STATEMENT OF DOMINIQUE EGAN

Name: Dominique Egan

Occupation: Legal Practitioner

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.

2. This statement is true to the best of my knowledge and belief.

3. I am the Director of Workplace Relations and Legal Counsel at Australian Medical Association (NSW) Limited (***AMA(NSW)***). I have held these positions since January 2020. Prior to commencing at AMA(NSW) I worked in private legal practice for twenty years advising medical practitioners and medical organisations, including AMA(NSW) on, inter alia, employment and industrial matters.

4. AMA(NSW) is the registered industrial body for Visiting Medical Officers (***VMOs***) in New South Wales.[1] AMA(NSW) has a statutory role to recommend to the Minister for Health[2], and / or seek the appointment of an arbitrator[3] to determine the terms and conditions and rates of remuneration for Sessional and Fee-for-Service VMOs. AMA(NSW) provides industrial and employment advice and support to members, medico-legal advice to members, and is the peak medico-political body in New South Wales.

5. AMA(NSW) is not the registered industrial body for employed medical staff in the New South Wales Public Hospital System. AMA(NSW) staff do provide individual workplace advice and support to employed medical staff in New South Wales and are very familiar with the relevant industrial instruments.

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

7. AMA(NSW) engages with its members, and non-members, in many ways. As the Director of Workplace Relations, I lead the Workplace Relations Team at AMA(NSW). The Workplace Relations Team deals with, on average, 200 member enquiries each month. Those enquiries include but are not limited to VMO arrangements, Staff Specialist and Doctors-In-Training arrangements, private hospital arrangements, workplace disputes and investigations, medico-legal advice, HR advice regarding employed staff in medical practices. In addition, as Legal Counsel I provide advice to the Chief Executive Officer, Board and Council of AMA(NSW), and I am responsible for policy advice on the workplace relations and legal matters.

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[1] Section 271 *Industrial Relations Act* 1996
[2] Section 87 *Health Services Act* 1997
[3] Section 89 *Health Services Act* 1997

8. In the last 6 months I have attended Medical Staff Council meetings at many hospitals to speak with VMOs (and Staff Specialists) about the changes AMA(NSW) proposes to seek to the VMO Determinations (see below), to canvass VMOs about matters that should be considered in addition to those identified to date, and it has also provided an opportunity to speak with medical practitioners about their current experiences in the Public Hospital System. Some of these meetings have taken place in person, others online and others a combination of the two. In the last 6 months I have spoken with the Medical Staff Councils at the following Hospitals: Port Macquarie, Westmead, Blacktown, Nepean, Coffs Harbour, Liverpool, Hornsby, Orange, Tamworth, John Hunter, Wyong, Gosford, St George, and doctors working in the Southern NSW Local Health District.

9. AMA(NSW) regularly meets with key stakeholder groups including Colleges and Societies and convenes meetings of groups such as Chairs of Medical Staff Councils, the meetings with the Medical Defence Organisations, and with regulatory bodies.

10. The current workforce is exhausted due to chronic understaffing. In addition, New South Wales doctors are amongst the lowest paid in Australia, as the Government continues to fail to address the need for reform of terms and conditions. Award and contract conditions must be updated to attract and retain the best and brightest in the New South Wales Public Hospital System.

11. AMA (NSW) regularly surveys Doctors in Training (**DiT**) and Senior Doctors. In 2021 AMA(NSW) conducted a survey of Senior Doctors regarding a range of matters including their sense value in the New South Wales Public Hospital System. Similar questions were asked of DiT in the annual AMA(NSW) Hospital Health Check survey in 2022. The results revealed that 46% of DiTs stated they felt valued by their hospital and 54% would recommend their hospital to another colleague.[4] In comparison, two-thirds of senior doctors said they did not feel valued but their hospital.[5] 62% of respondents to the 2021 survey said they considered the number of medical staff to be inadequate. 69% reported that they feel stressed by a lack of resources and 60% said they were stressed by an excessive workload.

12. In 2022 AMA (NSW), in anticipation of the 2023 New South Wales State Election, commissioned Deloitte to prepare a White Paper to examine the pressures on the health system, including the level of burnout and stress experienced by doctors and the possible reform options. As a part of this process, a survey was undertaken of doctors working in the Public Hospital System. One of the matters about which doctors were asked was the time they allocated to the Public Hospital System, and if changes could be made to make the work more efficient and effective, what they would do with the additional time. Almost two thirds of respondents indicated that they would reduce their time working in the Public Hospital System if able to do so. The

[4] AMA(NSW) Hospital Health Check Survey 2022
https://www.amansw.com.au/hhc-2022-key-findings/
[5]AMA(NSW) Senior Doctor Pulse Check Survey 2021
https://www.amansw.com.au/senior-doctor-pulse-check-2/

Deloitte White Paper, *Medical Workforce Pressures in New South Wales*[6] found health workers in New South Wales will need to deliver 40% more activity per worker relative to current service levels to meet forecast needs based on health workforce projections.

13. The Deloitte White Paper,[7] also identified several major challenges facing the New South Wales Health System. Those challenges include:

    - The growth in demand for services over the past decade: annual growth for primary care growing by 2.8% and hospital services by 2.2% compared to population growth of 1.3%;
    - Changes in patient expectations: patients demand improved access and experience;
    - There remains more to be done to improve health equity outcomes for First Nations People, rural and regional communities, lower socioeconomic communities, and culturally and linguistically diverse communities;
    - Significant investments made in sectors such as aged care and disability services have yet to make clear impacts on the health sector demand; and
    - Governments are fiscally unable to solve the health sector's issues only with more investment due to fiscal constraints.

14. The 2024 AMA Public Hospital Report Card found that while New South Wales remains the best performing State in key metrics, the State experienced the longest median wait time for planned surgery. People in New South Wales are now waiting over twice as long for planned surgery than they were 20 years ago.[8] Delays in access to surgery means patients are often sicker with more co-morbidities when they do have their surgery.

15. The New South Wales health system faces a number of challenges, including ambulance ramping, hospital log jam, long planned surgery waitlists, and the pressure from our growing and ageing population with complex, chronic health conditions. The New South Wales Government has dedicated significant funding to building new infrastructure, but there has not been the same resourcing dedicated to increasing workforce numbers to staff the current and future institutions.

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

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

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

16. AMA(NSW) supports a strong Public Hospital System and a strong Private Hospital System. There are a finite number of medical practitioners to serve both systems. Working arrangements that provide flexibility for medical practitioners to work across both systems is essential.

VMO arrangements in NSW

17. Other than the Australian Capital Territory (and very limited numbers in Victoria and Queensland) New South Wales is the only State or Territory in which VMOs in the Public Hospital System are independent contractors. In Victoria there are VMOs who provide services to rural and regional health services under fee-for-service contracts. In Queensland a VMO can be engaged as a contractor under contract with a medical practice company, as a part of a partnership under contract, or as an individual employee.[9]

18. AMA(NSW) wrote to the Ministry of Health in 2023 at or about the time it was preparing submissions for this Inquiry and applying for re-applying for Authorisation from the Australian Competition and Consumer Commission to collectively negotiate on behalf of VMOs with the Ministry and Local Health Districts, and again in February 2024 seeking the current numbers of VMOs working in the New South Wales Public Hospital System. To date, no response has been received from the Ministry. Based on statistics from 2011 when an audit of arrangements was undertaken by the Auditor-General, there were approximately 8,000 VMO appointments in the NSW Public Hospital System. Approximately 5,700 of VMOs were appointed under sessional contracts, