospital system insofar as VMOs are concerned, but it must be the function of hospital managements to fully utilise the resource thereby available. In other words, a determination containing, as I intend the new determination will do, provisions appropriate to meet the modern public hospital system must contain commensurate levels of remuneration. It is, I think, the necessary and responsible task of hospital managements to ensure the services provided by VMOs are indeed commensurate with the compensation to be paid to them, and equally it is the responsibility of a VMO undertaking a sessional contract to meet fully his contractual obligations. As to a less than required commitment to the public hospital system by VMOs as affecting the system itself, the decision of the Industrial Commission in Court Session in *Re Crown Employees (Hospital Medical Officers) Award* (C.I.C.S. - 88/1595, 88/1617 & 89/16 - 8 September 1989) disclosed the

effect of VMO activity on the work of resident medical officers. The case concerned a claim, consented to by the Health Administration Corporation and the Public Employment Industrial Relations Authority, for salary increases ranging from 4 percent to 15 percent on work value grounds. The Court Session observed in the judgment, as follows (*ibid* at 5,6):

> The evidence discloses, as is confirmed by the annexed agreed statement, that the work of medical officers employed in the public hospital system had been affected by very significant changes in the practices and procedures of their profession and that the value of that work for the community has greatly increased. In addition to that fact, changes resulting from alterations to workload and emphasis need to be brought to account.
>
> Visiting medical officers ["VMOs"] have over the years attended public hospitals in order to provide specialist treatment for both hospital and private patients. They have played a significant role in advising and assisting medical officers in their acquisition of learning and experience and in the performance of their work. The evidence in these proceedings is to the effect that the VMOs have, since their dispute with the government in 1984, reduced to a significant extent their level of participation in the public hospital system. The result has been that employed medical officers are now called upon to perform work which, until recently, was performed by the visiting specialists. Thus the quality of knowledge and skill now called for from the medical officers is enhanced and is substantially different to that previously expected of them.
>
> The lot of the medical officer has been further exacerbated by a growing shortage in their numbers which will worsen in 1990 and 1991 as a consequence of an extension in the basic degree course. The system is overstretched with the HAC attempting to maintain a fortnightly limit of 130 hours of work by medical officers.
>
> The factors described above compound one upon the other such that the work being performed by medical officers is markedly different to that performed by them at the time of the last work value adjustments in their awards which occurred in 1982.

That case, in my view, provides very meaningful and practical evidence of the important role which VMOs have to perform in the public hospital system. I have commented earlier in these reasons on the effect of the 1984-85 doctors' dispute and that it is a dispute long since ended. That that must actually occur is reinforced by the *Hospital Medical Officers Case*, and the determination I propose to make hopefully will facilitate the process. I find support for the approach of giving VMOs the

benefit of full weight for structural efficiency considerations from the comments contained in recent annual reports of public hospitals and area health services as to the general involvement and participation of VMOs to the advantage of hospitals. Many reports were tendered by the AMA in that respect, and, although it is impracticable to refer to them all, they included all area health services for the last two or three years and very many public hospitals. A perusal of the reports discloses no real criticism or adverse comment in any way of VMOs, and the following extract from the 1989-90 Annual Report (at p.18) of the Eastern Sydney Area Health Service was not atypical:

> A number of the hospitals within the area are preparing for accreditation which has had importance to ensuring high standards of care and service meet the requirements of the Australian Council of Health Care Standards. Quality assurance programs have been highlighted and activities geared towards quality improvement. Staff at all levels are involved in programs designed to monitor and evaluate the quality of care and service offered to patients and clients. Many different measures are used and wherever possible improvements to care and service are implemented as a result of quality assurance activities.

The 1988-89 Annual Report (at p.3) of the Illawarra Area Health Service said - "We appreciate the co-operation and support we have received from the Medical Staff Council throughout the year and hope we can all continue to 'work together for a healthier community'". And further, (at p.10) - "The full involvement of the Medical Staff Council at Board and Committee Meetings has been maintained at all times."

Dr. Jensen gave detailed evidence of the introduction at St. Vincent's Hospital of the recommendations by Booz-Allen & Hamilton, Consultants, for the development of surgically related strategies and procedures to reduce the average length of stay of in-patients at the hospital. The Surgery Procedures Task Force was established in mid-1989, of which Dr. Jensen is a member, with the role of implementing the recommendations; opportunities examined by the task force included

increasing the percentage of surgeries performed as out-patients, reducing the days a patient is admitted prior to elective surgery and increasing the utilisation of general operating theatres. It is apparent from Dr. Jensen's evidence he and other VMOs on the task force, as well as nursing and administration staff, were heavily involved in a structural efficiency exercise of considerable scope and importance. Indeed, as is clear from the 1990 Annual Report from St. Vincent's Hospital, that hospital was, and still is, conducting a re-structuring of many of its medical and surgical facilities as evidenced from the Annual Report (at pp.13,14) as follows:

> St Vincent's is undergoing a series of changes designed to ensure that it maintains its place as a leading teaching hospital providing high quality care to its patients. These changes are not just a reaction to change in community attitudes towards health care, but have been generated deliberately by the hospital in anticipation of the future needs of the community.
>
> The delivery of heath care at St Vincent's is being changed by concentrating services around the patient and the disease process.
>
> In the year under review, the hospital embarked on the establishment of its first patient-oriented division, the Heart/Lung Vascular Institute. Five other Institutes will be launched in 1991, and most patient care will eventually be grouped within the hospital in six patient-oriented Institutes. Each Institute will provide a comprehensive service focused on treating various clinical disorders, eg. heart/lung vascular, oncology (cancer), neurosciences, and will operate almost as a mini hospital with a high degree of management autonomy.
>
> The executives and clinicians within each institute will be required to commit to the discipline of a detailed financial budget.
>
> The significance of the introduction of the Institute structure at St Vincent's cannot be overrated, for it involves altering the traditions of 130 years of health care. I am very conscious as Chairman that this process is not without some pain for both management and clinicians ...St Vincent's like all other major public teaching hospitals in Australia has not been organised in a patient or user oriented structure. As this long standing structure is replaced the onus will be on the heads of the new Institutes, in the years immediately ahead, to recreate the same spirit of cohesion and collegiate rapport that has so distinguished the old divisional structure at St Vincent's for more than a century.
>
> The support from the Medical Executives Board and all the health care professionals at St Vincent's for the conversion to Institute status is appreciated enormously by the Board. This conversion,

incidentally, offers to those same professionals a degree of day-to-day management, control and responsibility greater than they have ever experienced.

The Institute structure, which is revolutionary within the Australian hospital system will result in better patient care by the decentralisation of decision making to those persons involved in the clinical management of patients.

Finally, the Department of Health in February 1992 published clinical services proposals for allied health, medical and nursing services as part of the structural efficiency programme for the health system in the State. A foreword to the proposals conveniently sets out the purpose and aim of them as follows:

I am pleased to present to Staff, Management, Health Unions and Professional Associations the *Clinical Services Proposals* for Allied Health, Medical and Nursing Services as part of the Structural Efficiency Program for the Health System.

These Clinical Services Proposals will be used by the Health System to plan and implement pilots in consultation with unions in a range of hospitals and community health services. Evaluation of the pilots and subsequent award changes will form part of the negotiation process with the relevant Health Unions.

Facing change at the workplace is a difficult process, for all of us. However, it is vital that we provide continually improving, efficient and cost effective health services. In an era where financial resources in the public and private sectors are tight, it is important that initiatives which seek to maximise productive efficiency are pursued vigorously.

The Clinical Services Proposals provide the framework for re-organising work to achieve cost effectiveness, to meet the clinical requirements of our customers and to provide rewarding career opportunities for staff.

The key principles underlying the changes are:

- providing customer focussed services;
- integrated team work to provide efficient and cost effective health services;
- creating local flexibility to re-organise the mix of services, levels and numbers of staff;
- providing effective resource management;
- monitoring performances;
- increasing accountability;
- improving job satisfaction and career opportunities;
- advancing equal employment opportunity principles.

Everyone in the Health System is involved in the challenge of reviewing current work practices and re-organising work, health

services and organisational structures in order to achieve increased efficiency and cost effectiveness.

I look forward to these proposals being considered co-operatively and in a timely manner by the Health System and relevant Health Unions.

Implementation across the Health System can occur only with strong commitment from Area Health Service Boards and Management, Regional Offices, Hospital Boards and Management to the piloting process, and the involvement of staff in changes in work organisation. The involvement of unions at state and local level will also be critical to this implementation process.

The proposals were forwarded to Dr. M. Nicholson, Medical Secretary of the AMA, with the invitation for him and colleagues to attend an information session. It was not possible to arrange a convenient time to suit all concerned, and the evidence did not disclose what subsequently has occurred. However, the AMA nominated a number of persons to attend, including VMOs, and no doubt AMA involvement will occur or has by now occurred. An examination of the proposals shows a most comprehensive programme, and, I would have thought, with relevant VMO involvement as part of the provision of medical services by them to public hospitals.

I am satisfied, and to a significant degree, that VMOs generally are involved in the implementation of structural efficiency measures in public hospitals. To the extent some of them have resisted change, then, in my view, that is a matter for hospital and area health service managements to attend in the performance of services by the VMOs concerned. The determination I propose to make will arbitrarily impose on VMOs terms and conditions of work of a structural efficiency nature to which VMOs providing services under sessional contracts will be bound. I find the structural efficiency principle has been met for the purposes of the assessment of rates of remuneration.

Work value changes: A major plank in the AMA's case for increased remuneration was alleged changes in the value of work performed by

VMOs since the last determination in December 1985. The changes were said by Mr. *Sperling* to justify an increase of 20 percent in the rates of remuneration for work value changes alone and reliance for that was placed on the evidence given by each of the forty-three VMOs who gave evidence. The effect of the work value changes was reflected in what has been referred to earlier as the AMA's exercise one in calculating new hourly rates; using the current rate as a base, the exercise added the additional superannuation benefit and *State Wage Case* increases since February 1988 to which sum a work value adjustment of 20 percent was added to give a new hourly rate for a senior specialist of $159.41. Exercises two and three were based upon the staff specialists remuneration package and so no direct reference in the calculation was made to work value, although a 15 percent increase, said to be for work value but really it was an anomaly, awarded by consent to staff specialists from 12 December 1989 in *Re Medical Officers - Hospital Specialists (State) Award* ([1990] 33 I.R. 79) would be comprehended within those two exercises.

The Minister did not deny there had been increases in work value for VMOs during the past decade, but relied on the evidence of Dr. MacArthur that such changes had certainly not been greater than for staff specialists; indeed, the submission was put by Mr. *Kenzie* that staff specialists in general have a wider range of duties than VMOs, with a greater administrative workload, and they tend to perform more procedural work in the medical specialties and are more involved in research. Senior counsel pointed out also that the work value period of review for staff specialists was twelve years from 1978 to 1990 whereas that for VMOs was only seven years from 1985 to 1992. He denied too that the evidence in this case was representative of VMOs in the specialist classifications and submitted it was certainly insufficient to cover general

practitioners, who, in any event, could not rely upon the 15 percent obtained by staff specialists. Mr. *Kenzie* submitted that acceptance of Dr. MacArthur's evidence would suggest a work value increase for senior specialists of less than 15 percent, subject to consideration of work value within structural efficiency concepts.

In the result, it was submitted for the Minister that if the AMA succeeded in retaining the structure of the 1985 determination, including the system of actual hours, then no increase whatsoever on structural efficiency grounds should be granted, and, at most, modest increases based on work value changes would be warranted. On the other hand, if the Minister's approach, earlier referred to as the preferred approach, including the up-front hours concept, were accepted then it would be appropriate to grant VMOs increases on an appropriate base rate which took account of the AMA's work value change evidence and *State Wage Case* increases since February 1988. Effectively, that would merge the work value and structural efficiency claims.

In light of my finding as to the 1985 determination not being a proper base on which to assess current rates, the AMA's exercise one therefore becomes irrelevant. However, accepting the base rates in the 1983 determination as the proper starting point, but with the datum point from which to measure changes being 15 December 1982, the AMA's approach in exercise one in terms of concept requires consideration. Viewing it from 15 December 1982, the question then is whether that course is available under the principles of wage fixation.

The work value changes principle from the *State Wage Case - May 1991* is in the following terms:

> WORK VALUE CHANGES
>
> (a) Changes in work value may arise from changes in the nature of the work, skill and responsibility required or the conditions

under which work is performed. Changes in work by themselves may not lead to a change in wage rates. The strict test for an alteration in wage rates is that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification.

(b) Where new or changed work justifying a higher rate is performed only from time to time by persons covered by a particular classification or where it is performed only by some of the persons covered by the classification, such new or changed work should be compensated by a special allowance which is payable only when the new or changed work is performed by a particular employee and not by increasing the rate for the classification as a whole.

(c) The time from which work value changes in an award should be measured is, unless extraordinary circumstances can be demonstrated in special case proceedings, the date of operation of the second structural efficiency adjustment allowable under the 4 October 1989 *State Wage Case* decision.

(d) Care should be exercised to ensure that changes which were or should have been taken into account in any previous work value adjustments or in a structural efficiency exercise are not included in any work evaluation under this principle.

(e) Where a significant net alteration to work value has been established in accordance with this principle, an assessment will have to be made as to how that alteration should be measured in money terms. Such assessment should normally be based on the previous work requirements, the wage previously fixed for the work and the nature and extent of the change in work. However, where appropriate, comparisons may also be made with other wages and work requirements within the award or to wage increases for changed work requirements in the same classification in other awards provided the same changes have occurred.

(f) The expression "the conditions under which the work is performed" relates to the environment in which the work is done.

(g) The Commission should guard against contrived classifications and overclassification of jobs.

(h) Any changes in the nature of the work, skill and responsibility required or the conditions under which the work is performed, taken into account in assessing an increase under any other principle, shall not be taken into account in any claim under this principle.

The immediate issue arising in the application of the principle is the explicit requirement for the measurement of work value changes to be, unless extraordinary circumstances can be demonstrated in special case

proceedings, the date of operation of the second structural efficiency adjustment allowable under the *State Wage Case August 1989*; that could not be earlier than 4 April 1990, being six months after the first structural efficiency adjustment was accessible on 4 October 1989. The present claims are necessarily being processed in special case proceedings in view of the level of increases sought, so compliance with the principle requires extraordinary circumstances to be demonstrated in order for the datum point to be 15 December 1982. That issue arose before the Full Commission of the Industrial Relations Commission of New South Wales in *Re Dental Officers (Public Hospitals and Department of Health) (State) Award* (F.C. - 91/416 - 16 December 1992) in which substantial increases in salary rates, ranging from 23 to 31 percent were sought, together with the prescription of an on-call allowance of 17.4 percent of salary and an allowance of 20 percent of salary in lieu of private practice. The rationale for the claim was identified by the Full Commission as the salaries and allowances payable to medical specialists employed in public hospitals under the Medical Officers - Hospitals Specialists (State) Award following the consent variation to that award in March 1990 of a 15 percent increase in salaries by *Fisher* P. ([1990] 33 I.R. 79). It was common ground the relevant principles to apply were those in the *State Wage Case - May 1991*. Work value changes were sought to be measured as from July 1985. After noting the case before *Fisher* P. was decided as an anomaly under the former anomalies and inequities principle, and by an agreement of the parties, the Full Commission said (*ibid* at 13,14):

> In the present case, having regard to the factors to which his Honour referred, there is even greater difficulty in justifying increases on change of work value grounds. At best, the length of period of comparison is only half the period applicable in the medical specialists' case, and that only if "extrarordinary circumstances" exist under par.(c) of the principle. In that regard we have to state that, in our view, the submissions by the PSA have not been made out, and accordingly the commencement of the

> comparison period must be taken to commence as from 27 June 1990, the date on which the second 3 per cent structural efficiency principle instalment was awarded.
>
> On this aspect we see the relevant circumstances of this case as being substantially similar to those considered by the former Commission, constituted as the Commission in Court Session, earlier this year in the *Hospital Employees (Engineers) Case* (C.I.C.S. - 91/378 - 17 February 1992). In that case the Commission in Court Session held that "extraordinary circumstances" within the meaning of the principle enabling change of work value considerations occurring earlier than the second 3 per cent Structural Efficiency principle increase to be taken into account had not been established. We make a like finding in the present case.

In the result, the Full Commission dismissed the claim by dental specialists on work value grounds. In response to a submission that the former anomalies and inequities principle, which was omitted from the principles prescribed by the *State Wage Case - May 1991*, was still available in its underlying concept to permit a wage increase on special case grounds where appropriate, the Full Commission said (at 14-17):

> As we understand it, the claim asserts that, like medical specialists employed in hospitals, dental specialists have been subject to changes of a "societal" nature as discussed by *Fisher* P. in the medical specialists' case, the effect of which has not been reflected in their salary structure. Such a failure has resulted in an anomaly, which should, in justice, be rectified by substantial salary increases, a guidepost to which is the percentage figure awarded in the medical specialists' case, namely, 15 per cent of existing salary rates.
>
> We do not see that submission as having substance. The fact is that the disparate industrial coverage of dental officers in public sector employment was specifically considered by the former Commission in 1985.
>
> ...
>
> In these circumstances, we are unable to take the view that the position of dental specialist is akin to that of medical specialist as recounted by *Fisher* P. in the *Medical Specialists Case*. We do not think that this is a case where the remuneration position of dental specialists is anomalous because they have failed to have applied to them considerations relating to shifts in clinical and administrative responsibilities, and societal changes in dental specialists' practice, separate from and in addition to changes in work arising from professional updating and skills development.
>
> We are also not convinced that the asserted close working relationship in the hospital environment between medical and dental specialists is a reason, having regard to the underlying

philosophy of the wage-fixing principles, why a salary increase of 15 per cent should be awarded. This argument seems to us to have overtones of comparative wage justice and maintenance of relativities, concepts which are proscribed by par.(a)(iii) of the former Anomalies and Inequities principle.

As to the meaning of the expression "extraordinary circumstances" as referred to in par.(c) of the work value changes principle, the Industrial Commission in Court Session in *Re Hospital Employees (Engineers) (State) Award* (C.I.C.S. - 91/378 - 17 February 1992 at 6-8) said:

> The "extraordinary circumstances" claimed by the Association to exist in this case such as to allow consideration of alleged work value changes before 4 October 1989 are basically the same as the matters relied on in its submission that the present case was part heard as at the date of the *State Wage Case - May* 1991.
>
> The Association again relies on the fact that a log of claims had been served on the Health Administration Corporation in March 1990, the fact that the conciliation committee was so advised in the second stage structural efficiency case for increases for hospital employees generally, and the fact that some discussions between the parties in relation to the log of claims took place before the formal application was filed on 14 May 1991. It also asserts that it would be unfair if other groups of hospital employees under other awards, in respect of whom claims for work value increases have been filed and are part heard, were able to take advantage of earlier datum points that the present group of employees merely because applications in respect of such groups had been filed and processed to a "part heard" stage before the date of decision in the *State Wage Case - May* 1991. It would also be unfair if the earlier datum point for work value changes could not be relied upon in the present case when work value changes for this particular group of employees had not been specifically relied on when the second stage structural efficiency claim for hospital employees generally had been granted.
>
> We have given full consideration to the submissions of counsel for the Association on this aspect of the case in light of relevant provisions of State Wage Cases and principles thereunder to which we have referred. In our opinion the Association has not made out a case that "extraordinary circumstances" exist which would justify a departure from the normal datum point requirements of par.(c) of the current Work Value Changes principle.

I have given earnest consideration to the reasoning of the former Court Session and the present Full Commission in the above-mentioned cases concerning the meaning of "extraordinary circumstances" in the work value changes principle as limiting the time from which work value changes should be measured. The point is of fundamental importance in

the arbitration I am conducting. The *Public Hospitals Act*, s.29M(1) requires me as Arbitrator, as soon as practicable after appointment, to determine the terms and conditions of work for VMOs. In so doing, as I have found, I am not bound to strictly apply, or even at all, the principles of wage fixation for the time being adopted by the Industrial Relations Commission; nor for that matter, I apprehend, am I bound to decisions of the Full Commission nor of the former Court Session because I exercise my functions as Arbitrator under the *Public Hospitals Act* and not under the *Industrial Relations Act* 1991. Nevertheless, and again as I have found, I am required under the *Public Hospitals Act*, s.29N(2) in making a determination to have regard to those principles. I have earlier decided, for reasons then stated, to apply the principles in making a determination for VMOs to the extent considered appropriate in all the circumstances. In so doing, however, I do not think one may be selective in applying one principle but not another, nor should one apply part of one principle but not another part, unless, of course, the particular circumstances made that not only practicable but almost inevitable. It seems to me the principles of wage fixation are an integrated whole and dependent for their integrity and viability on consistency of application and comity in the industrial setting. The economic circumstances, and the consequences flowing therefrom, are significant and so constitute a powerful reason justifying the application, in full, of the principles of wage fixation. Indeed, I have applied already the structural efficiency principle. I propose to apply equally the work value changes principle.

I conclude, and find accordingly, that extraordinary circumstances exist in the present case within the meaning of par.(c) of the work value changes principle to make the datum point from which changes should be measured for VMOs as 15 December 1982. The facts in the above cases for hospital engineers and dental specialists are relevantly distinguishable

from the particular circumstances of the case before me. Whilst this case was not, as I have found, part-heard as at the date of the *State Wage Case - May 1991*, the last determination for VMOs was made in December 1985, and, subject to *State Wage Case* increases from then to February 1988, the present rates for VMOs are those as at February 1988. The position is quite different for hospital engineers and dental specialists, both of which groups received the normal *State Wage Case* increases from time-to-time, including the first and second structural efficiency adjustments of 3 percent from the *State Wage Case August 1989*; the dental specialists received also the 2.5 percent increase from the *State Wage Case - May 1991*. On the other hand, VMOs were unable to obtain *State Wage Case* increases after February 1988 because the automatic adjustment provision in the 1985 determination was dependent upon a basic wage increase so that VMOs had to have initiated on their behalf an application under the *Public Hospitals Act* for an arbitrator to be appointed and a new determination made. Such an application was indeed made on 13 November 1990 after long-running negotiations between the AMA and the Department failed to resolve many issues, the subject of the present proceedings, which had arisen as a result of and consequent upon the 1985 determination. Those matters have been particularised earlier, together with the circumstances in which the discussions were held. Also, of course, there was the inquiry conducted by the Public Accounts Committee into payments to VMOs and which was the subject of report in June 1989; that, in itself, was the subject of discussion between the parties, but, again, no agreement was reached. That background, in my view, is quite different from that for the hospital engineers and dental specialists.

The decisive point, however, on this aspect seems to me to be the very nature of the 1985 determination . It is a determination which has stood for just in excess of seven years, but subject to continuing

discussions between the AMA and the Department as to its provisions, and as to which I have found, for reasons given, to be unsafe on which to base a new determination. Necessarily, then, one is forced back to the last work value assessment for VMOs in the 1982 determination, effective as from 15 December 1982, but as adjusted for the deferred work value increase by the 1983 determination. No appeal mechanism was available under the *Public Hospitals Act* as it stood at the time of the making of the 1985 determination, and so any changes had to await a further arbitration in which the terms and conditions of work for VMOs could be the subject of a full review. That, in the view I take, is quite a unique situation by comparison with that existing for the hospital engineers and dental specialists in their ordinary access to the industrial tribunal and with the full review and appeal procedures available. I am satisfied that that constitutes an "extraordinary circumstance" within par.(c) of the work value changes principle.

As to the appropriate datum point, the 1985 arbitration clearly was not a work value exercise being concerned with the settlement of the 1984-85 doctors' dispute and, as the decision of *Macken* J. noted, the assessment of compensation for the so-called "Medicare effect". The nature of the decision so made, in my view, makes it an inappropriate datum point. True it is a datum point as early as 15 December 1982, in excess of ten years, is a long time, but I observe the *State Wage Case - August 1989* provided for work value changes to be measured back to 1 January 1978. In that context, it seems to me 15 December 1982 is a not unrealistic date. I propose to adopt it in this case, and I turn now to consider the application of the work value changes principle.

Each of the VMO witnesses attended specifically and at some length to the work performed by them and the changes which had occurred in the practice of medicine since 1985, although some of the changes commenced

two or three years earlier. Some criticism as to the unrepresentative nature of the work value evidence called by the AMA was levelled by Mr. *Kenzie* as being biased towards specialists, and particularly senior specialists. The witnesses called by Mr. *Sperling* (see Appendix "E"), in summary, covered four general practitioners who had had at least ten years' experience or possessed a Fellowship of the Royal Australian College of General Practitioners, three of whom were from country hospitals and one from a large metropolitan teaching hospital; four specialists gave evidence, two of whom were from country hospitals in large centres and the other two from metropolitan teaching hospitals; thirty-five senior specialists gave evidence, with a general mix of country hospitals and metropolitan teaching hospitals. It is significant too that of the specialists there were nineteen physicians, fifteen surgeons and five anaesthetists. Necessarily, the evidence given by some of the specialists touched on the work of general practitioners, and the evidence of the general practitioners necessarily dealt with the work performed by colleagues with less experience. Overall, I found the evidence of considerable assistance, supplemented as it was by eleven videos of various surgical procedures to illustrate the changes in technology, techniques and knowledge. I am comfortable in receiving the evidence from the VMO witnesses as being representative of the profession as a whole.

Mr. *Sperling* made available a folder containing a summary of the work value evidence called both by the AMA and the Minister. The material was voluminous and detailed and I do not intend to recite it. Suffice it to say I have perused the summary.

The Minister's evidence was principally given by Dr. MacArthur, who identified a number of work value changes and made a comparison of the impact on VMOs relative to staff specialists. In some areas, the

changes were said to be greater on staff specialists, mainly in the use of computerised systems for medical information, blood samples, additional professional tasks of a clerical nature, budget responsibility, team approach to patient care in the areas of mental health, geriatrics and rehabilitation, and the development of intensive care units. Shortly stated, Dr. MacArthur identified the changes in work for VMOs since 1983 as being primarily related to technological change, increased medical knowledge, treatment of new diseases, and, to a lesser extent, organisational changes in public hospitals. He finally expressed the view that work value changes for VMOs were not greater than for staff specialists during the relevant period.

The special case before *Fisher* P. for hospital specialists as referred to earlier, has, it seems to me, direct relevance to the present question. The case was presented on work value grounds and also for the correction of an anomaly. A substantial volume of evidentiary material was tendered to his Honour, including an agreed statement of fact. That agreed statement contained the following work changes, as noted by his Honour in the judgment (*supra* at 81-83):

> These changes are as follows:
>
> (a) An explosion of information and technological change requiring broader and more detailed knowledge due to new and more complex diagnostic and procedural techniques.
>
> (b) An explosion of competing modalities which the hospital specialist must understand, access and apply.
>
> (c) Diagnosis is made more difficult because more information needs to be understood, thus, previously unavailable information needs to be correctly interpreted and acted upon.
>
> (d) Need to keep abreast of ever expanding knowledge and to understand developments in other specialties and sub-specialties.
>
> (e) Emergence of the new specialties of accident and emergency medicine, rehabilitation medicine, occupational health medicine, palliative care medicine, sub-specialties, eg

haematology, immunology, infectious diseases, oncology and rheumatology which have accelerated medical knowledge in these areas and thereby impacted on the work.

(f) There has been a change in the types of equipment being used commonly as a result of new technology. These advances have, in the main, added to existing technology rather than replacing that already existing, although some items of equipment such as MRI are totally new.

(g) There has been a rapid expansion in the number and complexity of drugs available for use. The range and cost of available drugs, together with financial constraints within hospitals, has resulted in increasing cost/benefit decisions having to be made.
The complexity of drugs now available requires Hospital Specialists to have greater awareness and understanding of the side effects and complications which may arise, eg when combinations of drugs are used.

(h) The increasing age in the population and the decrease in length of stay in hospitals have combined to result in older/sicker patients being treated more frequently. These factors have increased activity levels for hospital specialists and resulted in increased frequency of usage of clinical and diagnostic skills.

(i) The combination of factors listed above have resulted in life and death decisions being made more frequently.

(j) The teaching component of hospital specialists' work has become complied as a result of the above.

(k) The incidence of exposure to complex infections has increased and resulted in more sophisticated medical and surgical techniques being developed.

(l) Hospital specialists are now involved in accessing a wide range of medical information from computerised systems.

(m) Hospital specialists may be required by law to take blood samples from:

* persons suspected of driving whilst under the influence of alcohol;
* since 1988, persons suspected of driving whilst under influence of medication/drugs.

(n) Hospital specialists may be required to personally perform additional professional tasks of a clerical nature, consistent with legislative requirements;

* Cross matching of blood;
* Workcover information;
* AIDS reporting under the *Public Hospitals Act*;
* Transcover;
* *Mental Health Act* proceedings;
* Certification of the need for acute care;

* Guardianship cases;
* Reporting cases of possible child abuse;

(o) Hospital specialists must now carry the budget responsibility for decisions made in the units under their control.

(p) The emergence of an articulate and organised consumer lobby, and the establishment of the complaints unit has added a further dimension to the picture.

(q) The aftermath of the doctors' dispute has left hospital specialists with significantly increased teaching and clinical duties in some areas. (During the hearing this paragraph was withdrawn from the ambit of agreement).

(r) The "entry standard" for employment as a hospital specialist has been influenced by the inability of the medical schools to attract young academic staff. As a result, hospital specialist entry standards reflect university academic requirements.

As to the way in which work value should be assessed in terms of the principle, his Honour commented (*supra* at 83):

> While this total body of evidence and its detail is impressive, there are problems in relation to the presentation of what is a "historical" work value case proceeding by the accretion of detail and placing emphasis on changes and developments that have occurred over time. One of the difficulties is that this type of approach to work value considerations seems to be well removed from the closely defined concept of work value review in the wage fixation principle.

After referring to par.(a) of the principle, his Honour further commented (*supra* at 84):

> One of the problems with the application of the "strict test" to professional or managerial employment lies in the nature of change. Change must be accommodated, being an essential part of what professional practice is all about. It does not follow therefore, without more, that changes, even spectacular changes, necessarily fall within the work value principle.
>
> Secondly, it has to be understood that new techniques and procedures bring with them their own advantages. For every new technological advance there is likely to be somewhere an inferior technology in part or in whole abandoned. Superior technologies give superior results and tend to free practitioners from laborious, uncertain and more stressful practice. Changes, subject to habituation, do not necessarily make things more difficult or more demanding. They may, but equally they may remove problems, decrease anxieties and uncertainties and as well be more rewarding and more productive.
>
> This is particularly pertinent in a case such as this where it must be said that the practice of medicine generally has been making

> major strides decade by decade all this century and, indeed, perhaps even earlier. If this consideration was all that was necessary, increases in these fields and in many other professional and managerial fields could be granted without end.
>
> Thirdly, there are difficulties which arise out of the nature of the proceedings before this Commission. This application for a very large increase in remuneration - fifteen per cent - is well above the amount being received by those employed within the majority of classifications within this Commission's awards.

Proceeding from that work value material, and in the context of the three difficulties stated by his Honour in applying the appropriate test of change to professional employment, the further and different case presented of an anomaly led to the following conclusion by his Honour (*supra* at 88,89):

> I propose to make an affirmative finding that the circumstances displayed on the evidence before me demonstrates the existence of an anomaly within the meaning of the State wage principles. This anomaly may be defined in terms of the delays which have occurred since 1981 which have postponed a review of specialists' and senior specialists' rates at a time when major shifts in clinical and administrative responsibilities have been taking place separate from, and in addition to, those which might be expected to emerge from the ordinary and customary need for professional updating and skills development.

The case was thus decided on the existence of an anomaly only and the 15 percent increase in salary levels was accepted by his Honour as representing the assessment by the employing authority of an appropriate amount.

The approach to work value change in terms of the principles as adopted by *Fisher* P. was followed by the Full Commission in the above-mentioned case for dental specialists and in which it followed the earlier decision as to hospital engineers. For myself, I must say the approach to work value for professional employees in terms of the "strict test" contained in par.(a) of the work value changes principle is one with which I agree. But that, however, is not the end of the matter for VMOs and even though the anomalies principle, on which *Fisher* P. relied to grant the increases for staff specialists, was omitted from the principles by the

State Wage Case - May 1991. The cases for dental specialists and hospital engineers have been distinguished in their comparison with this case for VMOs where "extraordinary circumstances" have been established. I point out too that the Full Commission as to the dental specialists, unlike the position for VMOs, found "that the disparate industrial coverage of dental officers in public sector employment was specifically considered by the former Commission in 1985" and it was "unable to take the view that the position of dental specialist is akin to that of medical specialists as recounted by *Fisher* P. in the *Medical Specialists Case.*" Thus, and consistent with the paid rates awards principle, one may turn to the structural efficiency and wage adjustments principles, taking into account the evidence of work value changes of VMOs, to consider appropriate rates of remuneration on special case grounds.

Special case considerations: The assessment of a proper work value for VMOs was, as I have found, last performed during the 1982 and 1983 proceedings bearing in mind the difficulties associated with the 1985 arbitration. If ever a case called for classification as a special case, then, in my undoubted view, the circumstances as they have developed from 1983 through to the 1985 determination and the effect of *Hyslop (No.2)* require this case for VMOs to be so classified. It seems to me to be necessary in the public interest for rates of remuneration for VMOs to be assessed at proper levels in accordance with principle in order that the public hospital system, recognising the recent reforms and changes to it, may accommodate VMO participation at reasonable levels of compensation.

The way in which special cases should be approached was considered by the Industrial Commission in Court Session in *Re Crown Employees (Commissioned Police Officers) Award* (C.I.C.S. - 89/1617 & 90/109 - 1 May 1991 at 10,11) thus:

We approach a consideration of that material in terms of what the Australian Industrial Relations Commission said in the *National Wage Case August 1989* as to special cases as follows ([1989] 30 I.R. 81 at 98):

> Both the ACTU and the Commonwealth contended that increases beyond those generally available for structural efficiency may be approved in special cases, provided that the cases are processed through a special case mechanism and provided there is negligible cost or it can be demonstrated that it should be approved on public interest grounds.
>
> It is generally accepted that applications said to fall into the category of special cases must be dealt with at the same time as, and in the context of, the application of the structural efficiency principle.
>
> We have decided that all special cases should be tested against other relevant principles at the same time as the structural efficiency principle is being applied.

It will be apparent, therefore, that the "other relevant principles" which are to be taken into account with structural efficiency in assessing a special case must be seen "in the context of ... the structural efficiency principle". Thus, in the approach we take, reliance on the Work Value Changes Principle, as the parties did in the present case, is to be incorporated in the structural efficiency considerations. That concept was followed by the Court Session in *Re Teachers (Non-Government Schools) (State) Award* (C.I.C.S. - 90/161 & 90/513 - 17 August 1990 at 12-15) in the special case for private and Catholic systemic school teachers. The Commission there concluded "that the structural efficiency principle was 'the central element in a new system of wage fixation'" (*ibid* at 15); in our view that reinforces what was said in the *National Wage Case* (*supra* at 88,89) - "To achieve the goals sought, the structural efficiency principle must increase flexibility by changing employment conditions, work patterns, employee mobility, education and training." It is those identified aspects of structural efficiency to which we have given particular attention in the present case.

Those views as to special cases were expressly followed by the Commission in Court Session in the *Technical and Further Education Teaching Service Case* (*supra* at 37,38) and in the *Education Teaching Service Case* (C.I.C.S. - 89/566 & 90/767 - 12 September 1991 at 6,7). I too propose to follow them.

The finding I have made is that the structural efficiency principle has been met, and to a significant degree. Reliance by the AMA on the work value principle, however, must be seen to exclude those changes

resulting from what *Fisher* P. described in the *Hospital Specialists Case* as "the ordinary and customary need for professional updating and skills development." Nevertheless, and although in that case his Honour called in aid an "anomaly", VMOs, on the evidence, seem to me to be no less equally affected than staff specialists by what his Honour identified as "the delays which have occurred since 1981 which have postponed a review of specialists' and senior specialists' rates at a time when major shifts in clinical and administrative responsibilities have been taking place separate from, and in addition to, those which might be expected to emerge from" the ordinary professional changes. It is true his Honour looked at those changes from 1981, two years earlier than the datum point for VMOs, but, in the view I take on the evidence before me, the burden of the changes necessarily occurred towards the latter part of the measurement period in the late-1980s. For instance, in the proceedings before *Fisher* P., Dr. Horvath gave extensive evidence on those aspects, as indeed she did in the proceedings before me, and his Honour relevantly commented as follows (*supra* at 84-86):

> Dr Horvath in her evidence dealt with the context of managerial sociological and even philosophical shifts in medical practice, what these changes mean to practitioners and the advantages society in general received from them. Put at its widest, the evidence was about medical practice at the end of the twentieth century.
>
> ...
>
> Over the last ten years there have been general societal changes within medical practice which have led to much more of a team approach to individual patient care. There was, she said, less likelihood if a doctor said "do it this way" that people would simply do it. Salaried specialists had to ensure that they took note of rights and privileges of the other members of the team, including health professionals. There was much more discussion about the implications of decisions on the workload of others, the involvement of a wider range of health professional in decision-making itself and an advise and consent relationship between different members of informal teams, than has existed in the past. She felt that individual specialists had increased their range of competence, some more than others and there had developed a need to explain and justify treatment and prognosis.

Societal changes affected the relationship between staff specialists and the patient. Society was moving much more in the direction of consumer involvement in decision-making, with patients questioning the desirability of moving in a particular direction.

It was evident in a whole range of ways, outside as well as inside the hospital, that the specialist now deals with far more informed patients who seek to be involved in decision-making about their own treatment, their management and the outcomes they are expecting. The total system of health care was moving away from dealing with the isolated or episodic and moving increasingly into management of chronic conditions. Staff specialists, some more than others, have had to move into a new level of skills acquisition.

Further, there was a broad area that touched financial accountability perhaps parallelling many other areas in public administration, in and outside the health area. Senior salaried staff were been given budgets for specialty services and had to account for them and account for overruns. Questions of priorities affect decisions about patients. This Dr Horvath described as "a fairly disturbing area of health care". There has been some publicity about things like the availability of intensive care and access, waiting lists, people waiting unduly in emergency departments and so on. Basically, the profession is confronting circumstances where it was faced with more professional work than it can readily manage or more professional work that it can accomplish from available and appropriately skilled resources. This means hard choices have to be made about access and waiting and indeed in some cases access must be denied. Such decisions, which may have considerable impact on individuals, are part of hospital management today. From the point of view of the specialist it is a stressful area. "It involves really a fairly concerned human approach in looking at who gets it and who does not as much as the scientific issues involved."

...

Pressure on resources extended even to bed allocation. In a context where diagnostic testing is very much interventionist compared to what it has been in former times, both the bed and the technology and the time of a skilled operator are often in short supply and there can be a type of jostling for positions in the queue. This has of course brought pressure to bear on the effective turnover of beds in hospitals with what Dr Horvath described as a quite dramatic fall in the length of stay of patients in hospitals.

The team approach requires specialists to be more aware of developments in specialties other than their own. As Dr Horvath put it, "they need to know which ones to bring in and what they can contribute or else you end up with fifty people around a bed saying 'why am I here?'". The increasing number of sub-specialties in the last ten years and their growing importance adds to this problem. Dr Horvath cited accident emergency medicine and drug and alcohol care as specialties with relatively recent origins.

In the present case, Dr. Horvath gave comparable evidence in respect of the public hospital system as did Dr. Spring, Dr. MacArthur, Mr. Barker, Mr. Clout, Mr. Berry and Ms. Crawshaw. The evidence called by the AMA through the very many VMO witnesses attended to similar considerations, although, of course, that evidence dealt also with the "traditional" or "historical" work value changes which need to be read down in applying the "strict test" to professional work in terms of the test contained in par.(a) of the work value changes principle.

A consideration of the structural efficiency measures as outlined above, together with the relevant work value matters, leads me to the conclusion that since the datum point in December 1982 a very substantial case has been made out to justify an increase in rates of remuneration for VMOs over and above those allowable under *State Wage Case* decisions since that time. As I have intimated above, and consistent with the *Commissioned Police Officers Case*, I find that a special case for VMOs has been made out on public interest grounds. The 15 percent increase awarded by *Fisher* P. to staff specialists was referable to the period from January 1978 to December 1989 and the corresponding period for VMOs is from December 1982 to November 1992, but recognising most of the changes occurred in the latter part of the period. Also, insofar as VMOs are concerned, the evidence enables me to take into account the somewhat accelerated degree of relevant change in the period of three years from 1990 to 1992. It is true much of the special case material was directed towards specialists and not general practitioners; however, I accept that VMO general practitioners in public hospitals have been similarly affected. There was little evidence led to disturb pre-existing relativities, but, on balance, I think specialists have been affected to a greater degree than have general practitioners. I therefore find a special case made out for both VMO specialists and general practitioners to a

proportionate degree. The extent to which the special case is made out in terms of compensation must take into account also that as independent contractors VMOs will have been required to meet the changes very much from their own independent resources, particularly in terms of information, knowledge and skill development, so as be able to meet the requirements of the public hospital system imposed on them as practitioners of the highest standing.

In the result, I would assess a special case increase for VMOs in respect of the period from December 1982, but based on rates as at December 1983, to the present time in an amount consistent with the 15 percent granted to staff specialists. The assessment I make is 18 percent for specialists, 15 percent for general practitioners with 10 years' experience or FRACGP, 12 percent for general practitioners with at least 5 but less than 10 years' experience, and 10 percent for general practitioners with less than 5 years' experience.

State Wage Case increases:

Since December 1983 increases have been granted to employees under industrial awards, including staff specialists, from *State Wage Cases* and a summary is set out below -

State Wage Case	Increase
April 1984	4.1%
April 1985	2.6%
November 1985	3.8%
June 1986	2.3%
March 1987	$10.00 per week 4% second tier
February 1988	$6.00 per week
August 1988	3.0% $10.00 per week second increase

August 1989	3.0% first adjustment 3.0% second adjustment
May 1991	2.5%

(The above increases represent a compounded increase of approximately 35 percent.)

Considering remuneration rates for VMOs from December 1983 means, for consistency of treatment with employees, that one needs to take into account those *State Wage Case* increases. There was no real issue in the proceedings that the increases up to and including the 2.3 percent from the *State Wage Case - June 1986* should be allowed to VMOs. As to the increases of a flat money amount per week, the Minister took the view that VMOs should receive no more than the hourly equivalent on a thirty-eight hour week basis, whereas, of course, the AMA held to the result of the decision of the Court of Appeal in *Hyslop (No.2)* whereby VMOs received a percentage increase in the total hourly rate equivalent to the percentage basic wage increase - that approach gave a VMO senior specialist an increase of $14.50 per hour for an equivalent basic wage increase of $16.00 per week (42 cents per hour); I have already found that in a new determination that position will be corrected to accord with the Minister's approach. The *State Wage Case* increases from the 4 percent second tier adjustment from the *State Wage Case - March 1987* through to the 2.5 percent increase from the *State Wage Case - May 1991* were not granted automatically to employees but were dependent upon individual awards recognising the concepts of restructuring and efficiency, and latterly that of structural efficiency, by specific arrangements between the parties to those awards. The Minister took the view here that no such arrangements had been made as between VMOs and hospitals so that such increases should not be allowed. I have, in dealing with structural efficiency considerations, made a finding that such measures should be

arbitrated and imposed on VMOs by the new determination for reasons then given. For those same reasons, I propose to take into account in assessing rates of remuneration for VMOs the benefits of all *State Wage Cases* up to and including the most recent increase of 2.5 percent.

The "rolled-up" rate concept

The 1981 determination, at the same time as it abolished the concept of sessions in favour of services being provided on an hourly basis, introduced the "rolled-up" rate as the normal hourly rate comprising a base rate plus a percentage loading for superannuation, split sessions and leave, and a money amount to cover practice costs. The determination itself only prescribed the normal hourly rate and the reasons for determination contained an explanation of its make-up and how it had been assessed. That method continued until the 1985 determination removed the loading for practice costs from the rolled-up rate and placed it in a separate clause in the determination.

In the present proceedings, no party sought any change to the concept of a rolled-up rate, but the Minister proposed the determination should specify the base hourly rates, the make-up of the loading in lieu of allowances and paid leave, the normal hourly rates as comprising the base hourly rate plus the loading, background practice costs allowance, and total hourly rate comprising the normal hourly rate plus background practice costs allowance; the total hourly rates thus obtained were to be paid for "core services", being those services provided by a VMO to public patients under a sessional contract. Apparently, the proposal was designed to meet difficulties in the construction of the present determination as to the appropriate rate at which a VMO was to be paid for a call-back and for public holiday work as illustrated by the decision of the Court of Appeal in *Hyslop (No.1)* (*supra*). The AMA, on the other hand, adopted the rolled-up rate as being the normal hourly rate

consistent with the present determination, as comprising a base rate and the loading with the background practice costs allowance in a separate clause. The AMA's claim made plain the basis of payment for a call-back and for public holidays with a result consistent with the Minister's intention.

I must say the specification of remuneration for VMOs in previous determinations is not easy to follow and caused me some early difficulty in following the pattern. I apprehend the Minister's claim, even though intending to clarify the position, still has, at least for me, a confusing aspect with the number of hourly rates referred to and in the context of core services. I think the matter should be clarified in a new determination, as a matter of drafting if nothing else.

In dealing with the hours during which services are rendered, I decided to move to the concept of "ordinary hours" being the hours agreed between a VMO and the relevant hospital or area health service as specified in the sessional contract. The well understood concept of "ordinary hours", it seems to me, is preferred terminology rather than "core services". In a corresponding way, I propose to express the remuneration for a VMO as an hourly rate for each ordinary hour specified in a sessional contract; that ordinary hourly rate will be a rolled-up rate comprising the base rate and any loading, but excluding the background practice costs allowance. The rates for call-back and public holidays may then appropriately be based on the ordinary hourly rate of remuneration plus any loading. I trust the scheme I intend to determine will be readily understood, particularly by those not versed in the history of previous determinations.

It remains to deal with matters not previously mentioned.

Split sessions loading: The present determination contains a loading of 5 percent as part of the rolled-up normal hourly rate as compensation for

"split sessions". The AMA sought retention of the loading, whereas the Minister sought its replacement by the "extended sessions" loading in the same amount of 5 percent of the base hourly rate and consistent with the up-front hours contract. I have earlier in dealing with hours of service, for the reasons then given, accepted the extended sessions loading as a proper provision. The question remains, however, whether the split sessions loading should be retained.

The split sessions loading arose initially in the 1976 arbitration at a time when VMOs worked and were remunerated for "sessions" of three and one-half hours. In the 1976 reasons, Mr. *Rogers* reasoned the matter thus (Pt.6 at pp.1-3):

> ... I am of the opinion that I should accede to so much of the A.M.A.'s claim as would seek to class a 3 1/2 hour period which requires more than 2 visits as a split session.
>
> The A.M.A. seeks to justify the loading of 25% on the basis of the additional travelling time involved. That travelling time may vary greatly. If the session is performed in say three visits instead of two visits, then the A.M.A. split session provision would apply. The additional travelling time involved may be no more than going from rooms in a medical centre to a hospital across the road and on completion of the session, back again, a maximum of perhaps ten minutes. On the other hand, I recognise that the travelling time may be much more than that. In addition, one can also conceive of circumstances where the 3 1/2 hours may be made up of more than three visits. In those circumstances, it seems to me, to be unreasonable to impose the burden of the extra travelling time on the V.M.O.
>
> A 25% loading would, in effect, require some 50 minutes of additional travelling time. There is really no evidence before me which would justify such a loading or indicate any other figure that would be reasonable. In doing the best I can and erring on the side of generosity, I am of the opinion that a loading of 10% should be paid in respect of split sessions. Inevitably this will mean that a practitioner who is in the immediate vicinity of the hospital, will be advantaged over those whose rooms are some distance removed. Also, a practitioner who is required to pay 4 or perhaps 5 visits to make up a split session, will be disadvantaged, compared to one who is required to make only three visits. It would seem to me that the practicioners who are most likely to be affected in this regard, are Physicians, who may desire to make a round in the morning and/or the evening and have no obligation at the hospital beyond perhaps half an hour or three quarters of an hour. Surgeons and other practitioners involved in theatre work, would generally

speaking, be required to be at the hospital for other purposes and in most instances, will be unlikely to be involved in as may visits in a split session as a Physician.

The split sessions provision was continued by agreement of the parties in the 1978 and 1980 determinations. The 1981 determination, as I have indicated, adopted the Health Commission's proposal for the abolition of sessions and split sessions and their replacement by a base hourly rate to include a split session loading of 5 percent. I quoted earlier, in dealing with the 1981 determination, the extract from the reasons of *Macken* J. adopting the Health Commission's proposal. The change from a loading of 10 percent for a split session to a loading of 5 percent of the base hourly rate, although not explained, apparently recognised the change from the payment of the 10 percent loading for a split session only, that is a period of three and one-half hours as a result of three or more visits to the hospital by the VMO, whereas the 5 percent was payable to all VMOs for each hour of service provided. The closest one comes to the explanation in his Honour's reasons is the comment setting out the calculation of the base hourly rates (at p.11) - "The split session loading has been calculated at 5 percent of the base rate, assuming an average ratio of sessions to split sessions of 1:1." In any event, it seems clear from the 1978 proceedings that the split session loading compensated for the additional travelling time involved in attending a hospital on a number of occasions to meet sessional obligations. The 10 percent loading at that time in respect of a session lasting for three and one-half hours represented twenty-one minutes for additional travelling time when a split session was worked; the loading of 5 percent of the base hourly rate as introduced by the 1981 determination represented additional travelling time of three minutes per hour, but was paid to all VMOs for each hour of service irrespective of the number of occasions a hospital was attended.

Also, Mr. *Rogers*, in allowing the 10 percent loading, said he was "erring on the side of generosity".

The 1982, 1983 and 1985 determinations made no alteration to the 1981 provision, so that current rates of remuneration for VMOs contain a 5 percent split sessions loading.

The Minister's case was forwarded on the evidence of Dr. Child who said - "The concept of a split session allowance is illogical since the introduction of an hourly based contract." Mr. *Kenzie* submitted there was virtually no evidence to suggest that VMOs generally attended public hospitals more than twice in any one day, as their statements of evidence disclosed a somewhat regular pattern of attendance. It was further submitted many of the VMO witnesses only had one public hospital appointment which made it even more difficult to contemplate attendances more than twice a day. Senior counsel pointed out also that the factor of additional travelling time, which the split sessions loading was designed to meet, was relied on by the AMA as justification for its claim for a part-time loading of 10 percent and as justification also for its separate claim for a 50 percent loading for associated time; double counting would inevitably result if all of those claims were to succeed in whole or in part. The account taken by *Macken J.* in 1985, although not quantified, of the part-time nature of the work and recognition for associated time should have resulted in the removal then of the 5 percent split session loading, even though neither party asked for it to be done. It should, so it was submitted, be done now.

In seeking retention of the loading, Mr. *Sperling* submitted on the history that it was included as compensation for the working of broken time by a VMO, including multiple visits on the one day and short visits in isolation which were uneconomical. He contrasted that situation with the concept of part-time work which was referable to working separate but

whole segments of time, such as two days per week or two mornings per week. Notwithstanding the statements by Mr. *Rogers* in the 1976 reasons as to the rationale for the split sessions loading being related to additional travelling time, Mr. *Sperling* submitted that since 1981 travelling time could not be seen as the specific reason for it.

Although the split sessions loading was introduced at a time when the sessional concept was in force, I have some difficulty in accepting the Minister's proposition that the introduction of an hourly based contract made the split session loading illogical. Indeed, I would have thought an hourly based arrangement rather than blocks of sessions of three and one-half hours each would be indicative of a move towards a greater number of attendances by VMOs at hospitals. In that respect, *Macken* J. in the 1981 reasons observed (at p.4) - "It appears to have its origin in the length of service originally estimated to be taken to deal with out-patients and ward rounds. ... hospital work is not organised into that type of span any longer ... a sessional period of three and one-half hours (is) anachronistic in the current medical world."

The basis for the split sessions loading is, in my view, compensation for additional travelling time occasioned by multiple hospital visits. In the absence of evidence to the contrary, I am prepared to accept the incidence of VMOs attending hospitals on occasions no less frequently than they did in 1976; the continuation of this loading in the 1981 determination, when the sessional concept was replaced by the hourly based concept, through to the existing determination, and by agreement of the parties, persuades me against its removal. There is no sufficient case advanced for the Minister to require otherwise. The 5 percent split sessions loading will be included in the new determination.

Associated time loading: In the AMA's third exercise, which calculated a normal hourly rate for VMOs by reference to the staff specialists' current

remuneration package, an amount of 50 percent for associated time was added to the value of the package as part of the process of moving to an appropriate rate for VMOs. Because, as the AMA said, *Macken* J. took account of associated time in determining rates of remuneration in 1985, albeit without quantifying the amount, consideration for associated time was therefore included in the AMA's exercises one and two in developing an hourly rate.

In his final address, Mr. *Sperling* supported the claim for associated time in the following way:

> What we would propose as the relevant question is this: once one has ascertained - and may I interrupt myself by saying I am looking to pose a relevant question if one is going to have regard to what a staff specialist earns, then we would say the relevant question is having ascertained the hourly rate of remuneration for a staff specialist counting in his salary and other benefits, what else needs to be taken into account?
>
> The "what else" is in some instances a question which directs the mind to things on which one can more readily put a dollar value than others but a dollar value one has to arrive at. We would suggest the range of considerations that have to be brought into account would include the following:
>
> First of all, there is time necessarily expended for the purpose of the sessional contract other than the time applied to the service itself.
>
> This is the concept of associated time referred to in our working document, but let me endeavour to give it content.
>
> There would be time taken in travelling from rooms to the hospital and between hospitals. There would be time taken in the rooms attending to the management of waiting lists and theatre bookings. There would be time taken in the rooms attending to arrangements for diagnostic procedures or patients who are in the hospital. Dr Stenning in particular said this was something a surgeon had to do.
>
> Then there is time taken in the rooms writing reports to other doctors concerning public patients in the hospital or immediately following their discharge, particularly by specialists to GP's where hospital arrangements for discharge summaries are inadequate. There is time taken in consultation from the rooms with other doctors involved in the management of the case. There is time taken on the telephone to relatives concerning patients who are in the public hospital.
>
> One must then recognise that the doctor is spending time in his practice on administration and it is administration to maintain an

infrastructure which supports both his private and public work. So although it cannot be capable of precise measurement, your Honour has heard enough to obtain an impression to enable a reasonable proportion of such time to be taken into account.

Lastly in this list of associated time matters, there is the time required to write up claim forms, for monitoring sessional payments and for keeping such records as the determination may require for the purposes of audit.

In all of those respects, for every hour the doctor spends on sessional work he is required necessarily to spend time on matters which are necessarily associated with it and which should be taken into account in assessing a fair and reasonable rate which is going to be based on the face to face hours or the actual hours spent in the hospital under the sessional contract.

...

HIS HONOUR: You have fixed the associated time at 50 percent?

SPERLING: We have in our document. I must say this is an aspect of the case which requires a kind of judgment which is not immediately amenable to figures of that kind. At the end of the day your Honour is going to fix a fair rate for the work and your Honour is going to recognise if as a step or one of the alternative ways of looking at the matter one is going to have regard to what a staff specialist earns for an hour, then there are certain additional things which have to be taken into account, and one of them is the VMO must spend time out of the hospital in doing things that have to be done in order to enable that sessional work to be done properly, and we say those additional things have to be taken into account.

Whether your Honour came to the view on the whole of the evidence it looks as though VMO's in this range of activity may well be spending half an hour in their rooms for every hour they spend in the hospital, that may be the impression. The impression may be more or less than that, but it is an aspect we would say needs to be recognised and needs to be recognised in the assessment of the rate.

We certainly do not suggest your Honour would do anything like specifying a loading that would be in a particular percentage. We merely identify it as something which has to be taken into account. It is not capable of precise quantification but is a matter for judgment and evaluation.

The AMA's case, then, was clearly based on the proposition, as stated in its particulars provided to the Minister - "That the VMO would have to spend in the generality 50% more time than a staff specialist spends to earn the equivalent hourly rate." Mr. *Sperling* extracted from the transcript, according to classification and specialty, the relevant evidence of VMO witnesses as to allocation of their time, both paid and

un-paid. The evidence was voluminous and it is only possible to obtain an impression. My conclusion from a perusal of the material does not establish the rather excessive claim for associated time of 50 percent, and I am quite unable on the evidence to accept the proposition that VMOs spend 50 percent more time than staff specialists to earn an equivalent amount of money. The evidence simply did not attend with any assurance to that latter question, and, indeed, earlier decisions to which I have referred concerning the hours worked by staff specialists, an average of fifty-five hours per week has been mentioned, are against the AMA's proposition. Another difficulty is that the evidence tended not to distinguish associated time spent as between private patients and public patients, although there was an amount of evidence as to the private/public patient mix for various VMOs so as to provide at least some measure; that mix, as would be expected, varied markedly from VMO to VMO, although private:public ratios generally ranged from 80:20 to 60:40. Nevertheless, the evidence certainly established that VMOs expend time in the nature of associated time for which no allocated sessional payment is made, and it is to be undoubted that such time has been a consideration in the assessment of rates of remuneration for VMOs in previous determinations just as it must be included as a component in the fee-for-service amounts received by VMOs in respect of their private patients.

In the 1985 proceedings the AMA attempted to have included in the rolled-up rate a loading to cater for associated time in the amount of 25 percent. In ruling on the claim, *Macken* J. dealt with it in his reasons (at pp.24-26) by noting that a loading for associated time had not been before included in the rolled-up rate but that there was "no doubt that certain work associated with the treatment of public patients in teaching hospitals is performed in the private rooms of the V.M.O. nor any doubt that, in order to carry out sessional obligations, it is necessary to travel

between hospitals." In the result, his Honour recognised it as appropriate to include such a factor in the sessional rate and did so by "having regard to all factors involved in the performance of the professional duties of a V.M.O." Significantly, I observe his Honour, like the AMA here, included in associated time the concept of "some remuneration for travelling time between hospitals"; I am reminded of the inclusion of such time within the AMA's argument for continuation of the split sessions loading. Therefore, it seems to me, that factor as part of associated time must be discounted to avoid double-counting.

To the extent associated time is part of the rolled-up rate, then, in my view, any adjustment to that rate by reason of *State Wage Case* increases, structural efficiency measures, work value changes and special case considerations must necessarily increase the associated time component in money terms. The evidence in no way succeeded in establishing any relevant increase in the quantum of associated time spent by VMOs, so that, it seems to me, there is simply no basis for its re-assessment in the manner sought by Mr. *Sperling*. I therefore decline to adopt the AMA's approach for associated time.

Finally, on this aspect in relation to exercise three based on the staff specialists' remuneration package, I might point out, as Mr. *Kenzie* reminded me, that the exclusion of the 50 percent associated time loading in the calculations leads to a "dramatic impact" in the results. I propose to deal later with exercise three, but perhaps it is timely to note that by excluding the associated time component, but even retaining the part-time loading of 10 percent and the 49.3 percent loading, the calculation of an hourly sessional rate for a VMO senior specialist by reference to a senior staff specialist Scheme A, B and C of $147.91, $193.43 and $224.28 become respectively $101.69, $132.99 and $154.19.

Part-time loading: Again in exercise three the AMA included as part of the calculation of hourly rates for VMOs from the staff specialists' remuneration package a part-time loading of 10 percent. In his final address, Mr. *Sperling* put the basis for the inclusion of a part-time component in the assessment of VMOs' remuneration on the following basis:

> On the evidence your Honour has heard, this is not distant from the kind of things which happen in hospital practice where a doctor might attend the hospital once a day and see a few or more patients depending on the nature of the occasion but it would be conformable with the evidence your Honour has heard in this case there would be many instances in which a visiting medical officer on a ward round would be in the hospital for less than two hours and conformable with the approach in this award it should be recognised attendances of that sort need to be considered in a different light. There would be other attendances which would be longer. A surgeon may be there for 4 or 5 hours when he is operating, but when he checks on his surgical list one would be surprised if that would take 2 hours. All we say is there is recognition of the part time nature of the employment and again we say this is a matter your Honour will take into account.

Mr. *Sperling* relied on the Public Hospital Nurses (State) Award (268 N.S.W.I.G. 920 at 943 of 3 April 1992) which in cl.25 provides for payment to permanent part-time employees a rate calculated on the basis of one thirty-eighth of the appropriate weekly rate with a minimum payment of two hours for each start; senior counsel submitted that the minimum payment recognised a reasonable entitlement for a part-time employee to be paid on a different basis, particularly if for a relatively brief period of attendance. And, so it was suggested, an analogous basis existed for the prescription of a part-time loading of 10 percent for VMOs.

In the 1985 reasons (at pp.25,26) of *Macken* J., reference was made to the AMA's claim for a part-time loading of 10 percent on the basis "that it was an accepted industrial principle that rates for part-time employment should be loaded to compensate for the intermittency of such work." Then, as now, the AMA relied upon comparable loadings

applicable to part-time nurses and to employees under other awards. His Honour, like the claim for associated time, reflected the part-time element in the rolled-up hourly rate without identifying a particular amount.

The Minister resisted inclusion of a part-time element.

As with associated time, the evidence plainly did not attend to quantification, although it may be undoubted VMOs are engaged on a part-time basis in a regular manner for the duration of their sessional contracts; that is the essential nature of their engagement and for which the rates of remuneration compensate. How then, may it be asked, may an appropriate remuneration be fixed and then be increased by a further amount to compensate for the intermittency of the part-time nature of the work? I think the answer must be that it cannot be so. Generally, at least as I understand it, part-time employees under industrial awards, and unlike casual employees, do not attract loadings for the part-time nature of the work for which they are employed being paid on an hourly basis equivalent to the hourly rate for full-time employees and in receipt of other benefits on a proportionate basis. Therefore, I do not agree it is an accepted industrial principle for part-time rates to be loaded to compensate for intermittency. Reliance by the AMA for its part-time loading claim on the Public Hospital Nurses (State) Award must be seen against the background that that award was varied in 1986 to introduce a thirty-eight hour week and to eliminate a 15 percent allowance for employees regularly or "permanently" engaged as "part-time" for less than a full week. The Industrial Commission in Court Session in *Re Public Hospital Nurses (State) Award* ([1986] 15 I.R. 93), dealt with the history of part-time regulation under the award and said in its judgment (*ibid* at 96,97):

> The use of the term "part time" in this industry has, on one view, been a misnomer. This is perhaps best illustrated by reference to

the 1970 Public Hospital Nurses (State) Award (178 IG 437 at 447) (when the then existing allowance of 25 per cent was reduced to 15 per cent). In that award, in cl 14, "Part time and Casual Employees", a part-time employee was defined as "an employee who is engaged and is paid by the hour". Although some changes in conditions occurred, part time workers remained hired on an hourly basis and were not entitled to a number of prescriptions in the award, including such aspects as overtime, higher grade pay, uniforms and laundry allowance, fares and expenses and transport and living out allowance.

Strictly speaking, therefore, they were not part time employees as that term was commonly understood then and now. Rather they were "casual" employees with an hourly engagement and with a number of benefits applying to full time employees not available to them.

Presumably the adoption of the term "part time", instead of the more apt term "casual", arose because "casual" was the term applied in the award to employees engaged on a 40 hour week basis for a period of 13 weeks or less. "Part time" was a description first adopted in 1963 (148 IG 212 at 221) although it was questionable that it was appropriate in the case of an employee engaged and paid by the hour.

VMOs are not "casual" in the sense of being engaged on an hourly basis, but rather they are engaged under a sessional contract for a set duration for a specified number of hours each week, fortnight or month, as the case may be; the engagement, therefore, is truly of a "part-time" nature and not "casual" as would give rise to questions of intermittency. The analogy made with the Public Hospital Nurses (State) Award is, therefore, against the AMA. In any event, to the extent part-time considerations may be applicable to VMOs, like with associated time, the hourly rate already makes provision and there is no evidence of any change in that respect.

I disallow the AMA's claim for additional and separate consideration of part-time factors in assessing rates of remuneration.

Components: The views expressed above result in the rolled-up rate being expressed in the new determination as the ordinary hourly rate and to comprise the following components -

Base hourly rate (excluding loading and allowances) - remuneration for the nature of the work performed, including the

conditions under which it is performed, in terms of the knowledge, skill and responsibility required; and compensation for the "independent contractor" element in the conduct of a professional practice.

Loading -

Leave	26.83%
Extended sessions	5.00%
Split sessions	5.00%
Total:	36.83%

Cancelled sessions

The existing determination contains a provision, introduced by agreement, whereby a VMO is entitled to payment for cancelled time at the normal hourly rate where less than fourteen days' notice is given to him by the hospital, but where anaesthetists and surgeons have operating theatre time cancelled by the hospital the notice period is not less than twenty-eight days; there is a proviso to the effect that if the VMO is able to utilise any part of the cancelled period in the rendering of medical services then payment for that part of the cancelled period shall not be made. The AMA, with a minor amendment, sought the continuation of the provision. The Minister sought its exclusion.

In view of my decision to include in the new determination the requirement for sessional contracts to be on an up-front hours basis it becomes unnecessary to decide the claim for payment of cancelled sessions as such a provision would have no utility. The up-front hours system, as earlier explained, is based upon payment for a specified number of hours regardless of whether those hours are worked or not in a particular period. Nevertheless, the matter was fully argued and so it seems to me desirable to express some views on the cancelled sessions claim, but without finally deciding the issue.

Mr. *Sperling* relied on the operation of the provision since January 1986 and submitted no concrete evidence had been given of the clause operating in an unfair way or of being abused; nor were any administrative difficulties found. After being in operation for seven years, as Mr. *Sperling* put, there was a forensic onus on the Minister to show the clause work unfairly. Evidence from Dr. Jensen was relied upon to the effect that cancelled time could only rarely be usefully used, and, in any event, the proviso was a sufficient safeguard.

Mr. *Kenzie* contended for the Minister that a cancellation provision was unnecessary and inappropriate for an independent contractor who would have the benefit of using cancelled time to perform other gainful work, such as in his private practice.

Notwithstanding the fact the provision was inserted by agreement in the 1985 determination, I have some difficulty in accepting as reasonable payment for cancelled time to a professional independent contractor who spends a relatively minor part of his overall practice in the public hospital system. That position would be particularly so with such a long period of notice of fourteen or twenty-eight days, as the case may be. As it happens, those views do not have to be settled, but if otherwise a cancellation provision were necessary in the determination I would think, on the evidence, attention would have to be directed to the length of the present notice periods.

Annual adjustment of remuneration rates

The *Public Hospitals Act*, Pt.5C envisages the appointment of an arbitrator for the purposes of making a determination of the terms and conditions of work for VMOs, including the rates of remuneration, following proceedings by way of review and having regard to certain specified matters. Thus, if any change, however minor or routine, be sought to a determination so made after a review then application must

be made for the appointment of an arbitrator for a new determination to be made. In making the first determination in 1978, *Macken* J., by consent, included a provision making the normal hourly rates prescribed by reference and in relation to the basic wage for adult males; where, as a result of a *State Wage Case*, the basic wage was increased by the Industrial Commission in Court Session, then the provision operated to increase the normal hourly rates to the extent necessary to give effect to the change in the basic wage. In inserting the adjustment provision, his Honour said (at p.12,13) - "To obviate six-monthly applications for new Determinations, based solely on indexation changes, I have included in the Determination an agreed clause to make applicable to the base hourly rates future wages movement flowing from State Wage Case judgments." The provision was continued in each subsequent determination and was repeated in the 1985 determination notwithstanding a claim by the Health Administration Corporation for its deletion. It was this "basic wage provision" which was the subject of interpretation by the Court of Appeal, as referred to earlier, in *Hyslop (No.2)*. In his 1983 reasons for continuing the provision, his Honour said (at pp.4,5):

> The Corporation, for its part, seeks the deletion of the clause bringing into effect the specifications made pursuant to s.57 of the Industrial Arbitration Act 1940. The A.M.A. seeks to have that provision continue.
>
> In origin the basic wage clause was a consent provision which the parties included when Determinations first came to be made. It has had the effect of reducing the number of applications for new Determinations as hourly rates have kept in line with variations arising from State Wage Case Decisions from time to time.
>
> Mr Cullen argued that the wording of the clause did not achieve the desired effect. He also argued that the current State Wage Case Decision required undertakings to be given and, therefore, such a clause with an automatic operation should not be included in a Determination.
>
> Subject to a change to identify the current basic wage (viz. $92.90 for males) the new Determination will contain a similar clause. It has its origin in the wish of the parties; it has been maintained in

> Determinations over the years by consent of the parties and it has been given effect to by both parties. Its convenience as a mechanism for avoiding the need for constant applications for new Determinations justifies its continuation. I expect it to have the same fruitful future existence as has justified its inclusion in past Determinations.

In the present proceedings, the AMA sought originally a remuneration adjustment provision not referable to the basic wage but according to movements in the Consumer Price Index. The reason for the change was, as Mr. *Sperling* explained, because movements in the basic wage ceased in February 1988 and thereafter increases from a *State Wage Case* did not vary the basic wage; the indexation clause in the determination was, therefore, inoperative with the result that normal hourly rates for VMOs had not been increased since February 1988. During the proceedings, the AMA amended its claim to enable annual adjustments to normal hourly rates in accordance with movements in the index for full-time adult average weekly ordinary time earnings kept by the Australian Statistician. Later still in the proceedings, but without actually amending its claim, the AMA suggested normal hourly rates might more appropriately be adjusted by the index kept by the Australian Statistician for movements in professional award rates. In either case, however, rates were not to be reduced.

The Minister opposed the AMA's indexation provision. The circumstances as they have developed with *State Wage Cases* in the adjustment of rates, and specifically the basic wage, make it inappropriate, in my view, to fix rates for VMOs by reference and in relation to the basic wage. In any event, the interpretation applied by the Court of Appeal in *Hyslop (No.2)* as to the true meaning of the present indexation clause justifies a clause so framed not continuing in the new determination as being industrially inequitable for the reasons earlier given. The possibility of such a consequence, nevertheless, makes one hesitate to include any indexation provision at all because of concern it

may operate in terms contrary to the arbitrator's intent. But there is a more general reason, in the opinion I have formed, against including any indexation provision in a determination; that is that rates for VMOs would be adjusted in the future automatically according to some formula over which the arbitrator had no control and for reasons which may or may not relevantly apply to VMOs. I think it must be apparent the terms and conditions under which VMOs provide services to public hospitals are complex and have their own distinctive features. In that situation, I think an indexation provision to be wholly unsuitable. I would decline it for that reason.

It should also be remarked that the use of the CPI and AWE movements for the purpose of wage and salary adjustments, and I would add rates for independent contractors, and without consideration of other material as to economic consequences, reasons for the increase, sectional movements and so on, is burdened with debatable problems. Future adjustments of rates of remuneration for VMOs should, in my firm view, be made on consideration of all relevant material in proceedings during which the parties have the opportunity to be heard. That does not necessitate proceedings as lengthy perhaps as the present arbitration, and circumstances would dictate the nature and extent of such proceedings.

By reason of the principles of wage fixation, to which I am required to have regard, an indexation provision of the type sought by the AMA here is, in my view, contrary to those principles which require "improvements in pay and conditions (to) be processed in accordance with (those) principles". The wage adjustments principle is based upon the concept of structural efficiency and with no reference to CPI or AWE movements. Not only would acceptance of the AMA's indexation claim be inconsistent with the principles, it would take into account matters to which the principles have no regard.

Comparison with staff specialists

The AMA relied, as it did in 1985, on comparisons with the total remuneration for staff specialists, and in particular the private practice arrangements available to staff specialists and the additional earnings therefrom; conference and travel benefits available to staff specialists were referred to also. Exercises two and three conducted by the AMA in calculating new rates for VMOs were based upon the comparison with staff specialists, but as exercise two was premised on the correctness of the 1985 assessment of VMOs' rates I do not propose to deal with it. I will concentrate on exercise three.

The AMA's approach was to make the comparison between the VMO senior specialist and the senior staff specialist, and then to apply proportionate increases to the hourly rates for the other VMO classifications so as to maintain relativities. For ease of understanding I reproduce as Appendix "P" hereto the AMA's exercise three.

The exercise proceeds on the basis of taking the total remuneration package for each of the Scheme A, B and C senior staff specialist and adding to it components peculiarly relevant to VMOs as independent contractors. I point out that the varying remuneration packages for the staff specialists depend upon the scheme under which they are employed, the details being set out in Appendix "K" hereto, and concern the extent to which they are or are not engaged in private practice. The mathematics of the exercise were not put in issue, but Mr. *Kenzie*, in denying the aptness of the comparison, took issue with the inclusion in the staff specialists' remuneration package of the various allowances and benefits as being irrelevant for VMOs. I do not see the need to rule on those submissions in view of the approach I take to the AMA's exercise.

Even assuming the validity of comparing VMOs with staff specialists, the exercise does not make out the AMA's case that present

VMOs' rates are comparatively lower than those for staff specialists. In saying that, I emphasise, as earlier indicated, that the AMA did not offer the exercise as a mathematical comparison nor on a point-to-point comparative basis, but rather as a guide in the fixation of VMOs' rates and to indicate that the increases otherwise claimed on work value and other grounds were reasonable. I turn to consider the exercise itself.

Accepting the amounts stated as total remuneration for a senior staff specialist, the additional components require adjustment in view of other facts and the decisions I have taken already. Firstly, the calculation of an hourly rate for a senior staff specialist has been based on a thirty-eight hour week whereas as Mr. *Rogers* noted in the 1976 arbitration staff specialists, like VMOs, work an average week of fifty-five hours; that fact would seem to be still correct by reference to the evidence in this case from Ms. Wang and the August 1991 Department of Health's publication entitled "Profile of the Medical Workforce in NSW, 1990". Second, I have excluded for VMOs separate consideration for associated time. Third, a part-time loading for VMOs has been excluded. Fourth, the 49.3 percent loading has been reduced to 36.83 percent. Making those adjustments to exercise three, the resultant hourly rates for a VMO senior specialist compared to a Scheme A, B and C senior staff specialist are respectively $58.54, $76.56 and $88.76. Even if one were to accept the basis of a thirty-eight hour week, and clearly on the evidence that would be at the extreme, the resultant hourly rates for a VMO senior specialist would be respectively $84.72, $110.80 and $128.46. The current hourly rate for a VMO senior specialist of $110.50, therefore, more than favourably compares.

Scheme D for staff specialists was not relied upon by Mr. *Sperling*, but Mr. *Kenzie* submitted if a comparison were to be made with staff specialists then Scheme D was the most comparable with a VMO. Under

Scheme D, the details of which are set out in Appendix "K", the staff specialist is engaged on half-time employment and the balance of the time is to enable his engagement in private practice for which he retains any fees obtained. The period of employment, then, is really on a part-time basis for which 50 percent of salary is paid plus 50 percent of the 17.4 percent special allowance for on-call and re-call; leave is allowed at half-time rates. Set out at Appendix "Q" is a summary of the conditions applicable to Scheme D staff specialists, including present salary rates. It will be seen that the Scheme D senior staff specialist is paid an amount of $71.41 per hour on the basis of working half-time, that is nineteen hours per week. I agree with Mr. *Kenzie* that a Scheme D staff specialist is more akin to a VMO than are the Scheme A, B and C staff specialists who variously work full-time or three-quarter time and with varying arrangements for private practice or payment in lieu thereof.

The similarity of work performed by VMOs and staff specialists makes inevitable a comparison between the two groups. Indeed, I point out that the work value changes principle in par.(e) expressly enables comparisons to be made with wage increases for changed work requirements in the same classification in other awards provided the same changes have occurred. In the foundational arbitration conducted by Mr. *Rogers* in 1976, comparisons with staff specialists were made and it is plain he took those matters into account in reaching a final view as to VMOs. In the subsequent arbitrations before *Macken* J., the position as to staff specialists was again a relevant factor. I propose here to similarly treat the comparison with staff specialists' salaries insofar as the VMO specialist classifications are concerned; as to the VMO general practitioner classifications, I have had in mind existing relativities in the present determination as maintained since 1976, and also, in broad terms,

award rates for resident and career medical officers as set out in Appendix "J" to these reasons.

Comparison with fee-for-service VMOs

In the 1985 proceedings, the AMA relied to a considerable extent on a comparison between remuneration for VMOs under sessional contracts and those remunerated on a fee-for-service basis. *Macken* J. in his 1985 reasons (at p.8) observed:

> Not only did the introduction of modified "fee-for-service" contracts into the non-teaching hospitals formerly regulated by sessional payments provide a stark contrast with the rates paid per session to V.M.O.'s in the teaching hospitals, but there had also been important changes made in the private practice arrangements conceded to staff specialists (award employees) in the teaching hospitals pursuant to which their position relative to the V.M.O.'s in the same hospitals was greatly enhanced. These two contrasts provided the means by which the A.M.A. quantified its claim for a substantial increase in the sessional rates paid to V.M.O.'s in the teaching hospitals.
>
> The A.M.A. made clear that the claim for higher sessional rates to be applicable to V.M.O.'s in teaching hospitals does not have its origin in "comparative wage justice" relationships with staff specialists, or those V.M.O.'s working pursuant to modified "fee-for-service" arrangements. The A.M.A. argued that the introduction of the modified "fee-for-service" arrangements, the additional payments made to staff specialists, and the claim for higher rates for V.M.O.'s in the teaching hospitals, all originate from persisting structural change taking place in the field of medicine and medical economics.

His Honour commented further (at pp.14,15) as follows:

> The very offer of the governments of an interim increase of $12.50 per hour and the re-introduction of modified "fee-for-service" contracts at non-teaching hospitals, together with the post-Penington changes made to staff specialists' salaries, is sufficient indication that, on this occasion, hourly rates for V.M.O.'s have to be fixed in money terms, ignoring elements of professional status, hospital admissions and the like.

The AMA here made no comparison with fee-for-service VMOs, but the Minister did. Three VMOs who gave evidence in the present proceedings, namely Dr. Jensen, Dr. Stening and Dr. Beattie, gave evidence also in the 1985 proceedings and Mr. *Kenzie* tendered tables

working the comparative exercise conducted in 1985 using current sessional rates and fee-for-service fees. Each of the three witnesses concerned are senior specialists so that the current sessional rate for them is $135.50, made up of an hourly rate of $110.50 plus $25.00 for background practice costs, being the relevant comparative figure with a fee-for-service contract. The exercise disclosed that if the three VMOs worked under a fee-for-service contract instead of a sessional contract they would receive respective hourly rates averaging out at $126.00, $139.74 and $136.68. The conclusion must be, it seems to me, that a comparison with fee-for-service VMOs does not enable one to draw the same conclusion now which *Macken* J. was able to draw in 1985, that is, "fee-for-service contracts ... provide a stark contrast with the rates paid per session to V.M.O.s." I find that this comparison does not support the AMA's claim for an increase in present sessional rates.

Comparison with other professions

The AMA's fourth exercise relied on other hourly rates for various professional groups on the basis, as Mr. *Sperling* put it, that "the 'smell' test tells us ... that if solicitors, counsel and accountants are earning $250 or thereabouts an hour, $135 an hour for a visiting medical officer just cannot be right." Mr. *Kenzie* submitted the exercise was of no assistance because -

- no attempt to liken or relate the work and conditions under which it was performed to that of VMOs;
- the rates were those fixed by the professionals themselves in the marketplace;
- the *Public Hospitals Act* lays down a regime whereby rates for VMOs are to be determined by independent arbitration;
- the mere existence of the rates said nothing about their reasonableness or legitimacy;

. the rates, in any event, were applicable to professionals engaged on a casual rather than on a regular part-time basis.

I think those points by Mr. *Kenzie* are well taken. I would add that the AMA's exercise is contrary to par.(e) of the work value changes principle which limits comparisons with other rates to those for "the same classification in other awards provided the same changes have occurred" - to me, that supports the points made by Mr. *Kenzie*. I therefore do not take account of those other professional rates.

Proper approach to assessment

On the one hand, the AMA's claim seeks a significant increase in remuneration rates, and, on the other hand, the Minister's claim seeks a significant reduction. In the context of the principles of wage fixation is evident the thrust to contain labour costs. Thus, the principles are directed to ensuring by a structured system how and to what extent wages and employment conditions may be improved; there is nothing in the principles limiting movements the other way. For instance, the opening paragraph to the principles states that they "have been developed with the aim of providing ... a clear framework under which all concerned ... can co-operate to ensure that labour costs are monitored ..."; the commitment principle requires "(a)ny claims for improvements in pay and conditions (to) be processed in accordance with these principles"; the structural efficiency principle refers to "increases in wages or salaries"; and the wage adjustments principle provides a maximum increase, with a claim for increases in excess to be processed as a special case. The *National Wage Case August 1989* ([1989] 30 I.R. 81 at 98) provided that cases for increases beyond the maximum were to be processed as special cases and provided further that there is negligible cost or approval demonstrated on public interest grounds. The question, of course, is whether the principles contemplate reductions in terms and conditions of employment insofar as

employees are concerned, and, if so, what approach should be adopted in deciding such a claim. In the *National Wage Case June 1986* ([1986] 14 I.R. 187 at 212) the Australian Conciliation and Arbitration Commission on this aspect said:

> As to the suggestion that current standards should not be reduced, we do not believe that we should prevent employers from applying to change existing provisions, although we emphasise that a strong case would need to be established before existing award provisions would be reduced whether those provisions were introduced by consent or by arbitration.

In an earlier case, *Re Automotive Services (Northern Territory) Consolidated Award & Other Awards* ((1984) 293 C.A.R. 86; [1984] 13 I.R. 63), a Full Bench of the Australian Commission considered applications by employers to vary fourteen awards to delete the district allowance provision in the Northern Territory. In terms of approach, the Full Bench said (*ibid* at 110; 84,85):

> We have given particular attention to the Union argument that implicit in the Principles is a restriction on reductions in wages or conditions of employment to balance, as it were, the explicit restrictions on enhancement. While accepting the general thrust of the unions' submission, it does not mean that such claims are excluded from consideration by a Full Bench. Clearly the onus is on the employer applicant and a strong case would need to be made out. In our view, that test has been satisfied in these proceedings.
>
> On the basis of the conclusions we have reached, it could be argued that we should simply abolish or phase out the current allowances. In all the circumstances we consider the first course would be too drastic. The second course would prolong the implementation of our decision over many years bringing a degree of uncertainty and instability to wage determination in the Northern Territory. We are therefore not prepared to take either of these courses. We have decided that the proper course in the circumstances is to retain the district allowances at their existing levels but without further adjustments by indexation or otherwise. In this way the allowances will lose their significance over time.

It would seem, therefore, the test for a reduction in wages or conditions as applied by the Australian Commission is that the onus is on the employer to make out a "strong case". Even then, it would seem that the nature of the remedy requires consideration in terms of the degree of

its impact and in accordance with the circumstances: cf. *Re Darwin Institute of Technology (Salaried Staff) Award 1986* (Print H1716 of 31 March 1988).

In considering the basis of approach, I said I proposed to make such determination as was proper in accordance with all relevant circumstances; as to previous determinations, I said I did not propose to disregard them but would take them into account to the extent thought relevant and as a guide or aid in arriving at a proper determination as a just and reasonable settlement of the present claims: see *Government Railways and Tramways* (*supra*) and *Gas Meter Makers* (*supra*). I repeat the observation of the Industrial Commission in Court Session in the *Bonus Payments Case (No.2)* (*supra* at 776) - "The fact that one judge in 1968 deemed certain rates to be just and reasonable to award did not make those rates just and reasonable for the term of his award or any other period of time in the sense that it would not be open either to the same judge or another judge, when asked to exercise his powers under the Act, to deem other and different rates to be just and reasonable." Within that concept, it seems to me well open to require the moving party for a reduction in benefits to make out a strong case as that is simply the onus required in arriving at a just and reasonable settlement of the claims in accordance with all relevant circumstances. I propose to approach the present claims in that way.

I might immediately deal with material relied upon by Mr. *Kenzie* as to remuneration paid to VMOs in other States. He recognised, of course, that VMOs elsewhere than in NSW were part-time employees and not independent contractors, but nevertheless the submission was made that relevant assistance could be gained in a broad sense in terms of the value placed on the work. Strictly speaking, the approach is within the work value changes principle in par.(e), although the difficulty, it seems to

me, is in considering such an exercise in the absence of full knowledge as to the basis used and factors taken into account which may be peculiar to a particular State; so too, there is the difficulty in balancing one term and condition as against another and translating that to a particular aspect in the NSW context. I think matters of principle decided by tribunals in other States to be most helpful, but I remain cautious in relying too much on other standards, certainly on a point-to-point comparison. Nevertheless it may be helpful, and as a convenient reference, to include the material in this respect tendered by Mr. *Kenzie* and which I do as Appendix "R" to these reasons. I extract therefrom the total hourly rates (base rate, loading and background practice costs) for a senior specialist as follows -

State	**Total Hourly Rate**
	$
Victoria	51.00
Queensland	79.18
South Australia	95.65
Western Australia	80.14
Tasmania	90.00
Average rate:	79.19

Although I have found a proper starting point to assess new base rates for VMOs to be 14 December 1983, the interim increase of $12.50 per hour offered and accepted in April 1985, and effective on and from 1 July 1984, pending an arbitration into the level of sessional rates has caused me some concern. The interim increase was a material fact in the resolution of the doctors' dispute, and, importantly, it was part of an agreement between the parties. It was too the basis upon which *Macken* J. built the increases which resulted from the 1985 arbitration, bearing in mind, of course, my conclusion that the result of that arbitration was

attendant with such difficulties as to make it unsafe on which to base a new determination. Indeed, his Honour granted a final increase by escalating the $12.50 per hour to amounts ranging from $17.00 to $30.00 per hour according to classification to which was added the 49.3 percent loading. Given, as I have found, that that approach was wrong, it seems to me the $12.50 amount still remains for consideration in a new determination because it was an agreed increase. The question is whether that is sufficient, rightly or wrongly on the merits, for it to be continued. I think it is. There was no question in the proceedings that the interim increase was anything other than a genuine offer to resolve a most difficult dispute with public interest implications so that an arbitration could be conducted in a proper and orderly way. I emphasise the offer was accepted, and, for their part, VMOs returned to the public hospital system and the AMA proceeded with the arbitration. Even if one may have reservations about the strict merits of the interim increase, as indeed I have, I think it is too late now after nearly eight years to remove it. The agreement must be honoured. Therefore, in making the new determination I propose to include as an element in the base rate an amount representing the interim increase of $12.50 per hour escalated by increases from *State Wage Cases* since April 1985 giving an amount of $15.87 per hour; that new amount should, as for the base rates generally, be adjusted by the special case increase on structural efficiency and work value grounds.

It will be apparent from my conclusions throughout these reasons that I find a case has not been made out by the AMA for any increase in sessional rates for VMOs. That finding essentially arises by reason of the inordinate increases in the normal hourly rates granted in 1985 ($44.00 per hour for a senior specialist), the effect of the decision in *Hyslop (No.2)* ($14.50 per hour for a senior specialist), the economic consequences in the

current climate, and comparisons with rates for staff specialists, fee-for-service VMOs, and VMOs in other States. I interpose for completeness to note the increase in 1985 of the background practice costs allowance of $21.50 per hour for specialists - thus, with the increase in the normal hourly rate, a senior specialist as a direct result of the 1985 arbitration received an increase of $80.00 per hour. One then must consider whether the Minister has made out a strong case for base rates to be reduced, and, if so, to what extent.

A matter of concern, however, must be the apparent failure by the Minister to seek a new determination for a period of in excess of five years after the 1985 determination was made to obtain relief against the alleged errors in that determination. Mr. Clout addressed that question in his evidence and said:

> It may be suggested by the AMA that this matter and others over which then was disagreement as to the correct interpretation of the 1985 Determination could/should have been resolved by the Department seeking an interpretation from Justice Macken as to what his intention was or, in the alternative seeking a further Arbitration. Further it may be suggested that the period between the 1985 Determination and this current Arbitration suggests that the concerns now experienced by the Department have a recent origin.
>
> On the first point, I am aware that the legal advice tendered to the Department indicated that once the Arbitrators Determination had been handed down, the Arbitrator had no further power to act and specifically had no power to hear and rule on an interpretation of the Determination.
>
> On the second point, a further Arbitration could have been sought at any time beyond six months after Justice Macken's Determination. I am aware that this was seriously considered by the Department and then the Minister. The view was taken in the 1986-87 period that given the massive disruption to hospital services that had occurred in 1984-85, it was necessary for service delivery to be enabled to get back to normal and, a request for a further Arbitration would have been viewed as provocative and, possibly prevent such return to normal. The occurrence and proximity to Federal and State elections was also a factor. In the period from mid 1987 through to the change of Government in March 1988, there was much consideration given to seeking a further Arbitration, specifically to address the concerns with the

existing Arbitration and, as an alternative to running cases before the Equity Division of the Supreme Court.

I made several such recommendations during this period which I know where considered by the then Secretary of the Department and the Ministers of that time. The decision was taken not to seek any Arbitration. I suspect that the upcoming State election at that time was not an insignificant factor in such decision. The same recommendations in respect of seeking a further Arbitration, were made by myself and other officers within the Department soon after the election of the new Government in mid 1988. At this time however the matters had commenced before the Supreme Court and the post election priority of the Government was negotiating the return of the orthopaedic surgeons and, establishing and consolidating relations between the Minister/Department and the AMA/Medical profession. By the time these two matters had been completed the Public Accounts Committee Inquiry had commenced.

Dr. Jensen was cross-examined as follows:

Q. Will you agree that in relation to the negotiations that took place after the announcement of the PAC Inquiry, at least until some period before November 1990, when negotiations were going forward in good faith, it is readily understandable why neither side was going off to have the whole determination arbitrated then?

A. Yes.

Should this aspect preclude, as the AMA urged, the Minister seeking now a reduction in rates? I have deliberated on this question, and, on balance, I think not. The evidence provides an understandable explanation in the circumstances, and one which was really accepted by Dr. Jensen. The evidence also, as recited earlier herein, established a series of discussions and correspondence between the parties as to specific problems with the 1985 determination from January 1986 through to March 1989 and it was on 13 November 1990 the AMA applied for the appointment of an arbitrator when negotiations failed to resolve the issues. Therefore, I do not see delay as being a bar to the Minister's claim for reduced rates being successful.

I have no doubt, for reasons earlier stated, that the Minister has satisfied the test and there is no circumstance which would sufficiently require present rates to be continued. According to the views I have formed, it would be inequitable to continue rates at their present levels

without appropriate reductions having in mind the quantum of increases granted in 1985 and the further increases as a result of *Hyslop (No.2)*. I consider existing rates for VMOs are unduly excessive for no sufficient reason and have been so for in excess of seven years. The assessment now of fair and reasonable rates in all the circumstances requires rates be reduced accordingly. Not to do so, in my view, would be to perpetuate an anomaly and an unwarranted imposition on the scarce resources of the public hospital system.

I was troubled in settling on final rates by the question of at what point the rates should be current and for how long. I raised this difficulty with the parties and the AMA took the position, if its indexation claim failed, that rates should be fair and reasonable for a period of twelve months. The Minister submitted that rates could be fixed having in mind they would operate for a future period. I think the parties' approach is correct, and it is consistent with the long-standing approach of the Industrial Commission in fixing rates intended to be relevant for a reasonable period into the future: see *In re Crown Employees (Legal Officers - Crown Solicitor's Office, &c.) Award* ([1972] A.R. (N.S.W.) 376 at 402) and *In re Crown Employees (Teachers) Award* ([1964] A.R. (N.S.W.) 463 at 482,483). I see no utility in fixing rates one day which will be out-of-date the following day. Therefore, the rates I propose to fix will be current and up-to-date rates as at the commencement of the new determination and for a duration thereafter of at least two years. That is not to say no party should move in the meantime for a new determination as to rates of remuneration. The *Public Hospitals Act* enables a new determination to be sought at any time. I think it to be important, however, that the basis on which rates are fixed is known, and, of course, it would always be open for good and cogent reasons for parties to seek an adjustment during the period of "currency" of new rates.

For the foregoing reasons, the factors taken into account by me in assessing base rates for VMOs are -

- Base rates as at 14 December 1983.
- *State Wage Case* increases up to and including May 1991.
- Structural efficiency, work value changes and special case considerations.
- Interim increase on 1 July 1984 adjusted by *State Wage Case* increases and as a special case.
- Comparison with staff specialists' rates.
- Comparison with fee-for-service VMOs' rates.
- Comparison with VMOs' salaries in other States.
- Previous fixations of rates, including rationale therefor.
- Level of current rates, reasons therefor and period in operation.
- Current context of the public hospital system, including economic consequences.
- Reasonable period for which new rates will be relevant pending review.

Findings

I find new base hourly rates for VMOs should be as follows -

Classification	**Base Hourly Rate**
	$
General practitioner - less than 5 years	46.00
5 to less than 10 years	50.25
10 years or FRACGP	59.25
Specialist	67.00
Senior specialist	72.00

Applying the 36.83 percent loading (being 26.83 percent for leave, 5 percent for extended sessions and 5 percent for split sessions), new ordinary hourly rates for VMOs should be -

Classification	Ordinary Hourly Rate $
General practitioner - less than 5 years	63.00
5 to less than 10 years	68.75
10 years or FRACGP	81.00
Specialist	91.75
Senior specialist	98.50

The determination will provide accordingly.

CHAPTER 10 - BACKGROUND PRACTICE COSTS

A material element in the conduct of a medical practice is the cost incurred in terms of expenses. For instance, in the 1985 Medical Fees Enquiry for Medicare Benefit Purposes the medical fees index used for adjusting the schedule fee allowed total practice costs (salaries, wages, motor vehicle and other practice costs) as a percentage of gross income of 60.02 percent for general practitioners, 53.73 percent for physicians, 52.77 percent for surgeons and 43.09 percent for anaesthetists. Where a VMO renders services under a sessional contract a component, known as background practice costs, has been included by way of an allowance to compensate for expenses incurred. The issue of background practice costs was of major importance in the proceedings insofar as both the principles to apply in its assessment and the quantification of an allowance.

Earlier assessments

In considering previous determinations I traced the history of the allowance for background practice costs and the basis on which it had been assessed. In 1976, Mr. *Rogers* found he was unable on the evidence to make any recommendation as to a specific allowance but had the matter in mind in fixing the sessional rates. The problem confronting Mr. *Rogers* was, as he said (Pt.5 at p.4) - "The patient mix between private and hospital patient varies tremendously. The extent to which a practitioner may utilise his facilities for the purpose of hospital patients also varies greatly. ...the total amount of the practice costs has been covered in calculating the fees to be paid by private patients." The problem so identified by Mr. *Rogers* was not that he did not have material before him as to the practice costs incurred by VMOs as the AMA conducted a survey of general practitioners and specialists in city and country areas to establish a financial profile of a fair average practice. The "complicated question" seen by Mr. *Rogers* was in ascribing those costs to hospital

patients. In other words, it seems to me, the approach was taken that in order to fix an allowance to compensate for a VMO's background practice costs it was to be referable to the costs incurred in respect of hospital patients and not merely as a proportion of total practice costs.

The first determination made by *Macken* J. in 1978 attended to the assessment of practice costs and his Honour allowed additions to the base hourly rate of $2.00 for specialists and $1.50 for general practitioners. Those amounts were repeated in the 1980 determination. The 1981 determination included a practice costs loading in the base hourly rates of $2.50 for specialists and $1.90 for general practitioners. The 1982 and 1983 determinations continued the approach of including a loading for practice costs in the rolled-up rate, adjusted by *State Wage Case* increases. It was as a result of the 1985 determination that the allowance was removed from the rolled-up rate and included as a separate amount with substantial increases of 616 percent for a specialist and 655 percent for a general practitioner, in new amounts of respectively $25.00 and $20.00 per hour. I have earlier in these reasons in dealing with the 1985 determination examined in some detail the question of background practice costs. I made the finding, which I confirm, that the increases granted were unsupported by any statement of the principle on which they were assessed, and indeed ran counter to the approach adopted in previous determinations. The increases determined were inordinately high.

For convenience, I set out below the movement in the background practice costs allowance in previous determinations -

Determination	General Practitioner	Specialist
	$	$
1978	1.50	2.00
1980	1.50	2.00
1981	1.90	2.50
1982	2.17	2.85
1983	2.40	3.15
1985	20.00	25.00

After referring to a survey of practice costs conducted on behalf of the AMA by a leading firm of accountants, *Macken* J. in the 1985 reasons (at pp.23,24) quantified the new allowance as follows:

> A leading firm of accountants was asked to survey private practice cots for purposes of the Determination and calculated the hourly rate at maxima of $32.14 per hour for General Practitioners and $39.29 per hour for Specialists; the minimum respective levels being $28.57 and $32.14 per hour. Although this falls far short of the V.M.O.'s own estimate of the private practice costs incurred during sessions in public hospitals it provides a convulsive jump in this cost from the current loadings.
>
> As such a loading cannot be quantified with great precision and because, in any event, it involves a high degree of averaging between the specialties, I prefer the accountants' conservative approach to assessing this loading. For these reasons I propose to fix a loading in the sum of $20.00 per hour for General Practitioners and $25.00 per hour for Specialists on account of background practice costs. This sum will be paid in addition to those sums calculated under the title of Remuneration.
>
> While expressed as a separate payment in this Determination I expect that in practice a rolled-up sum will continue to be paid to V.M.O.'s and that it will be calculated to include the private practice loading.

Allowances principle

The cases put by the parties each recognised the allowance for background practice costs was a reimbursement of expenses actually incurred by a VMO. Putting aside for the moment the matter of principle as to which expenses are appropriate to include in terms of the rendering of services to public patients, the issue falls for consideration in

accordance with the allowances principle laid down in the *State Wage Case*, as follows:

> 1.Existing allowances
>
> (a) Existing allowances which constitute a reimbursement of expenses incurred may be adjusted from time to time where appropriate to reflect the relevant change in the level of such expenses.
>
> ...

Although the AMA sought a significant increase in the allowance, the Minister sought a significant reduction. Therefore, apart from the allowances principle, attention will have to be given to the proper approach where a reduction in rates is sought, that is whether a "strong case" has been made out.

AMA's claim

New allowances for background practice costs were claimed by the AMA in the amount of $66.66 per hour for specialists and $50.00 per hour for general practitioners, being increases of respectively 166.6 percent and 150 percent. Annual adjustment of the allowances was sought according to movements in the Consumer Price Index, provided that in no case were the allowances to be reduced. The claim required the allowance to be payable during each hour a VMO provided services under a sessional contract, including during call-backs and on public holidays.

Minister's claim

A re-expression of the background practice costs allowance was sought by the Minister on the basis of survey results of actual expenses incurred according to a VMO's area of practice or specialty. The revised amounts of allowance claimed were $10.28 per hour for a surgeon and $5.73 per hour for an anaesthetist, a physician and a general practitioner.

No indexation provision was claimed for adjustment of the allowance so that any variation would have to await a further determination.

Parties' approach to assessment

A fundamentally different approach was adopted by the parties to the task of assessing an appropriate allowance for background practice costs. On the one hand, the AMA proceeded on the basis that the allowance should be assessed according to the total costs incurred by a VMO in his practice as a medical practitioner, for both private and public patients, with the hourly allowance in the determination for public patients being a proportion of the total costs incurred. Put another way, a VMO's practice should be regarded as a single entity so that practice costs were recovered equally from all patients. On the other hand, the Minister, whilst accepting the objective of the allowance as being the reimbursement of actual costs incurred, followed what was called the "attributable costs approach", that is the reimbursement of the additional costs incurred by VMOs as a result of their performance of sessional work in the public hospital system; it was submitted for the Minister that such an approach was commercially realistic and consistent with the approach adopted in other States. The Minister conceded *Macken* J. in 1985 followed a different course, thus giving rise to the very significant increases at that time, but that such an approach was wrong as being unfair and involving an unwarranted and fundamental departure from the established principle in assessing the allowance as part of VMOs' sessional remuneration.

AMA survey: The AMA supported its claim with a survey conducted by Duesburys, Chartered Accountants, under the supervision of one of its partners, Mr. R. M. Borthwick. The methodology adopted was that Duesburys designed a draft survey form which was settled by solicitors and counsel for the AMA and reviewed for statistical integrity by William

M. Mercer Campbell Cook & Knight Pty. Limited, Consulting Actuaries. The survey form was admitted into evidence and related to the year ended 30 June 1990; it comprised a series of questions covering the nature of the practice (either sole practice, partnership, practice company, associateship or other), salaries and wages costs incurred (payments to the VMO as principal, related persons such as spouse or other family member, another proprietor or an associate), average weekly hours worked, superannuation contributions (in respect of the VMO, partners, associates or co-shareholders, spouses or other related parties and unrelated staff), motor vehicle expenses (make, model and year of vehicle's manufacture), approximate market value of leased assets (motor vehicles, medical equipment, office equipment, furniture and furnishings, fixtures and fittings, and other), costs of premises (market value and whether owned or leased), financial documents of practice overheads (balance sheet, profit and loss account, and income tax return for the VMO, partnership, associateship, practice companies and service entities, as appropriate) and other practice assets and liabilities not otherwise disclosed. Whatever else may be said of the survey, it is apparent to me the survey form itself was most comprehensive and covered all financial aspects of a VMO's practice.

The survey was conducted over the period May-August 1991 when Duesburys forwarded the survey questionnaire to a population of 583 VMOs provided by William M. Mercer Campbell Cook & Knight and from which usable responses were received from 113 VMOs comprising 25 general practitioners, 28 physicians, 23 surgeons and 37 anaesthetists. Criteria for selecting usable responses was strictly applied and an analysis of the responses was carried out by Duesburys. In collating the returns, Duesburys reduced, on instructions from the AMA's solicitors, the total costs by about 8 percent in respect of certain specified

matters, the legitimacy of which was thought to be open to question, such as bad debts, collection expenses, conferences, drugs and dressings, laundry and dry cleaning, magazines and journals, medical supplies, professional development, subscription to AMA, surgery supplies, surgical assistance, tapes and cassettes, theatre fees, uniforms and work clothes. Certain other adjustments were made to the motor vehicle expenses and occupancy costs for premises to ensure reasonable business use and proper market levels. Mr. Bruce Vincent, a principal with William M. Mercer Campbell Cook & Knight, reviewed the statistical integrity of the survey conducted by Duesburys. He confirmed the survey population had been selected at random, and, after analysing the results, expressed the conclusion that "(t)he survey of background practice costs of VMOs conducted by Duesburys (gave) reasonable estimates of the average background practice costs of VMOs."

During the proceedings, Duesburys indexed the results using the Consumer Price Index to make them current as at 30 June 1992. After statistically weighting the results, Duesburys reported annual background practice costs as at 30 June 1992 as follows -

Classification	**Annual Practice Costs as at 30 June 1992**
	$
General practitioner	83,712
Specialist	112,795

The AMA allowed, on the evidence, a working year for a VMO of forty-seven weeks and total hours for which a fee was rendered, for both private and public patients, of thirty-six hours per week, giving total annual chargeable hours of 1,692. The respective annual practice costs for general practitioners and specialists were then calculated on an hourly

basis giving $49.47 per hour and $66.66 per hour respectively - the quantum of the AMA's claim.

It only remains, in reviewing the AMA's approach, to refer to the evidence given by Mr. Borthwick as to the proper principle to apply in determining the allowance payable to a VMO for his public hospital work to compensate for practice costs. Mr. Borthwick relevantly said:

> The fundamental consideration in this regard is what should be done as a matter of fairness.
>
> Commercial practice may be a relevant consideration. In practice a provider of goods or services will set a price for those goods or services which will recoup:
>
> 1. Firstly, all overheads incurred.
> 2. Secondly, a fair reward (notional salary) for his personal effort having in mind his time occupied and his particular skills and experience.
> 3. Thirdly, a fair return on the capital employed in his business.
> 4. And finally an additional return to allow for the risks and personal liability attaching to his business.
>
> ...
>
> If a professional were to charge one group of clients at a lower rate than another he would need to charge the other group a proportionally higher rate or suffer a personal loss of income. There has therefore to be a reason for differential pricing of services by modifying pro rata recoupment of expenses or otherwise.
>
> There are circumstances where a professional may consider that a different to normal charge rate is appropriate.
>
> ...
>
> In considering a fair approach to sessional remuneration it is also relevant to consider the interrelationship and interdependence of the sessional and non-sessional segments of a typical VMO's practice. It is our understanding that in most cases the two segments will have developed together and that neither would have happened without the other. A doctor would not take a VMO appointment unless he was also going to be in private practice and most doctors who intend to undertake hospital practice would not set up in private practice without contemplating a public hospital appointment as well.
>
> A hospital engages a sessional VMO knowing he is in private practice and will be giving only a proportion of his time to the

> hospital under the sessional contract. Inevitably, the expenses associated with the VMO's practice (eg. rent, staff, depreciation of equipment etc.) will continue to run whether he is engaged in sessional work or private patient work. The hospital like any other purchaser of services should expect to be charged a fee that includes a proportion of such expenses. One would not expect a doctor to charge less for house calls on the ground that his rooms (including rent and staff) were not utilised for a house call or were not utilised to anything like the same extent as for work in his rooms.
>
> In light of the above commentary regarding:
>
> - the practice of setting prices for goods and services in a commercial context
>
> - the interdependence of the establishment and development of a typical VMO's sessional and non-sessional work.
>
> we are of the opinion that it is fair that VMO's remuneration for sessional contract work should include a proportion of all of those practice overheads which continue to run whilst the VMO is doing sessional contract work, and that the proportion should relate to the time spent on sessional work relative to chargeable time in the VMO's practice as a whole.
>
> ...
>
> Even if the sessional work were an optional add-on, that would not be a reason against spreading fixed or common costs over the full range of services provided. But, for the reasons given earlier, we do not believe that the sessional work can fairly be treated as an optional add-on. There is only one "product", namely medical services, and the sessional and non-sessional segments of that activity are inter-related.

It will be seen that Mr. Borthwick's approach was to regard a VMO's public hospital practice as part of his total practice as a medical practitioner and for which the private and public segments were so inter-related as to justify the recoupment of practice costs from the private and public sectors on an equivalent basis according to the time spent.

In defending the approach taken by *Macken* J. in 1985, particularly as to the quantum of increases awarded, Mr. *Sperling* submitted the evidence of practice costs was based on 1976 data, according to a survey conducted by Dr. Guyot, the then Treasurer of the AMA, which was indexed for inflation but no account was taken of changes in VMOs'expenditure profiles over that ten-year period; it was submitted also that Dr. Guyot's analysis of the data was ultra-conservative. In

addition, Mr. *Sperling* relied upon the evidence given by the various VMO witnesses in order to corroborate the survey material as to the practice costs incurred and the hours spent by them in practice.

Minister's review and alternatives: Mr. *Kenzie* for the Minister challenged the assessment of the allowance for background practice costs made by *Macken* J. in 1985 as being based on seriously flawed survey data and in the absence of proper principle in approaching the issue, which, in any event, resulted in excessive and anomalous allowances by comparison with previous determinations and fixations in all other States. Senior counsel submitted that, notwithstanding the apparent anomalies discernible in the 1985 determination with respect to background practice costs, it was clear his Honour rejected the maximum costs approach and the accountants' survey figures in favour of lower rates so that the AMA's present approach has never been followed in NSW or in other States where it has been proposed.

The 1985 reasons for determination were examined in some detail by Mr. *Kenzie* by comparison with the reasons for earlier determinations as to background practice costs, and the material available to his Honour from the survey then conducted was critically reviewed. In a sense, it is unnecessary to review the 1985 determination because the parties in these proceedings really approached the assessment of the background practice costs allowance *de novo*; but some reference needs to be made to that 1985 determination, and regardless of the AMA's claim, in order to decide the Minister's claim for a reduction in the amounts of the allowance. I have earlier reasoned, and found accordingly, that the 1985 determination provided inordinately high increases, not only unsupported by any statement of principle but counter to the approach adopted in previous determinations. That finding, in the view I have taken, appears from the face of the reasons for the determinations made from 1976 to 1983 as

against the 1985 reasons, and so I do not propose to refer in that respect to the additional submissions made by Mr. *Kenzie*. However, one submission made by senior counsel as to deficiencies in the data relied upon in 1985 should be considered because it concerns directly the question whether those 1985 amounts should, if the AMA's present claim for increases fails, appropriately be included in the new determination. Mr. *Kenzie* submitted the financial data presented to *Macken* J. in evidence by the AMA's accountants was seriously flawed and if appropriate corrections were made then the amounts fixed in 1985 would have been between 35 and 45 percent lower, that is, corrected allowances would have been to the order of $9.00 per hour for general practitioners and $14.00 per hour for specialists. The submission was supported by a detailed mathematical analysis which is in evidence and which I do not see the need to recite. It is sufficient for present purposes to summarise the points made by Mr. *Kenzie*, which found their way into the calculations, as follows:

- The accountants used total practice costs in assessing an appropriate allowance for VMOs, but without any adjustments, notwithstanding the accountants' doubts, that some expenses should be excluded to the extent of a reduction of 8 to 12 percent. The expenses were those for entertainment, salaries to wives, home telephone costs, professional conferences and rent.
- In addition, and although the accountants thought exclusion appropriate, as did the AMA in the present proceedings, no adjustment was in fact made for expenses such as drugs and dressings, postage, stationery and telephone, accounting, bank charges, depreciation on medical equipment, cost of servicing capital, sickness and accident insurance and magazines.

- In calculating practice costs for specialists, figures for anaesthetists were excluded because their costs were so low by comparison with other specialties. However, a lower allowance was not sought in 1985 for anaesthetists so that the resultant allowance was calculated on an expense level higher than it would have been if anaesthetists had been included.
- In calculating an hourly allowance, the accountants reduced the annual amount by a divisor of 1,400 hours which, it was submitted, was unreasonably low, being based on a forty-hour week for thirty-five weeks per annum whereas medical practitioners worked far longer chargeable hours. In the present proceedings the AMA accepted 1,700 hours per annum and there was ample evidence to suggest a more accurate figure was 2,000 hours at the very least. If the 1,400 hours were replaced by 1,700 hours then the 1985 allowances would be reduced further by 18 percent, and if 2,000 hours were used they would be reduced by 30 percent.

In the result, Mr. *Kenzie* submitted that the 1985 amounts of the allowance for background practice costs should not be used as a base for consideration of the present claims unless they were first reduced to the extent indicated. In any event, as senior counsel submitted, the allowances were unjustifiably generous.

In challenging the AMA's approach, senior counsel generally submitted the claim was based on the 1989-90 survey as indexed to 30 June 1992, being a survey calculated according to total practice costs reduced by only 8 percent; the public purse should not bear a background practice costs component directly proportionate to the share of all the significant overheads of a VMO's private practice. The AMA's claim was

based on average chargeable hours for a VMO's practice of only 1,692 whereas a more realistic figure would be 2,200 hours per annum, thus reducing the allowances by spreading the cost over a greater number of hours. The rate for specialists was unusually high because it was spread across all specialties and the weighting factor applied did not sufficiently take into account the considerably lower level of costs for anaesthetists. Importantly, senior counsel pointed out the deficiency in the AMA's position in not recognising any part of a VMO's practice costs as being recovered through the normal hourly rate, as recognised by Mr. *Rogers* in 1976 and continued in later determinations. A major qualification in the overall exercise conducted by the AMA using the survey material was to make no, or no sufficient, reduction for those costs which continued to run while a VMO performed sessional work; there was an internal inconsistency in the AMA's approach by using total practice costs and at the same time recognising a reduction of 8 percent to eliminate some of those overheads.

In offering a proper approach to the calculation of the allowance, the Minister relied on the evidence of Stephen John Teulan, a principal and partner in the firm of Deloitte Ross Tohmatsu, Chartered Accountants, who specialised in the health industry with particular emphasis on financial management and analysis. Mr. Teulan was commissioned to assess the accounting approaches which may be appropriate in considering background practice costs in the context of the services provided by VMOs to public patients and to quantify the results of applying those approaches to available data. The data used for that purpose comprised the survey used in the 1985 arbitration, the 1987 AMA survey in Tasmania, cost data from the Financial Management Research Centre at the University of New England and data provided by the Department of Health on the level of hours worked by medical

practitioners and the proportion of such hours spent rendering services to public patients. The reports prepared by Mr. Teulan and received into evidence were most comprehensive and detailed. It is not practicable therefore to recite all of the material, and so I will endeavour to identify the thrust of it.

In terms of cost accounting principles, Mr. Teulan concluded:

> There are a number of principles which should be applied, irrespective of which costing approach is adopted. These should be clearly agreed prior to consideration of the data which are subject to various calculations.
>
> The costs of a medical practice can be broken into three categories:
>
> . costs which vary directly and solely in accordance with the level of private patients served by the practitioner. These are not relevant costs for the purposes of BPC;
>
> . costs which vary directly in accordance with the level of sessional contract work. These fall within the ambit of BPC; and
>
> . costs which do not vary according to the level of patient activity. These fixed costs are a matter of some uncertainty as to their relevance for BPC purposes. We believe that a strong argument exists, based on the nature of those costs, the relatively low proportion (on average) of sessional contract work in relation to a practitioner's total workload and the significant other benefits accruing to a practitioner from appointment as a VMO, that fixed costs are not relevant to BPC.
>
> We also believe that, if fixed costs were considered to be relevant, a simple apportionment between public and private patients based on the relevant practitioner hours of service would unfairly burden the public health system. That view can be supported by contemporary cost accounting approaches.
>
> Bearing in mind the above issues, we have applied three different costing approaches:
>
> . an attributable cost approach - which recognises only those costs which vary in relation to the level of public patient activity;
>
> . a notional full-time VMO costing approach - which includes the notional fixed and variable costs of a practitioner who would work full-time on sessional contract work. This approach highlights that most of the private practice infrastructure is irrelevant for public patient work; and

- a maximum cost analysis - which includes an apportionment over the hours worked by VMO's of all costs, excluding only those costs which relate solely to the levels of private patient activity or do not add the productive capacity of the practice. This is *not* a recommended approach, but demonstrates the absolute upper limit for any consideration of BPC.

Although three costing approaches were identified, Mr. Teulan used the "notional full-time VMO costing approach" as illustrative only and so attention may be focused on the "attributable cost approach" and the "maximum cost analysis". Those two approaches represented, in the result, the difference between the AMA and the Minister in assessing appropriate allowances for background practice costs, with the AMA adopting the latter and the Minister adopting the former. In supporting the attributable cost approach, Mr. Teulan viewed the maximum cost approach as inappropriate for several reasons, namely:

- The infrastructure of private practices is designed for their predominant purpose, which is rendering services to private patients. That infrastructure is far more costly than that required for public patients, where the hospitals provide to VMO's the professional staff, equipment, laundry and secretarial support. The apportionment of costs on that basis is particularly inappropriate when practitioners spend a relatively small portion of their total working hours in sessional work, as is the case in New South Wales.

- Contemporary costing techniques, such as activity based costing, look more carefully at the relationship between those overhead costs and the different patient groups. For example, a traditional approach may allocate receptionist's costs between public and private patients based on the proportionate time spent by the doctor with each of those groups of patients. Activity-based costing recognises that the receptionist may perform the following duties:

  - telephone related
  - bookings
  - complete patient card details
  - messages for practitioner
  - billing
  - typing
  - assist the patient

With activity based costing, the receptionist's salary would be allocated amongst these major activities and then each activity's cost would be allocated between the two service products (ie public and private patients).

It is likely that, in this example, all the costs associated with bookings, card details, billing and patient servicing would relate to private patients only, while the other cost categories may be attributed to both public and private patients.

If the contemporary activity based costing approach was employed, some of the significant relatively fixed costs, such as those relating to a receptionist, would be allocated based on the relatively high level of activity performed for each private patient compared to the low level of activity performed for each public sessional patient. Therefore, those costs would be allocated to private patients in a far greater proportion that the proportionate time spent by the practitioner with those patients.

We do not believe that the approach of including fixed and variable costs of a private practice is appropriate. The allocation of certain fixed costs over a practitioner's proportionate time with each patient group further distorts the costs. However, we have compiled the cost data on that basis to demonstrate what we consider the maximum levels of costs for BPC.

Based on the data available to him, Mr. Teulan indexed it to June 1990 dollar values and determined the average number of chargeable hours per annum for each chosen area of practice in respect of attributable costs and maximum costs. As to annual chargeable hours for the purpose of calculating hourly rates, Mr. Teulan concluded a specialist would work between fifty and fifty-five hours per week for forty-seven weeks per year and a general practitioner between forty-eight and fifty-five hours per week for forty-seven weeks per year, so that the respective annual chargeable hours to use in the calculation would be 2,500 and 2,350. That material was obtained from the NSW Medical Board Survey 1990, AMA surveys conducted in 1976 and 1978, the University of New England survey in 1987, the Tasmanian AMA survey in 1986 and the Department of Health survey in 1991. In the result, the table below summarises the cost per hour for each area of practice based on attributable costs and maximum costs:

Classification	Attributable per hour	Maximum per hour
	$	$
General practitioner	8.25	25.52
Physician	9.35	27.04
Anaesthetist	5.71	14.10
Surgeon	11.35	30.19

The resultant differences by applying the two approaches in principle are obvious, with the attributable cost approach supporting substantially lower allowances for background practice costs and the maximum cost approach supporting retention of the approximate level of the present allowances, save as to anaesthetists. Of course, the maximum cost figures, which were in 1990 dollar values, emphasise the excessive levels of the allowances determined in the 1985 arbitration some five years earlier, and, in that respect, support the earlier stated criticism by Mr. *Kenzie* of the 1985 assessment by the AMA's accountants which was accepted by *Macken* J. The results too are supportive of re-expressing allowances for practice costs from the present categories of general practitioner and specialist to more accurately compensate the particular areas of practice for the relevant expenses actually incurred.

Mr. Teulan was further commissioned to review the results of the AMA's 1989-90 survey on practice costs to ensure the methodology was consistent and to determine whether other information was available from the survey material which could assist in assessing the relevance of various costs for the purpose of fixing appropriate allowances for VMOs. Again a comprehensive and detailed report was prepared by Mr. Teulan, the major conclusions of which were as follows -

. The processing of data by Duesburys was consistent and rigorous.

- Errors did not significantly compromise the data.
- The overall practice costs from the AMA's 1989-90 survey were very similar to the costs in the August 1991 report by Deloitte Ross Tohmatsu based on the other earlier surveys.
- The major problems in the conduct of the AMA's survey related to the inadequacy for assessing occupancy costs, overstated salaries, wages and superannuation costs by the impact of payments to related persons, overstatement of motor vehicle expenses by the inclusion of multiple and prestige vehicles, and higher accountancy costs as a result of complex taxation arrangement for individual VMOs.
- The statistical validity of the AMA's survey as attested to by William M. Mercer Campbell Cook & Knight Pty. Limited by referring only to the averages of total practice costs by medical discipline was misleading because superannuation costs were distorted by large payments to related persons, and interest and leasing costs were distorted by a few large amounts.
- The indexation process applied by Duesburys in projecting the 1989-90 survey data to 1991-92 values stated the level of price increases for that two year period at between 8 percent to 9.25 percent whereas a more accurate increase was 6.8 percent.
- The conduct of the survey and its results were internally inconsistent with the preferred approach stated by Duesburys of including those costs which continued to run while the VMO was performing sessional work by not excluding potentially significant costs which did not continue to run.

- Duesbury's preferred approach would result in the public purse assuming responsibility for a VMO cost structure based on the infrastructure required to service private patients which had very little to do with the treatment of public patients.
- The number of hours used as the divisor to calculate hourly allowances was 1,692, contrary to other survey material as to the number of hours worked by VMOs.
- The revised claim by the AMA did not recognise cost differentials between specialties.
- The costs presented by Duesburys were overstated for the purposes of assessing practice costs.

Mr. *Kenzie* then led evidence from Mr. Teulan in quantifying the results of his review of the AMA's survey, and that was performed by him based on the different approaches in principle adopted by the parties and using a divisor of 2,000 hours per annum to obtain hourly allowances for practice costs. Mr. Teulan, however, first adjusted the results from the AMA's survey using the maximum cost approach to an adjusted maximum cost by removing the alleged distortions referred to earlier in the recording of expenses and then calculated amounts according to the attributable cost concept, that is the additional costs incurred as a result of a VMO performing sessional work. The results were as follows -

	Attributable per hour	Maximum per hour	Adjusted maximum per hour
1692 Hours	$	$	$
General practitioner	7.02	49.02	42.72
Physician	7.88	55.12	40.91
Anaesthetist	7.00	37.16	24.55
Surgeon	13.36	88.05	75.06
2000 Hours			
General practitioner	5.94	41.47	36.14
Physician	6.66	46.63	34.61
Anaesthetist	5.92	31.44	20.77
Surgeon	11.31	74.49	63.50
2200 Hours			
General practitioner	5.40	37.70	32.85
Physician	6.05	42.39	31.47
Anaesthetist	5.38	28.58	18.88
Surgeon	10.28	67.72	57.73

It was submitted for the Minister that the allowances for background practice costs should be fixed, as a result of the survey results, using the attributable cost method with a divisor of 2,200 hours giving amounts of $5.73 per hour for anaesthetists, physicians and general practitioners and $10.28 per hour for surgeons.

The net effect of the attributable cost approach as preferred by Mr. Teulan would be to fix the background practice costs allowances as including motor vehicle expenses, printing, postage and stationery expenses, and telephone expenses. Specific items which would be excluded if the adjusted maximum cost approach were to be adopted would cover salaries, wages and superannuation, occupancy costs, interest, subscriptions and insurance, accountancy fees, depreciation and leasing, and other overhead costs such as licenses and registrations and costs related to the use of a pager.

AMA's response: Mr. *Sperling* emphasised that until every dollar of expenditure in practice costs were recovered, a VMO would earn nothing

for the services he provided. In supporting Mr. Borthwick's approach in using maximum costs, senior counsel relied upon evidence given in the 1985 proceedings by Mr. E.D. Cameron, a partner in the chartered accounting firm of K.M.G. Hungerfords, who presented material to *Macken* J. and reviewed and evaluated the surveys conducted in 1976 and 1978 by Dr. Guyot. That evidence by Mr. Cameron stated:

> A practicing professional necessarily incurs overhead costs. In the case of doctors these would inevitably include
>
> . rental or ownership costs of an office or surgery
> . salaries for receptionist, nursing assistant etc.
> . motor vehicle costs
> . stationery, postages, telephone etc.
> . insurance - probably including professional indemnity insurance
> . medical supplies
> . other.
>
> Income earned by a professional is normally comprised of either a fee for specified services or a charge related to time spent or a combination of the two. Charge rates, be they for services or time, are either set by the individual or by an institute or body such as the Law Society. In my experience charge rates are set so that the professional will receive
>
> 1) a fair return for his skills, knowledge, time and effort;
>
> 2) an amount deficient to cover overhead costs necessarily incurred;
>
> 3) a fair return on capital employed in the practice (amounts invested in furniture and equipment, unpaid fee accounts etc. and, in some cases, goodwill paid to acquire the practice);
>
> 4) a fair return for the risks involved in operating one's own business and being personally liable for one's own actions.
>
> ...
>
> Unless a professional charges all his clients or patients a fee to cover all of the aspects set out above, he must either increase his charges to other clients or patients to make up for those who do not pay the full fee, or suffer a consequential loss of income. It is quite normal in a professional practice in certain circumstances for a rate higher than the normal rate to be charged, such as where work is performed in an emergency or priority situation and/or where special skills and efforts are involved. It is also quite normal in a professional practice for lower than normal or standard rates to be charged in certain circumstances, such as for charities or where clients or patients are suffering financial hardship. Both of these

circumstances, however, must be and are normally exceptions rather than the rule.

...

Sessional payments to doctors are, by their very nature, payments to doctors who are in private practice. Being in private practice the doctors must incur overhead costs which will be incurred irrespective of the proportion of time spent in the surgery on the one hand and in public hospitals on the other. Any time spent with public patients at a charge which does not include a proportion of overheads reduces the doctor's earnings component for effort and skill per unit of time spent with patients generally. If the percentage of time with public patients is small (as in the case of work done by other professionals for charities and hardship cases) the doctor may still recover what he regards as a fair return for his time and effort overall. If it is large, however, the return for skill and effort from the practice as a whole may be unacceptably low, after overheads are met. Depending on the actual amount paid for sessional work and the level of overhead costs, the receipts for that work could conceivably be less than the overheads incurred whilst such services are being performed. In those circumstances a loss would be incurred during the period in which such services are being carried out and this loss would have to be recouped out of profit from other work, before there would be any net profit from the practice as a whole.

The evidence of Mr. Cameron was consistent with that given by Mr. Borthwick in the present proceedings and which evidence was expressly the subject of contrary comment by Mr. Teulan as follows:

1. While all overhead costs need to be recovered from the revenue of the business as a whole, a fair apportionment of overhead costs does not require the recoupment of overheads to occur on a uniform basis from each group of clients treated.

2. One of the key reasons for charging different clients different prices in commercial practice is that it costs less to serve one group of clients than another group of clients (ie less resources are used to service one group of clients than another group of clients).

3. In determining whether overheads should be borne by one group of clients or another, it is necessary to understand why those costs are being incurred. If certain costs are being incurred in order to service a particular group of clients, those costs should be allocated to that group fo clients.

4. If it can be assessed that the use of certain fixed overheads by a particular group of clients is significantly greater than by another group of clients, a uniform/pro-rata allocation of overhead costs makes the group of clients using fewer resources bear more than their fair share of costs.

5. Irrespective of interdependency and interrelationships between various services, it is critical to establish the true costs of providing each service. That is the starting point for any fair calculation of BPC.

6. The accepted method of determining whether multiple services exist in a business is to assess whether the services provided are resource homogeneous. If all the services provided use the same intensity of the practice's resources, then there is one service. If quite different types and levels of resources are used to provide different services, or to provide services to different clients, then there are multiple services. Services provided to sessional and non-sessional patients are clearly not resource homogeneous. Far less resources are used to service sessional work than private patients in the doctor's rooms.

7. Describing medical services as having only one service, "medical services", is a gross oversimplification. The Federal Government and the AMA already recognise that different services are provided by practitioners through the Scheduled Fee and the AMA Fee List. The fee differentials implicitly recognise, amongst other things, the different level of resources required to perform different services, including nursing assistance, equipment used, facilities required etc.

8. As there are separate services in a medical practice, these should be costed separately with the costs attributable to each service fairly apportioned, based on the reason why the cost is incurred and the extent of use of the resource by each service.

9. The "continues to run" concept is only another way of describing a simple apportionment of costs across all services on a uniform basis. It is inappropriate and unfair because:

   . it places on the public purse a responsibility for costs relating to an infrastructure developed and used for the purpose of treating private patients and which has very little to do with the treatment of public patients.

   . it represents a blank cheque approach whereby the public purse accepts financial responsibility for the financial consequences of personal and business decisions made by medical practitioners, no matter whether such decisions have a commercial basis or whether they relate at all to the treatment of public patients. The mere fact that a public hospital is aware that a doctor is in private practice does not mean that it is willing to accept or should accept the burden of costs associated with his private activities; and

   . it is contrary to the intention of BPC, as evidenced by statements in judgments and amounts set for BPC in New South Wales and the other Australian states. That intention has been very much directed toward reimbursement of additional costs incurred by the VMO as a result of performing sessional work.

10. Duesburys report of 12 March 1992 does not quantify the costs which continue to run while the VMO performs sessional work. The information obtained for the 1989/90 AMA cost survey is deficient in relation to its capacity to assist in quantifying either those costs which continue to run or those costs which do not continue to run.

Mr. *Sperling* summarised the point of principle as that "practice costs must be recovered, and, prima facie, it is reasonable that they be recovered pro rata. ... the AMA's case is that total practice costs should be apportioned pro rata, save only for such costs as are so exclusively related to the private work that it would be unreasonable to include them in the total costs to be allocated proportionately to the sessional work (that submission related to the reduction of 8 percent made by the AMA) ... an underlying concept in the AMA's case is that total practice costs ... provide an infrastructure which supports the practice as a whole and so enables all services, including public and private services, to be provided." In further emphasising the point, senior counsel submitted:

> The creature from whom the hospital is buying a slice of professional time is in private practice. He has to maintain an infrastructure (including rooms, staff, motor vehicle, etc), the cost of which he must recover out of the income generated by the practice. The infrastructure is necessary to enable the VMO to be in independent practice and hence to be able to provide services to the hospital as an independent professional person. The sort of service that a highly skilled professional in private practice can provide, suits the hospital. Otherwise it would service public patients exclusively through salaried medical staff. In fixing a rate for the service it should be recognised that this is what the hospital is buying.
>
> The major items of cost continue to run irrespective of what work is done. Rent does not cease to accrue when the doctor is out of his rooms. The rooms have to be kept staffed during business hours. The motor car continues to depreciate. And so on. The practicability of reducing actual occupancy costs and actual staff costs, where the doctor is at the hospital has been explored. It is very limited. Substantially, the costs of maintaining the practice as a whole will continue to run irrespective of whether the doctor is in the rooms or out of the rooms and, if out of the rooms, irrespective of whether he is operating or on a ward round, and irrespective of whether that is at a public or at a private hospital, and irrespective of whether he happens to be treating a public or a private patient or both during any particular hour of time.

> Mr Teulan agreed that, generally speaking, the more important fixed costs such as accommodation, salaries and motor car, are not reducible by reason of a relatively small amount of the working week being applied to a sessional contract ... If the costs of maintaining the infrastructure cannot be turned off when the doctor is at the hospital it is reasonable that hospital work, public and private, should bear a pro rata proportion of those costs.

Use of the divisor of 2,000 hours, or a higher figure, was strenuously resisted by Mr. *Sperling* in favour of the figure of 1,692 hours per annum. It was common ground that forty-seven weeks per year, as used by both parties in their calculations, represented a reasonable basis as being consistent with evidence given by the VMO witnesses, but, in fact, it was a very conservative approach because it did not take into account two weeks for public holidays; Mr. *Sperling* suggested it really would be closer to reality to take forty-five weeks per year. The other factor in the multiplier, the weekly chargeable hours, was pressed as thirty-six, on Mr. *Sperling's* submission, as being in accordance with the evidence of the VMO witnesses and the University of New England 1988-89 survey. The AMA's divisor of 1,692 hours was supported therefore as being for forty-seven weeks per year for weekly chargeable hours of thirty-six; the alternative of forty-five weeks per year would give a divisor of 1,620 hours. The Minister's proposal of 2,200 hours per year, being the 2,000 hours previously proposed plus 100 for on-call and 100 for associated time, was challenged as including time other than that for which a VMO was paid the background practice costs allowance; if the allowance was not paid, then, in Mr. *Sperling's* submission, such time could not be taken into account in the divisor. The Minister's proposal of 2,000 hours per annum included a component of forty-two hours per week which was wholly excessive on the evidence.

In light of criticism levelled during the proceedings, the AMA made final adjustments to its claim by excluding accountancy costs and sickness and accident insurance. By factoring in those adjustments, and based on

a divisor of 1,692 hours, the allowances for background practice costs became $61.68 per hour for specialists and $48.56 per hour for general practitioners. Mr. *Sperling* persisted with the single rate for all specialists, on the basis that provided the specialties were weighted appropriately the Minister would not pay any more overall. However, in the event it was thought more appropriate to express the allowances in categories as suggested by the Minister, the AMA re-calculated the results to give, on a divisor of 1,692 hours, the following hourly allowances:

Classification	Practice Costs per annum	Practice Costs per hour
	$	$
General practitioner	82,171	48.56
Physician	90,548	53.52
Anaesthetist	59,742	35.31
Surgeon	145,298	85.87

Mr. *Sperling* vigorously challenged the Minister's attributable costs approach as being wholly inappropriate and unreal. In so doing, I think senior counsel illustrated the real dilemma, as a matter of a value judgment, in selecting the maximum costs compared to the attributable costs approach by reasoning the difference in costs incurred by a VMO in treating public and private patients at a public hospital and private patients in a private hospital. Senior counsel said:

> The marginal cost of treating private patients in the public hospital would be much the same as for public patients. The only difference would be the cost of record-keeping and account rendering to the extent that this was more than for the sessional work. According to Mr. Teulan that does not attract a salary cost or an occupancy cost anyway. It would merely increase the stationery, postage and printing costs. Hardly significant. Telephone costs would be no different in quantum from those exclusively related to public patients. Motor vehicle costs would be even less because the chance of a visit to see only private patients would be low in view of the mix. So the marginal cost of treating private patients in the public hospital would be infinitesimal.

Then one comes to patients treated in private hospitals. The only difference here would be that motor vehicle running costs (petrol and depreciation due to wear and tear) would count for each trip. However, if the VMO travelled from rooms to the public hospital, then to the private hospital and then back to the rooms, the return trip to the rooms would not count because the VMO had to get back to the rooms from the public hospital anyway. Depreciation due to aging of the vehicle would not count because the car was just as much needed to see patients at the public hospital. So the marginal cost of treating private patients at private hospitals would be very little different. (To the extent that it would be different, the implication in the attributable costs approach is that private patients should be charged a different fee depending on whether they are treated in the public hospital or in a private hospital.)

The marginal cost approach can be applied to any individual service or class of services. What is the additional cost of treating this patient over and above what would be spent to support the practice anyway? Very little. What is the additional cost of treating patients with this ailment or with that ailment? Very little. What is the additional cost of treating hospital patients? Very little. What is the additional cost of home visits? Very little. What is the additional cost of treating patients in the rooms? Even that would not be a lot.

But even to consider the marginal cost of work in the rooms is very artificial because the doctor would not have a hospital practice at all without the full panoply of facilities to see patients for consultation in his rooms. By the same token he would not have a rooms practice without the capacity to treat patients in hospital, including uninsured patients who can be treated only in the public hospital. He cannot conduct a rooms practice or a hospital practice without incurring the cost of both and, in particular, without incurring the costs in common to both.

As to the reliance placed by the Minister on allowances applying in other States for practice costs, Mr. *Sperling* suggested that in those States it may not have been argued with the same depth and detail as it has it has been argued in these proceedings, and, in any event, VMOs in those States were employees and not independent contractors so that there was at least an argument the costs of their practices as a whole were immaterial and any allowance should provide for not more than the additional costs incurred in relation to the salaried work.

Costs of AMA's claim

Mr. Teulan assessed the overall impact of granting the AMA's final claim in terms of cost to the public hospital system as $36.6 million per

annum. For each extra one dollar added to the existing allowances for background practice costs, he assessed the additional costs as $0.92 million per annum.

Proper principles to apply

An assessment of allowances for VMOs to compensate for practice costs requires a resolution of the fundamental difference between the parties as to the proper principle to apply, either the maximum cost approach, even if adjusted, or the attributable cost approach. Of the very many issues requiring arbitration in these proceedings, this particular issue has been one of the most troublesome as involving major attention by the parties and directly contradictory expert evidence. In the final analysis, however, it must come down to a matter of a value judgment as to what is considered to be the proper principle to apply in all the circumstances.

On balance, I accept the attributable cost approach as the proper course to follow to determine background practice costs allowances. I find myself quite unable to accept that a public hospital should be required to compensate a VMO as a visiting practitioner to the hospital in the treatment of public patients in an amount which would equate with the practice costs incurred in the treatment of the VMO's private patients. The contrary view expressed by both Mr. Borthwick and Mr. Cameron, namely that it is fair for a VMO's remuneration under a sessional contract to include a proportion of all those practice overheads which continue to run whilst the VMO is doing sessional work, overlooks, in my view, the essential nature of the public hospital system in its care and treatment of public patients. So too, in my view, it overlooks the nature of the relationship between a public hospital and a VMO in the provision of medical services to public patients. It would seem the maximum cost approach is predicated on the concept that a medical practitioner's

practice is a single entity and that public patients and private patients are patients who should bear a proportion of the total overheads of the practice. I disagree. Certainly, on the one hand, the relationship between a medical practitioner and his private patient involves that private patient sharing equally with other private patients obtaining medical services the overhead costs incurred by the practitioner in providing them. On the other hand, however, the public patient is a patient of the hospital which may allocate that patient for treatment to a staff specialist or to a VMO as part of the VMO's sessional contract under which he agrees to treat public patients; and in referring the public patient to the VMO the hospital makes available its very considerable facilities, equipment, staff, support services, administrative support and so on. Further, as a visiting practitioner, the VMO enjoys the ability to admit to the public hospital his private patients, and to obtain other benefits not otherwise available to a practitioner in private practice, such as enhanced standing and prestige in the medical community, development of clinical expertise in the treatment of a wide variety of cases, access to new technology, referral of new private patients from hospital sources, inter-action with peers and colleagues, continuing education and maintenance of clinical standards in a collegiate environment. Mr. Teulan expressly considered the benefits available to a VMO in the public hospital setting, and concluded, with which I agree, as follows:

> These commercial and professional benefits are clearly of value to VMO's for their private practice. Although such benefits cannot be quantified, we believe that due to their significance these would be in the mind of a practitioner in accepting an appointment for sessional work. as such, they are relevant in considering the appropriateness of methods of cost reimbursement under BPO. If these benefits are recognised as being of importance, the stronger becomes the argument for reimbursement of direct costs only attributable to sessional work.

During the course of his evidence, I raised with Mr. Teulan the rationale for considering private and public patients separately in terms of applying in respect of the public patient additional costs only but excluding the fixed cost incurred by the VMO. Mr. Teulan responded:

> Q. If one looks at the doctor's practice in the totality of patients generally, that would seem to me in looking at it as a complete whole, one would therefore logically and conceptually apportion reimbursement to him for his background practice costs across all of his patients. That would mean necessarily putting aside difficulties in calculation, an apportionment to that part of the total patients referable to the public something referable to fixed costs. Why is it that that logic should be changed, if indeed my logic be right, where one instead of looking at the doctors total practice looks at it in terms of two compartments, private and public patients on the other?
> A. I think the first thing is we are not looking at the totality of fixed costs. For instance, in a public hospital if we were to look at all of the fixed costs in relation to the practice of a medical practitioner visiting a hospital, we would have far more fixed costs than variable costs than we have in this example, because we also have the hospital costs which are in fact often a duplicate of those which are in the practitioners own rooms, so we have equipment and the other facilities available to a doctor in the private practice, many of those in fact duplicated by the public practice. If we are looking at apportioning the whole of the fixed costs in relation to that practice, we would have to look at those fixed costs provided by the public sector, not the least of all is the public hospital setting, the equipment, the staff, the library and all the other facilities made available.
>
> So here we are looking at one portion of the overall fixed costs. You cannot say the total cost of treating this patient is incorporated by what the medical practitioner has in his tax return. We have to look at two things. In the health care industry it is not unusual to look at things in terms of an episode of care. A lot of things done in the health industry is on the basis "What does it cost the private patient in a particular setting for a particular episode of care?" and often in public hospitals when they do costings they cost the outpatients separately to the inpatient episodes of care, so they look at the relevance of costs in relation to each of those episodes of care. What they are saying is there are certain costs which are relevant to actually treating the patient in hospital and costs relevant whilst as an outpatient. You need to look at those differently, which need to be separately costed. The most important thing is the relevance of the cost. We have here a situation where the vast percentage of the time of visiting medical officers is not spent treating public patients in public hospitals but in conducting private practice. If we are in that situation, in my situation I will make decisions in full knowledge of that, should the public sector bear that cost when it is a separate payout, when I am not funding that particular arrangement but someone else is funding the treatment of that patient, either a health insurance fund or a Government. If I set

> out at the beginning of the year as a practitioner and say I am going to spend 70 to 80 per cent or a higher percentage of my time in a private practice and applying a cost structure to start with which is about developing rooms and employing staff, medical equipment, I think there is a legitimate argument to say "Why should that be borne by the public sector?" If that person was spending their time in the public sector rather than the private sector, that cost would not be incurred at all because that equipment is provided in the public sector. So the relevance of decisions made by the treating doctor in those rooms, the equipment and everything else is not really relevant to treating public patients in public hospitals. That is reinforced by the fact there are different payers of these services and they need to be recognised. Relevance of cost is probably the most important aspect of this but we are not getting the total picture of total costs by saying it is all part of the cost of providing the service, having inpatient episode and care and that should be borne equally by the private practitioner and the hospital.
>
> We need to look at it in terms of the totality of the costs which are incurred.

I found Mr. Teulan's response helpful in resolving the conceptual problem. I prefer, and adopt, Mr Teulan's approach from that of Mr. Borthwick and Mr. Cameron. Importantly, it seems to me, he emphasised the fairly substantial fixed costs incurred by the public hospital in providing for the treatment of patients, and, as he said, "(t)he most important thing is the relevance of the cost". Relevance, of course, must be a decisive consideration on this question, and I think it plainly unreasonable to expect the public hospital system to pay a portion of a VMO's fixed costs of practice where the VMO solely decides the nature, quality and standard of the facilities utilised by him outside the public hospital. In truth, in my view, those facilities are to enable the conduct of a private practice. To the extent a VMO incurs additional expenses by reason of rendering services to public patients, then to that extent and to that extent only is it reasonable to expect the public hospital to reimburse those expenses.

The conclusion reached by me on the conceptual question took into account the somewhat exhaustive evidence and arguments presented in the proceedings. However, supporting the conclusion which I have otherwise reached, and confirmatory of it, is the basis on which allowances

for background practice costs have been assessed in previous determinations. In my view, the principle applied has been, at least until the 1985 determination, the reimbursement to a VMO of the additional expenses incurred in the treatment of public patients - Mr. Teulan's "attributable cost approach". In his 1978 reasons (at p.17), *Macken* J. said - "I remain unconvinced that it is an appropriate principle to adopt that a base hourly rate for a visiting medical officer should be loaded so that, during the performance of his sessional work at a hospital, his rate of pay, while so engaged, should include a loading such as would bear the proportion of private practice costs which are incurred by the visitor." That principle was carried forward by his Honour in making the determinations in 1980, 1981, 1982 and 1983. It was not until the 1985 determination that his Honour departed from the principle, and, apparently, although it is not entirely clear from the reasons, accepted the "accountants' conservative approach" which included many of the fixed costs of a private practice rather than those expenses resulting from the performance of work under a sessional contract. The result was the extremely high increases granted in the background practice costs allowances. That means, I would conclude, the level of allowances in the existing determination is excessive as being based upon a principle which I find inappropriate. I think that to be a ground for their adjustment accordingly.

Although VMOs in other States may be employees, they nevertheless receive as part of the remuneration package consideration for expenses incurred in their practice. It is plain from the allowance paid that the principle adopted in assessing them is consistent with the conclusions reached by me in these proceedings. In making a new determination on 13 December 1979 for sessional medical officers in

Victoria, the Hospitals Remuneration Tribunal (*Leckie* J.) said in the accompanying reasons (at p.2) as to the costs of private practice:

> This leaves the question of an appropriate loading for costs in private practice attributable to the sessional medical officer's work in his appointment to a hospital.
>
> Here again, there will obviously be differences as between specialties and an averaging approach must be adopted. I reject the contention that such costs should be allocated on a time basis as a proportion of the total costs of private practice. They should be strictly those costs attributable to the sessional work. The major overheads will be much the same regardless of whether a sessional appointment is held or not. Clearly a modest amount is appropriate, and I have awarded a loading of 5%.

The Tasmanian Industrial Commission (Commissioner R.J. *Watling*) on 3 February 1992 gave reasons for a decision in a private arbitration in relation to hourly rates of pay for visiting medical officers in public hospital in that State. One of the components considered for inclusion in the hourly rates was an amount for a practice costs component. The Commissioner was asked to increase the loading from $17.58 per hour to $58.00 per hour by relying on a survey conducted by the AMA of certain medical practitioners who provided sessional services to Tasmanian public hospitals. The survey ascertained the hourly net practice costs for various groups were $35.84 for general practitioners, $18.98 for anaesthetists, $32.65 for physicians and $41.08 for surgeons. As to the practice costs component, the Commissioner said in the reasons for decision (at p.7):

> I, like Mr Jarman, have some misgivings about the quality of, and response to, the survey conducted by the AMA (exhibit H10) as it certainly raises as many questions as it answers.
>
> Even though the survey may well establish that net practice costs per hour have increased over the years for each of the disciplines, nevertheless it ignores such things as:
>
> (a) The fixed cost that would be incurred by a medical practitioner irrespective of whether he/she was a VMO.

(b) The sharing of costs with other medical practitioners in the same rooms.

(c) The intangible benefits that can be gained from working in a public hospital, e.g. the avenue to exchange ideas, intellectual challenge, working in a research environment, the use of facilities and equipment, but to mention a few.

(d) The decline (if any) in the treatment of private patients whilst undertaking work of a VMO and the amount of income lost because of it.

I am convinced, that, for a survey of this nature, to have any real meaning, it would have to clearly show the additional or extra costs required to run a private practice as a result of being a VMO treating public patients in public hospitals.

If I were to accept the survey presented by the AMA without question then, in that regard, I find myself in agreement with the statement made by Mr Justice Macken when determining this issue in New South Wales, wherein he stated, in part, in his 1985 Reasons for Determination the following:

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

It may be undoubted, therefore, that the Commissioner rejected the total costs approach in favour of, as I have done here, the additional or extra costs approach. As the Commissioner observed, he determined "all up" hourly rates by taking into consideration, *inter alia*, "(t)he additional costs incurred in running a private practice when time is spent with public patients in public hospitals."

As further confirmation of the appropriateness of the approach taken by me in this matter, the allowances made for background practice costs to VMOs in the other Australian States at the present time (see Appendix "R") are -

State	Practice Cost Allowance per hour
	$
Victoria	2.66
Queensland	7.95
Western Australia	9.04
Tasmania	Included in "all up" rate
South Australia	Not identified

Annual adjustment

The AMA claimed the allowances fixed should be adjusted annually according to movements in the CPI, with the proviso that no allowance should be reduced thereby. I do not propose to accede to this claim for the same reasons as I declined the claim for adjusting ordinary hourly rates of remuneration by reference to movements in AWE figures. In an area where a number of factors must be taken into account, it seems to me the only appropriate way to assess allowances is by a deliberate decision based upon material presented by the parties and not by the use of some index which may move, and no doubt will, for reasons quite unrelated to practice costs.

Assessment

The matter of approach in terms of principle having been decided, it remains to apply that principle to the assessment process.

The first point for resolution is the divisor to apply to the amount of annual practice costs, being the number of chargeable hours, in order to calculate an hourly allowance for background practice costs in the determination. As discussed, the AMA suggested a divisor of 1,692 hours, based on a forty-seven week year of thirty-six chargeable hours per week, although a more realistic divisor of 1,620 hours was suggested, being based on a forty-five week year for thirty-six hours per week. The

Minister, on the other hand, adopted a divisor of 2,200 hours, being based on a forty-seven week year for forty-six chargeable hours per week; at the very least, and as Mr. Teulan thought reasonable, a divisor of 2,000 hours should be applied. I have analysed the material going to this point, and am satisfied that an appropriate divisor to use is 1,692 hours. There is no real issue between the parties that a forty-seven week year is appropriate, the real debate concerned the number of weekly hours for which a VMO made a charge. The Minister included time spent during on-call and in performing associated work, but I do not agree such time should be included. In calculating an allowance, the procedure must be, in my view, to relate it to *chargeable* hours, that is the hours during which a VMO makes a direct charge for the services provided and in respect of which the allowance is payable. True it is that when a VMO is on-call he is paid for the period concerned, but at a rate lower than the ordinary rate of remuneration, and associated time is comprehended within the ordinary rate; however, the background practice costs allowance is not payable on such occasions so it must follow, it seems to me, that the time spent on such occasions may not reasonably be used in the calculation.

The second point for resolution is the quantum of annual practice costs which should be used. The survey material initially relied upon by Mr. Teulan, on the up-dating of the material from earlier surveys to 1990 dollars, disclosed total attributable costs per annum for the various areas of practice; he then notionally reduced those costs by 20 percent to account for inherent problems with the cost data provided by practitioners without independent scrutiny and to adjust for the use of service entities by practitioners which may overstate practice costs on average by as much as 25 percent. Set out in the table below are the results of Mr. Teulan's exercise, together the resultant hourly costs based on a divisor of 1,692 hours -

Classification	Expenses			
	Total		Adjusted	
	Annual $	Hourly $	Annual $	Hourly $
General Practitioner	19,392	11.46	15,514	9.17
Physician	23,376	13.82	18,701	11.05
Anaesthetist	14,276	8.44	11,421	6.75
Surgeon	28,379	16.77	22,703	13.42

The review by Mr. Teulan of the AMA's survey, using the attributable cost approach and a divisor of 1,692 hours, disclosed annual expenses and consequent hourly amounts as follows:

Classification	Expenses	
	Annual	Hourly
	$	$
General Practitioner	11,877	7.02
Physician	13,327	7.88
Anaesthetist	11,848	7.00
Surgeon	22,611	13.36

The expenses from the most recent survey are not greatly dissimilar from the earlier surveys as indexed to 1990 dollars. However, those 1990 figures from the earlier survey would, on the approach taken by Mr. Teulan, have to be increased by an indexation factor of 7 percent to bring them to a June 1992 level.

One, perhaps understandably, often has reservations about surveys. I am no exception. However on the evidence before me, the survey conducted by the AMA was found to be statistically valid and such as would give a usable result. True it is that Mr. Teulan questioned a number of the expenses included in the material, but adjustments made by him in moving towards the attributable cost figures necessarily attended to those problems. I am generally prepared to accept, for assessment of allowances for background practice costs, the AMA's survey

results as quantified by Mr. Teulan in his attributable cost analysis. I feel confirmed in the reasonableness of that approach by the marginally higher expenses resulting from the earlier surveys as reviewed by Mr. Teulan.

The remaining aspect requiring attention is the grouping of classifications in a determination to attract a particular level of allowance. The present determination prescribes an allowance for a general practitioner and an allowance for all specialists. The AMA desired the continuation of that approach. On the other hand, the Minister took the view that as the allowance was compensation for expenses actually incurred then the determination should group areas of practice accordingly. I agree with the Minister's submission. The surveys indicated a more accurate grouping would be to prescribe a single allowance for general practitioners, physicians and anaesthetists, and a separate allowance for surgeons. I think that to be appropriate and the determination will so provide.

In assessing an appropriate quantum, I propose to follow the same approach as with ordinary hourly rates, that is to fix hourly allowances having in mind they should be at a fair and reasonable level for an identified period. The period I propose to take into account is two years from the date of commencement of the determination.

Findings

On the basis of the conclusions reached above, the determination will provide the following allowances for expenses incurred in background practice costs -

Classification	Allowance per hour
	$
Anaesthetist, physician and general practitioner	9.00
Surgeon	15.00

CHAPTER 11 - ON-CALL AND CALL-BACK

Apart from the rendering of services during ordinary hours, an important facility exists for VMOs to be rostered "on-call", that is, to be able to attend public patients as required. Where the requirement arises, usually in an emergency situation, services are provided pursuant to a "call-back". The conditions to apply to those situations in a new determination were in issue between the parties in important respects. Indeed, the history of previous determinations shows that provisions for on-call, in particular, and for call-back have varied from time to time and have also been the subject of a number of disputes between the parties.

On-call

The AMA's original claim was for a continuation of the provisions of the existing determination. The Minister, however, desired a number of changes in terms of availability of a VMO during on-call periods, the quantum of the on-call allowance and the conditions under which it was to be paid. The AMA responded with a counter-claim. It is necessary to examine the development of the on-call concept.

Previous determinations and difficulties: In the foundational arbitration in 1976, Mr. *Rogers* recommended an on-call allowance at the rate of one-tenth of the normal sessional hourly rate for each hour a VMO was rostered on-call, except that the allowance was not payable for the period occupied by travelling time and call-back. In reviewing Mr. *Rogers* reasons above, I quoted at some length his reasoning and so I will not repeat it. It is sufficient to observe that a firm conclusion was reached by him that the burden imposed on a VMO whilst on-call for public patients was alleviated by him being on-call also for his private patients; a practitioner's commitment to private patients in hospital was recognised as being continuous, except during periods of leave and other absences from practice. And so it was that Mr. *Rogers* assessed the additional

burden of being on-call according to a roster for public patients. The other aspect considered was the time spent by a VMO on-call receiving telephone calls concerning patients. The comment was made that physicians tended to receive more telephone calls for advice than did their procedural colleagues such as surgeons.

In the 1981 proceedings, the Health Commission attempted to have the on-call allowance removed from a new determination. *Macken* J. changed the arrangement so that on-call was paid for an on-call period of twenty-four hours; the change was made to meet administrative difficulties. The position was reviewed during the 1982 proceedings as to the social implications of being on-call, and a distinction was drawn with being on-call to private patients because any commitment in that respect was known in advance. The AMA sought to increase the allowance, effectively 42 cents per hour, to $2.50 per hour between 8 a.m. and 6 p.m. Monday to Friday and $4.17 per hour outside those hours. His Honour fixed an on-call allowance at $20.00 for a period of twelve hours, that is $1.67 per hour. In the 1983 determination, his Honour fixed a new allowance of $20.86 for the first twelve hours and $1.75 per hour thereafter.

The matter was dealt with as a substantial issue in the 1985 proceedings, and I have earlier in these reasons detailed the issues which essentially concerned the claim by the AMA to return to an on-call allowance of 10 percent of the normal hourly rate for each hour spent on-call, whereas the Health Administration Corporation claimed a continuation of the 1983 provisions. His Honour decided to return to the percentage approach, namely 10 percent per hour, to "keep the V.M.O. in line with the staff specialist in this regard". I earlier remarked, for the reasons then stated, it was difficult to accept a return to the percentage approach as meeting that purpose because a staff specialist's on-call

payment was a fixed a percentage of salary, and he was on-call at all times, whereas a VMO over a period of one year would receive considerably more in payments by being on-call for the same period. Further, I noted the result of the decision of *Hodgson* J. in the Court of Appeal in *Hyslop (No.1)* to the effect that the on-call allowance determined by *Macken* J. was to be payable during the whole of the period a VMO was rostered on-call, including during a call-back or otherwise attending a hospital. Further, I remarked that a 10 percent allowance involved a significant increase in the on-call payment from about $1.75 per hour to $9.40 per hour for a senior specialist, an increase of 437.15 percent.

Those aspects of the 1985 determination, which represents the present provisions, were the subject of challenge by the Minister in the present proceedings who sought the prescription of an allowance of $5.50 per hour for each hour rostered on-call, except during periods of leave and during any period in which the VMO rendered services, such as during a call-back or whilst attending private patients. The AMA, effectively, sought the retention of the present provisions.

Issues: It seems to me the particular issues requiring decision are -

- Whether payment for on-call should be a flat money amount or a percentage of the normal hourly rate of remuneration.
- Whether the on-call allowance should be paid during a call-back, including during the travelling time involved.
- Whether the on-call allowance should be paid during the rendering of services to public patients at the hospital concerned under his sessional contract.
- Whether the on-call allowance should be paid during attendance on private patients.
- What should be the quantum of the allowance.

Minister's submissions: Mr. *Kenzie* in his oral and written submissions examined in detail the on-call provisions from 1976 to the existing determination. Senior counsel challenged, in particular, what occurred in 1985 with the reversion to a percentage allowance of 10 percent in lieu of a flat money sum by submitting that the reasoning of *Macken* J., as set out in his Honour's reasons (at p.29), was erroneous. His Honour returned to the percentage approach to "keep the V.M.O. in line with the staff specialists in this regard." However, Mr. *Kenzie* denied that staff specialists received an on-call allowance of 10 percent, and relied upon a statement by Mr. Conciliation Commissioner McArdle on 21 October 1987 in compulsory conference proceedings under the *Industrial Arbitration Act* 1940 in the matter of a dispute between the Health Administration Corporation and the Public Medical Officers' Association, New South Wales concerning the extent to which the 20 percent on-call/re-call allowance paid to staff specialists should be regarded as salary for superannuation purposes. That required a determination of the proportion of the 20 percent allowance which compensated for each of the two aspects, namely on-call and call-back. The conciliation commissioner said:

> My knowledge of industry generally leads me to understand that payment for being on-call is usually a small token emolument paid to compensate for the domestic inconvenience of holding oneself available. Where a person is actually recalled to work they usually receive 4 hours minimum pay at overtime rates per occasion of recall depending on their award entitlements. The dollar value to employees paid in these circumstances of payment for recall is therefore greatly in excess of payments received for being on-call. It would be unreal to suggest that an allowance in lieu of an on-call payment would be worth much more than 25% on one in lieu of payment for recall.
>
> Payments for recall in most awards, being paid as they are at overtime rates, are a particular reimbursement for unusual circumstances and not regarded as part of the regular salary. To my knowledge there are no examples of it being regarded as salary for superannuation purposes. There have been many examples brought to my attention however of payments providing for special

> circumstances which may or may not include on-call being regarded as part of salary for superannuation purposes.
>
> I therefore conclude that the State Superannuation Office should be asked to recommend to the relevant Superannuation Boards that the special allowance component of the Recall/Special Allowance be calculated as part of salary for Superannuation purposes. The part of the allowance compensating for being on-call and for other circumstances of employment should be 6% of the salary. That percentage of the allowance which compensates for being recalled should be 14% of salary and not be regarded as part of salary for superannuation purposes.

I find myself in agreement with the conciliation commissioner's conclusion, and for the reasons stated by him, that the on-call component of the 20 percent allowance paid to staff specialists would constitute by far the minor part, not "much more than 25%", so that the 20 percent allowance should be comprised of 6 percent for on-call and 14 percent for re-call. It seems his Honour in 1985 was informed in evidence by a Dr. Morgan that the agreement applicable to staff specialists allowed a 20 percent allowance made up of 10 percent for on-call and 10 percent for call-back; apparently, that situation was never challenged by the Minister in those proceedings, but the 1987 dispute before Mr. Conciliation Commissioner McArdle clarified the issue, and in a way which I find industrially reasonable.

Mr. *Kenzie* relied on evidence given by Mr. Clout and Mr. Brown, to the effect that an on-call allowance in various health industry awards was to compensate for the disabilities inherent in being on-call and subject to a requirement to return to duty if needed. As a disability allowance, it is appropriate to compensate by way of a flat money amount rather than a percentage because the disability, that is the restriction on social activities and the potential for call-back, are the same for all VMOs whether they be general practitioners or senior specialists. In summary, senior counsel submitted there was nothing in the evidence to justify a significantly different approach to the level of on-call payments for VMOs; specifically, he rejected the AMA's contention that higher levels of payment should be

made because VMOs were more valuable than any other category of health worker. By comparison with other health workers, senior counsel submitted the Minister's approach of an allowance of $5.50 per hour was reasonable compensation. Mr. Clout provided telling evidence, in my view, of the effect of the present on-call arrangements for VMOs by comparison with staff specialists as follows:

> The contention of the AMA is totally incorrect. First there are cases where specialist VMOs are on call 24 hours a day, seven days a week, 52 weeks of the year. Secondly, it is incorrect to say that it is theoretical only to consider a senior staff specialist who is on call 24 hours a day, 7 days a week, 52 weeks of the year. The methodology and the comparison are not invalid. Even if one looks at a different example where a staff specialist and VMO in the same specialty at the same hospital were sharing a one in two on call roster the result is almost as stark. The staff specialist would receive an on call payment for his half of the roster of $6,700 per annum, whereas the visiting medical officer would receive an on call payment of approximately $45,000 per annum though they share equally in the inconvenience of being on call for an equal period of time. Even if we take an example where there is one staff specialist and four VMOs sharing the on call roster in a particular specialty at a particular hospital each of the VMOs would receive a payment of approximately $18,000 per year for their one fifth of the roster as compared to the staff specialist who would receive $6,700 for his one fifth of the on call roster.

A method for compensating VMOs for on-call with the practical effects outlined by Mr. Clout, and which were not challenged by the AMA, cannot, in the view I have formed, be equitable.

A further problem was identified by Mr. *Kenzie* in that by the on-call allowance being expressed as a percentage of the normal hourly rate the loadings for leave, split sessions and extended sessions operated to thereby increase the amount paid. It was submitted no justification could be established for on-call payments being based on a loaded rate for such matters. The only solution, as senior counsel put, was to fix an allowance in a flat money amount. In the event, however, if it was thought appropriate to continue the percentage approach then the percentage

should be reduced from 10 percent to 5 percent of the base hourly rate, and not of the loaded normal hourly rate.

The implications of the present on-call allowances for VMOs, particularly in terms of the relationship with staff specialists, has been referred to already in general terms in my consideration of certain of the Minister's structural efficiency claims by reference to the evidence of Dr. Spring and Dr. Horvath. More specifically, however, Dr. MacArther said:

> As noted above, these allowances are at present a major cause of inequity both among VMOs in various specialties and between VMOs and staff specialists. They are also a major cause of inefficiency as they have discouraged reasonable networking of rosters associated with infrequent call-backs among neighbouring hospitals. This has had undesirable effects on the smaller hospitals which are no longer able to afford a multitude of "minor" rosters, and are consequently less well able to cope with trauma and other emergencies, for which they have in all other respects adequate facilities. The undesirable effects have extended to the teaching hospitals, which experience unnecessarily high levels of emergency and, to a lesser extent, elective workload which could otherwise be performed in district hospitals.

A comparison between the on-call arrangements for VMOs and staff specialists was the subject of comment by Dr. Horvath as follows:

> The on-call arrangements are unnecessarily advantageous to VMOs as against staff specialists and Clinical Academics as is demonstrated by attempts that have been made to re-arrange rosters to take advantage of extra income opportunities. In one service that was under my control, the VMOs actually formally asked the salaried staff to go off the roster so the VMOs' incomes could be enhanced.
>
> The on-call payments made to VMOs was apparently arrived at by reference to the 20% of base salary allowance paid to staff specialists. I have considerable difficulty in accepting that it is appropriate to regard half that 20% allowance (i.e. 10%) as the on-call component and therefore that it is appropriate for VMOs to get similar on-call loading. The fact of the matter is that the allowance paid to salaried specialists is an "all incidents" allowance, which covers not only the holding on-call in accordance with a roster, but also covers all occasions of overtime (akin to "extended hours" in sessions); of call-back, and of work on weekends and public holidays. There is no other payment under the Award for overtime or penalty rates, and no "hours" clause. To this extent, there is a considerable difference from the VMO on-call 10% loading which only covers the one aspect, and (unlike the staff specialists) has no maximum payment figure (other than the theoretical $96,798 per

annum). That is, whilst staff specialists receive the same special allowance even if their on-call and/or call-back requirements (for instance) doubled in a particular year, a VMO facing a similar change in work requirements would receive double the payment for that increase in work.

The generosity of the current on-call allowance to VMOs has meant they have frequently resisted appropriate roster changes and controls. I was involved in dispute committees at Royal Prince Alfred Hospital concerning such VMO resistance.

The practical implications of the situation were dealt with by Mr. Clout, who observed:

There is little doubt in my experience that the level of income that can be generated by being on call, under the current payment system, has been a significant factor for many VMOs when determining their attitude to proposals by hospitals to change on call rosters. The resultant resistance to networking of on call rosters between hospitals, deletion of sub-speciality groups from the on call roster and limiting the periods of the day or week to be covered by the on call roster, has led to disputation between hospitals and the VMO's/AMA. In many cases the hospitals' proposed rosters have not be pursued because of the likely reaction by the VMO's. the outcome has been increased costs which in the hospital manager's views could not be justified.

It may be suggested by the AMA that the hospitals simply determines the rosters and that is the end of the matter. Fortunately this is not the reality in the health system. The rosters must be prepared and implemented in consultation with medical staff or they will not be adhered to and patients would be at risk. They are constructed on the basis of a clinical requirement and within the available budget. Any factor which affects the construction and effective implementation of rosters based on these two criteria, must be specifically prohibited. Excessive on call allowances is one such factor.

Mr. *Kenzie* referred to the difficulties experienced by hospital administrators in attempting to rationalise on-call rosters, and in respect of which I have commented earlier in these reasons, with the proposition that so long as on-call payments remain so attractive and generous then the position will not improve. Senior counsel supported that by reference to the evidence given by Mr. Barker which dealt with the cost repercussions of the 1985 determination, as follows:

Prior to the 1985 Macken decision the on-call rate was around $1.75 per hour which is now $9.40 per hour to a senior specialist. The cost of this decision is significant and is estimated (pending the

results of the recent V.M.O. survey) at some $27 million P.A. or 24% of total sessional payments. By comparison call backs are estimated at $10.7 million.

Prior to the 1985 decision the cost of on-call is estimated at around $5 million per annum.

In his costing of the AMA's claim, Mr. Barker gave the actual cost for the year 1990-91 for on-call payments at $30.7 million out of a total VMO cost for that year of $157.5 million. It is of significance, in my view, in considering the quantum of the on-call allowance, to note that whilst the on-call payments for the 1990-91 year were $30.7 million, the call-back payments for the same year were the much lesser figure of $20.4 million. Having in mind that call-backs involve the actual rendering of medical services whereas periods on-call are essentially for "availability" purposes, it is perhaps not surprising, as dealt with by the various witnesses for the Minister, that attempts have been made to change the on-call arrangements to make them more cost effective. It is those attempts, as the evidence has shown, which have met such resistance by VMOs. In light of the history both before and after 1985, I accept the probability that the large increase in the on-call allowance in 1985 contributed directly to that situation. The level of the allowance, then, coupled with the arrangements, inevitably justifies, in the view I take, a review of it.

Apart from the quantum of the allowance itself, the conditions under which it has been paid, on the Minister's submission, require review. The Minister's proposals seek to overcome the effect of the decision of the Court of Appeal in *Hyslop (No.1)*, as to the meaning of the present provision, to ensure the on-call allowance would not be payable during periods of call-back, including during the travelling time involved, on the basis it was simply unreasonable for a VMO rendering medical services to be paid a loading during a call-back and at the same time continue to receive the on-call allowance - that was double counting. Indeed, and without reasons, *Macken* J. in 1985 was said to have

overlooked in the on-call prescription the need to reintroduce the provisions that existed between 1976 and 1981 which prohibited on-call payments during call-back periods. The matter should now be corrected. A similar reasoning applies, as Mr. *Kenzie* submitted, to payment of the on-call allowance when a VMO rendered services to public patients at the hospital concerned under his sessional contract and even when he attended private patients. In other words, once it be accepted the true nature of an on-call allowance compensated for disabilities then it was inappropriate for such allowance to be paid whilst a VMO was actually performing work for which hourly remuneration was paid.

The AMA's reliance for its claims on the incidence of telephone advice given by VMOs whilst on-call was opposed, and for that the Minister depended on the evidence given by Dr. Child, which, in brief, may be illustrated by his evidence as follows:

> The evidence confirms my general understanding of the situation. There is a wide variation in the incidence and duration of telephone advice whilst being on-call, being most frequent and lengthy in respect of physicians and an unusual event in respect of anaesthetists.
>
> The extent that time spent on the telephone adds to the disability of being on-call therefore should not be given any weight when considering the rate payable for all disciplines.
>
> Alternatively a special allowance could be struck for such work.
>
> In a up-front hours situation, if an individual Visiting Medical Officer could make a case that the incidence of telephone advice was a significant feature in VMO's hospital work, allowance could be made for increasing the agreed hours to take account of that fact.

That evidence by Dr. Child was supplemented by the following oral evidence:

> Q. When on call, in addition to the possibility of being called back, the visiting medical officer must be available for telephone consultations?
> A. Yes.

Q. Are there differentials as between different arms of the profession in relation to the susceptibility of being required to give telephone consultations?
A. Quite wide differentials.

Q. Tell his Honour something about that?
A. If we look at anaesthetists, virtually every time an anaesthetist is called when he is on call, he has to come back. Otherwise there's not much point in calling him.

If we look at the surgeons, depending upon the severity of the case, he may have to come in at short notice with very little telephone consultation. There may be a telephone consultation followed by his having to come in at relatively short notice.

If we look at physicians, particularly if there is registrar staff within the hospital, the likelihood of his having to come back is very much lower, but nevertheless there may be a lengthy and intellectual conversation over the telephone which may be followed up by another telephone call about the same patient somewhat later - during the on call period - but it may not be necessary for the physician to make a specific journey to see the patient except to catch up with that patient in his otherwise ordinary time. There are wide variations.

The general practitioner - where there are general practitioners in existence on call back - their on call periods is also very high and one of the reasons for that is that they often work with a much lower level of senior RMO and registrar cover.

Q. What about the issue of telephone consultations in the case of general practitioners, as opposed to others?
A. Certainly there would be telephone consultations but by and large the general practitioners tend to come back. Often in the case of a GP, to see patients in the emergency department where there may not be RMO cover, but once again that is more of a feature of fee for service general practitioners.

In the result, Mr. *Kenzie* submitted it would be inappropriate to consider the creation of a new allowance for telephone advice in view of the wide diversity of experience, and the matter would be best left for consideration as part of the up-front hours negotiations.

Finally, senior counsel relied on the evidence of Mr. Barker as to the economic consequences of the AMA's position with respect to on-call. Mr. Barker up-dated during his evidence the earlier cost figures for the year 1990-91 to give total on-call payments for the 1991-92 year of $31.28 million; for every one percent increase in the normal hourly rate, the additional on-call cost would be $0.23 million per annum.

AMA's submissions: Issue was taken by the AMA with the Minister's proposition that the on-call allowance was to compensate for a disability. Reference was made to the telephone advice given by VMOs, which, it was said, distinguished the nature of the payment. Essentially, Mr. *Sperling* put a VMO provided medical services during on-call and reference was made to the very many VMO witnesses who gave evidence to that effect. Mr. *Sperling* helpfully tendered a summary of that evidence, and I have reviewed it. The evidence covered the disability aspects of being on-call as well as the incidence of telephone conversations. As a general impression, the evidence was consistent with the evidence given by Dr. Child as to the diversity from specialty to specialty in the nature and extent of telephone consultations.

As to the quantum of the current allowance, senior counsel denied it was excessive relative to staff specialists, and relied upon a survey conducted by the Department of Health for the year 1987-88 which disclosed that VMOs averaged 964 hours on-call for an average payment of $8,615.00, that is, $8.94 per hour. However, I point out that the same survey demonstrated 397 VMOs received annual on-call payments in excess of $20,000.00, and it further showed multiple examples of high on-call payments but with minimal or zero call-back payments. For instance, an orthopaedic surgeon was paid $26,263.00 for on-call but nil for call-back; a cardio-thoracic surgeon was paid $28,877.00 for on-call but with no call-back; a plastic surgeon was paid $48,504.00 for on-call and only $235.00 for call-back; an ophthalmologist was paid $39,518.00 for on-call and only $195.00 for call-back; and an ear, nose and throat surgeon was paid $23,678.00 for on-call but with no call-back payment.

The objections by the Minister of VMOs' reluctance to accept rearrangements of on-call rosters was said by Mr. *Sperling* to be consistent with a *bona fide* belief as to the need for the current roster

services, and the objections by VMOs to preserve their income from on-call rosters was as consistent with the rate being reasonable as unreasonable; in any event, roster reduction was a matter for firm management and not for a reduction in the rate to a less than reasonable amount.

The Minister's assertion of the countervailing benefit to VMOs in obtaining private patients from being rostered on-call was exaggerated as the evidence from the VMO witnesses showed that only a "small amount" of benefit would be obtained in that respect.

The attempt by the Minister to have on-call payments stopped during periods of call-back and at other times when services were being rendered was opposed by the AMA because the concept of on-call involved being available to attend the hospital at times which were not routine or pre-planned. Therefore, as Mr. *Sperling* said, the on-call rate should continue because VMOs remain amenable to a call-back to another case following the one attended.

In summary, Mr. *Sperling* on this claim submitted:

> The points raised by the Minister distract from the only real question: *What is a fair and reasonable rate for on-call having regard to its incidences* including the following?
>
> (a) There *is* a value to the community in having professionals of the highest calibre available to supervise the management of public patients by telephone and to provide prompt treatment if required in an emergency. The rate should reflect the value of the service provided.
>
> (b) The rate is not merely for being available. The incidence of consultation services provided by telephone is significant, and the VMO must exercise judgment as to whether to come in. Both factors distinguish the VMO from the ordinary case.
>
> (c) Under industrial awards for salaried employees, on-call rates are usually accompanied by generous provision for minimum time when the employee is actually called in. 3-4 hours seems to be the norm, at overtime rates (see Exhibit BB). This point supports the reasonableness of the AMA's claim in relation to on-call and call back as a package.
>
> It is not a primary concern whether the rate for on-call to be fixed by the arbitrator is expressed as a *percentage* of the normal hourly

> rate or *in dollars*, provided it reflects the above considerations. That would include the preservation of graduated rates related to the classification of the VMO. The percentage formulae is a convenient way of serving these objectives but a formula in dollars could do so.

Conclusions as to approach and quantum: I am satisfied the evidence establishes that the on-call allowance, both historically and at the present time, compensates a VMO for the disability incurred in holding himself in readiness for a call-back, together with telephone consultations as required but to a widely varying degree. It follows, in the opinion I have formed, an allowance in a flat money amount is more appropriate than a percentage approach because the disability would be experienced equally by a VMO be he a general practitioner or a senior specialist. The giving of telephone advice, in itself, would support the granting of a graduated allowance, but, in my view, the on-call allowance essentially is designed to meet the disability of being on-call and thereby restricting activities of a social and family nature. Even so, and notwithstanding the difficulties of assessment, I consider some amount should be included for the incidence of telephone consultations, albeit to a very small degree.

The original assessment in 1976 of the allowance at one-tenth of the normal hourly sessional rate was at a time when hourly rates were considerably lower than at present; the change in 1981 to a flat money sum recognised the difficulties of the percentage approach. The change in 1985 back to the percentage approach allegedly was to make the payment consistent with that allowed to staff specialists. However, the submissions of Mr. *Kenzie*, which I accept, establish the error of that reasoning. Therefore, I see no reason not to adopt the basis for payment as decided in 1981. The change in 1985 was compounded by the inordinate increase in normal hourly sessional rates and by the decision in *Hyslop (No.1)* to make the on-call allowance payable during a call-back and at other times

a VMO rendered services. The fixation in 1976, which operated until the 1985 determination, excluded payment of the allowance for the period occupied during a call-back and the travelling time involved. Also, the 1976 arbitration recognised the alleviation of the burden on a VMO being on-call for public patients by having to be on-call for private patients at the same time. I must say that that dual requirement is, to me, of some consequence in assessing the quantum of the allowance and as being against its fixation as a percentage of the ordinary hourly rate. I have no doubt that a most important factor in arbitrations is the avoidance of double-counting.

In the avoidance of double-counting, I do not accept the on-call allowance should be payable during a call-back, including the travelling time involved, nor when a VMO renders services to public patients at the hospital concerned under his sessional contract. It is true the VMO may at such times be contacted to perform further services, but he is being paid for the services rendered and at call-back rates which contain a loading on top of the normal hourly sessional rate. If a VMO is otherwise attending a public patient during a period he is on-call, then, on the face of it, he would be on-call during a period of ordinary routine service. I find some difficulty in understanding in that situation how he could be rostered on-call, although it apparently occurs. One solution would be for the on-call roster itself to exclude periods of such service, but to make it clear I think the determination should exclude also payment of the on-call allowance not only during call-back periods but during periods of routine service as well. In that respect, however, I have some reservations about excluding payment where the VMO is attending one of his private patients during an on-call period. I think the resolution of that apparent dilemma is best achieved by considering the VMO's sessional commitments as distinct from his commitments to private patients; if a VMO happens to be

attending a private patient during a period on-call and receives notice of a call-back, presumably he would be required to meet his sessional commitment to attend the hospital concerned within a reasonable period of time. On balance, I have decided it is reasonable in such circumstances for a VMO to continue receiving the on-call allowance even though attending a private patient. To make the position clear I would propose the sessional contract contain a condition as to a VMO's participation in an on-call roster, the basis for which gives rise to payment of the allowance, to provide he must not only be able to attend the hospital concerned within a reasonable period of time but also must be "prepared to attend". I think that is the best way to meet the problem.

Findings: For the reasons set out above I propose to determine the on-call allowance at an amount of $7.00 per hour during which a VMO is rostered on-call, except that the allowance shall not be payable during periods of leave of absence, nor whilst a VMO is travelling or rendering services pursuant to a call-back or otherwise in accordance with his sessional contract. A sessional contract should require a VMO participate in an on-call roster as the hospital or area health service concerned may reasonably require, and when so rostered the officer should be readily contactable at all times and be able and prepared to attend the hospital concerned within a reasonable period of time.

Call-back

The consequence of being rostered on-call is the ability of a VMO to be required to return to the hospital to render services on a call-back. There was much contention during the proceedings as to what constituted a call-back and the loading which should be payable.

Existing provisions: The 1985 determination, as indeed with previous determinations, defines a call-back as meaning "called to attend a hospital patient at a time when the V.M.O. would not otherwise have attended the

hospital." The determination provides further for the payment of a call-back made at the request of the hospital to be the normal hourly rate plus a loading of 10 percent in respect of call-backs commencing within the hours of 8.00 a.m. to 6 p.m. Monday to Friday and a loading of 25 percent for call-backs commencing at other times. The duration of a call-back includes the actual travelling time from the place of contact to the hospital and return to a maximum of twenty minutes each way, with payment for one call-back to be not less than one hour of call-back time plus the actual travelling time. Where a VMO renders services by way of a call-back on a public holiday, payment is to be at the normal hourly rate plus a loading of 50 percent. In dealing with this subject matter in 1985, *Macken* J. concluded in his reasons (at pp.30-32):

> The A.M.A. seeks a number of changes to the clause providing for payment for call-backs of V.M.O.'s at the request of a contracting hospital. It is first sought to provide that daylight call-backs be within the span of 9.00 a.m. - 5.00 p.m.; where currently the span is 8.00 a.m. - 6.00 p.m. It is also sought to provide loadings of 50% and 100% respectively for daylight as against after hours call-backs. Currently the Determination provides for such call-backs to be paid for at the levels of 10% and 25% respectively. The A.M.A. also seeks to have the duration of call-backs include the actual travelling time from place of contact to the contracting hospital and return, with a maximum of thirty minutes each way. The present Determination is for twenty minutes each way.
>
> Mr. *McAlary* argued that all of the evidence supported the view that a 'medical day' runs between 8.00 a.m. and 6.00 p.m. and as nothing was put to me to justify any change from the current span of hours it will remain the same in the new Determination.
>
> The existing loadings for call-backs are 10% in relation to daylight hours, and 25% where a call-back takes place before 8.00 a.m. or after 6.00 p.m. The A.M.A. seeks to increase these loadings to 50% and 100%. These increases were opposed by the Health Corporation which argued that no reason had been advanced for loadings of such a high order.
>
> No evidence was led to justify these claims and I was not referred to any industrial instruments containing call-back provisions as high as those sought by the A.M.A. For this reason I propose to re-enact the two loadings as they are in the existing Determination.
>
> The A.M.A. also sought to have call-backs include actual travelling time from the place of contact to the contracting hospital and return

with a maximum of thirty minutes. Once again no material was produced to justify this change and the application is, accordingly, rejected. A further issue arose as to when a call-back period is to commence for purposes of the differential loadings. The Health Corporation wants it made clear that the clause applies when a V.M.O. is called to attend a hospital patient as a consequence of being "on-call". It wants to have recognised that, where a return to a hospital is other than as a result of a call from t hospital, it must be authorised by the Chief Executive Officer of the hospital. I will accept the proviso of the Health Corporation, it being understood that the approval of the Chief Executive Officer of the hospital will be presumed unless he otherwise indicates to the V.M.O. that he wishes to query the "call-back" payment.

The existing Determination provides for a minimum payment of one hour, including travelling time where applicable. The A.M.A. claims a minimum of not less than two hours, plus actual travelling time. I have made the new Determination with a minimum payment of one hour, as it is in the existing clause; but exclusive of travelling time where applicable.

The final matter in dispute under this clause is the question as to whether a call-back should be deemed to commence from the time the V.M.O. is called or (as favoured by the Health Corporation) it should commence from the time the V.M.O. leaves his residence to commence the call-back. Some identification of the point of commencement is necessary to determine which of the two call-back allowances are to prevail.

It would seem to be clearest for a call-back to commence at the time when the V.M.O. leaves the place of contact to return to the hospital and the Determination will read accordingly.

The changes made by his Honour to the prior determination involved the minimum payment for a call-back of one hour excluding the travelling time (whereas previously travelling time was included in the minimum payment) and the point of commencement of a call-back to be from the time the VMO left his residence or place of contact.

Effect of claims and issues arising: Mr. *Sperling*, in putting the AMA's claim for a revised call-back provision, submitted its effect as follows:

The proposed definition is intended to incorporate the following concepts.

(a) The VMO should be paid at ordinary rates during the times when he would ordinarily be at the hospital as a matter of routine; and at call-back rates when he is called to the hospital outside his usual routine.

The evidence shows that VMOs have a routine. Surgeons have regular operating lists on particular days. VMOs have a pattern of attendance for ward rounds. Where a VMO did not have a fixed time for say ward rounds but ordinarily came, say, in the morning on a particular day of the week or in the afternoon, the definition would be construed to treat attendance for an ordinary ward round as ordinary time.

(b) The definition *is* intended to classify as a call-back an attendance on a day when the VMO would not ordinarily come to the hospital and where the attendance cannot reasonably be postponed to the next occasion when the VMO would ordinarily be there.

(c) The definition is intended to cover situations in which the VMO exercises his discretion to attend a patient without being requested to do so, such as where a junior member of the hospital staff contacts the VMO but does not know whether an attendance by the VMO is required.

Or where a VMO contacts the hospital to ascertain the condition of a patient about whom he is concerned and, on being told of the patient's condition, believes he should attend.

It is also envisaged that there may be cases in which the VMO decides than an unstable patient should be checked irrespective of any communication with the hospital but because of what the VMO knows from a previous attendance.

It is important to bear in mind that this definition is intended to operate not only in relation to large teaching hospitals but in relation to some hospitals where there may be no resident medical staff on duty at all or only very junior medical staff.

(d) The definition places the discretion squarely with the VMO. The only basis on which that could be challenged would be that the VMO did not honestly hold the opinion that such an attendance was necessary. We say that is as it should be.

(e) It is unlikely that any definition would be entirely satisfactory in all the circumstances. The evidence shows that many VMOs provide some call-backs without charging a loading, and some never charge the loading. A bit of give and take seems necessary, but the Minister wants a clause narrow enough to enable audit to the point of demonstration in every case. That should not be the test.

Other than as outlined above, the AMA sought the retention of the existing provisions.

The AMA's approach was to re-define a call-back to include periods when a VMO would not ordinarily attend the hospital, but where attendance was in fact made because it could not reasonably be postponed;

situations sought to be included as a call-back included where a VMO exercised his discretion to attend a patient without being requested to do so by the hospital if the VMO believed he should attend, either because of concern on being told of the patient's condition or from knowledge of a previous attendance. Essentially, then, the AMA's proposal sought to place attendance by way of a call-back, and hence to attract the loading, squarely within the discretion of the VMO.

On the other hand, the Minister claimed a call-back provision basically in terms of the existing determination, but with a call-back being limited to hours other than between 8.00 a.m. to 6.00 p.m. Monday to Friday, payment of the background practice costs allowance as a discrete amount and not subject to the call-back loading, the minimum payment for a call-back to be one hour inclusive of travelling time, and the provision of medical services during a call-back to be "as a matter of urgency" in response to a request from the hospital to attend for that purpose. The discretion in a VMO to decide to attend on a call-back was opposed as being contrary to hospitals' requirements.

The issues for resolution then were the four matters raised in the Minister's claim. The major issue was attendance by a VMO in the exercise of his discretion rather than being specifically requested by a hospital to attend, although the Minister recognised a "deemed" call-back could occur in circumstances where the VMO attended as a matter of urgency and the attendance was later verified by the hospital or area health service. The remaining issue of some importance was the exclusion of a call-back during the period from 8.00 a.m. to 6.00 p.m. Monday to Friday.

Call-back hours: The basis for the Minister's claim in excluding a call-back during the hours of 8.00 a.m. to 6.00 p.m. Monday to Friday was based on the view that such hours constituted ordinary business hours for

which no loading should be paid and also the predictability of attendance during such hours. Mr. *Kenzie* relied on the evidence, in particular, of Dr. Child and Dr. Horvath to support this change, with both of them emphasising the ability to predict the extent of call-backs during periods when "ordinary doctoring" is performed. Accepting the predictability aspect, Dr. Horvath as to the disruption which may be caused to VMOs' practices in attending a call-back gave the following evidence under cross-examination:

> Q. You would appreciate that a call back during the hours 8 to 6 can very often be very more disruptive to the doctor than a call out of hours?
> A. It depends on what anyone is doing at the time, yes.
>
> Q. One would suppose in the course of an ordinary day between 8 a.m and 6 p.m the doctor would have some programmed commitment, is that so?
> A. You would expect that.
>
> Q. And also he may have ordered his commitments in a way that they can be left because he is on call, but nonetheless could be very much more disruptive to him to be called during the day time rather than at night?
> A. That is the nature of medical practice. It is a constant set of disruptions.

It was stressed for the Minister a VMO rostered on-call during business hours on a particular day could organise his other commitments accordingly so as to minimise the likely disruption; also, of course, VMOs were available for a call-back to attend their private patients in both public and private hospitals on a continuous basis. In such circumstances, submitted Mr. *Kenzie*, a call-back during ordinary business hours should be at normal sessional hourly rates rather than with a loading of 10 percent. The AMA's position, as outlined by Mr. *Sperling*, was for retention of the present provision. Senior counsel emphasised it was not so much a question of the predictability of call-backs but rather when during the spread or ordinary business hours a VMO would be required;

the disability lay in organising a practice around that relevant time. I think there is force in this submission.

A 10 percent loading has always been payable since 1976 for a call-back during "ordinary business hours", having been recommended by Mr. *Rogers* and continued by consent. Indeed, there was some evidence to suggest that for a VMO a call-back during ordinary business hours, when he was conducting his private practice, was more disruptive than a call-back at night or over a weekend. I am not prepared to go as far as that, but it seems to me to be clear that for an independent contractor conducting a separate practice, and even though he may be on-call, the possibility of a call-back during such hours is disruptive to some extent. I accept the long-standing assessment of the disruption at 10 percent. The determination will so provide.

Practice costs allowance: The Minister originally sought the exclusion of the background practice costs allowance during a call-back. However, during the proceedings that stance was modified to accept the allowance as being payable during a call-back, as it is at the present time, but not so as to increase the allowance by the amount of the call-back loading. The AMA persisted in the position a call-back constituted a charge on ordinary time, and, as such, the call-back loading should be calculated on the total rate comprising the ordinary hourly rate and the background practice costs allowance. I disagree.

The background practice costs allowance should be paid during a call-back, but not be increased by the call-back loading. The allowance for practice costs represents a reimbursement of expenses actually incurred and those expenses would not be any different according to when a call-back may be made. Therefore, whilst the background practice costs allowance should be paid during a call-back, it should not be increased by the call-back loading according to the time the call-back occurs.

Minimum payment: The 1985 determination, whilst continuing the long-standing provision for a minimum call-back period of one hour, added to the minimum period the travelling time actually incurred to a maximum of twenty minutes each way. Under the determinations from 1976 to 1983 travelling time was included in the one hour minimum. Thus, since 1985 a VMO travelling from his rooms to attend a call-back and taking ten minutes each way for a call-back lasting for thirty minutes would be entitled to payment for one hour for the call-back and twenty minutes for travelling time, a total of eighty minutes payment for thirty minutes work; under previous determinations, and the Minister's present claim, payment would be for the one hour minimum. Other examples can readily be given; with the maximum travelling time of twenty minutes each way for a call-back of twenty minutes the present determination would give a payment of one hour and forty minutes whereas prior determinations, and the Minister's present claim, would result in a payment of one hour.

I must say the reason for the change in 1985 is not clear, at least to me, and his Honour gave no reason for the change of the long-standing provision. Having in mind the existence of the call-back loadings of 10 percent and 25 percent, and 50 percent for a public holiday, I am unable to accept the reasonableness of adding travelling time to a minimum call-back period. Of course, if the actual call-back occupied at least one hour then the travelling time involved would be paid in addition to that one hour to a maximum of twenty minutes each way. The AMA relied upon minimum call-back periods in a number of industrial awards as ranging from three to four hours so that, it was said, the present claim for VMOs was eminently reasonable. However, I point out that the call-back provision for VMOs includes in the call-back period, and therefore subject to the relevant loading, the travelling time from the place of contact to the

hospital and return. I see no reason to add to the minimum call-back provision the additional payment for travelling time, and certainly not at loaded rates.

Attendance: In relation to the Minister's proposal adopting the concept of "urgency", including the "deeming" facility, and the AMA's approach to include as a call-back an attendance at a hospital where a VMO considers such attendance to be necessary even though the hospital made no request, a considerable amount of detailed evidence from both sides was given to support the respective contentions. I find it unnecessary to refer to that evidence because it seems to me clear that the alleged confusion in respect of call-backs, and to which the respective claims represented solutions, arises from a misunderstanding or a mis-reading of the call-back concept.

Fundamentally, in my view, a call-back occurs where a VMO, like an employee under an industrial award, is required to return to the hospital to render services during a period when he would not otherwise have attended the hospital; the requirement must be as a result of a request from the relevant hospital or area health service. The question whether a VMO is requested to attend is a question of fact in the circumstances of a particular situation. Cases arising where a VMO is contacted by a hospital but the hospital staff member, say a resident medical officer or a nurse, is uncertain whether the VMO should attend, thus requiring, as the AMA submitted, the VMO to exercise a discretion, seem to me not realistically to arise. If a resident medical officer or other member of hospital staff sees fit to contact a VMO regarding a patient but without formally or actually requesting the VMO to attend, then, it seems to me, that may well represent a constructive call-back - in other words, the hospital staff member has effectively given to the VMO the right to decide whether a call-back is necessary because he has consulted the VMO

in a matter in which he himself cannot decide. If a particular member of a hospital's staff does not have the authority granted by the hospital or area health service to contact a VMO in relation to patients then that hospital or area health service, in my view, should lay down a procedure whereby a responsible staff member is specifically nominated to carry out that function; otherwise, the kind of difficulties outlined in the evidence will continue to occur. I am firmly of the view that re-defining a call-back in terms of "urgency" or by reference to "deeming" provisions would in fact compound existing difficulties. I would suggest much of the problem is attitudinal, no doubt on both sides, in a situation where the existing determination provision sufficiently lays down the test, namely, whether the VMO is required to attend the hospital when he would not otherwise have attended. As I say, that is a matter of fact and best provided and determined as such. For instance, and looking at the AMA's claim, where a VMO returns to attend a patient because of his observations when the patient was last seen or in response to a pre-arranged call from hospital staff that a patient is exhibiting certain symptoms, seem to me clearly to be outside the concept of a call-back. Those situations, in my view, represent an attendance at the hospital by the VMO when he would otherwise have attended the hospital, that is in the ordinary course of the treatment of the patient. The hospital did not request the attendance, rather the VMO in the ordinary course of treating the patient pre-arranged or foresaw an attendance in the ordinary course on the happening of certain events; the events occurred and the VMO attended. Again, the matter is best left as a decision of fact as to whether the VMO was requested by the hospital to attend when he would not otherwise have done so.

I therefore propose to include in the determination the definition of a "call-back" in its present form, but making it clear that the attendance is

to be in response to a request from the relevant hospital or area health service. For additional clarity, I will include a provision that a call-back may arise whether or not a VMO is rostered on-call, as situations can well be envisaged when a VMO is not on-call but is nevertheless required as a result of some emergency to provide services during a period of peak load, such as may arise from certain accidents or natural disasters.

The remaining matter in which I consider clarification is required concerns a call-back on a public holiday. I apprehend the parties were not in disagreement during the proceedings that where a call-back commences on a public holiday then the loading to be paid during that call-back should be the public holiday loading of 50 percent in lieu of the 10 percent or 25 percent loading, as the case may be. The existing determination allows the 50 percent loading when a VMO renders necessary services on a public holiday; the Minister's claim seeks to exclude call-backs from the public holiday loading; and the AMA's claim expressly mentions a public holiday call-back as attracting the 50 percent loading. I think it reasonable for a call-back commencing on a public holiday to attract the loading of 50 percent, but where the call-back commences at a time other than a public holiday and continues into the public holiday, then the loading should be the 10 percent or 25 percent, as the case may be. Notwithstanding the AMA's written claim, that outline of how the provision should operate was given by Mr. *Sperling*, and, as I say, I consider it reasonable.

Findings: The call-back provisions of the new determination will be in accordance with the existing determination, subject to the changes found herein to be reasonable, namely -

- The background practice costs allowance to be payable during a call-back but not subject to the call-back loadings of 10 percent, 25 percent or 50 percent, as the case may be.

- The minimum payment for a call-back of one hour to include travelling time to a maximum of twenty minutes each way.
- The definition of "call-back" to include a period whether or not a VMO was rostered on-call to attend the hospital.
- The definition of "call-back" to make it clear that attendance to be in response to a request from the relevant hospital or area health service.
- A call-back commencing on a public holiday to attract the public holiday loading of 50 percent for the duration of that call-back; a call-back not commencing on a public holiday but continuing into a public holiday shall attract the loading of 10 percent or 25 percent, as the case may be, for the whole of that call-back period.

CHAPTER 12 - DETERMINATION

I propose to make a new determination pursuant to s.29M(1) of the *Public Hospitals Act* 1929 as to the terms and conditions of work for VMOs rendering medical services under sessional contracts to give effect to the conclusions reached and findings made in these reasons.

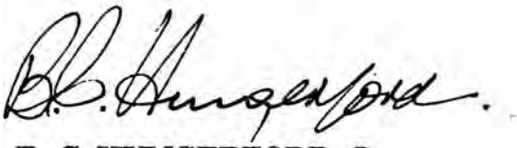
Operation

The determination will deal comprehensively with the terms and conditions of work appropriate for inclusion in sessional contracts so that the provisions of all previous determinations made by an arbitrator should be rescinded and replaced by the new determination. It will so provide. By consent, the determination will not apply to pathologists nor to radiologists. Otherwise, the determination will apply to all VMO appointments under sessional contracts throughout the State.

Effective date

The new determination will contain provisions for the introduction of very many structural efficiency measures, together with ordinary rates of remuneration and allowances lower than those presently applicable. Clearly, time will be required for the public hospital system to accommodate the changes of the nature proposed and new sessional contracts with most, if not all, VMOs will have to be made. I will allow a period of three months before the new determination takes effect.

The determination to be made shall have effect on and from 1 July 1993.



B.C. HUNGERFORD, J.
ARBITRATOR

Chambers
25 March 1993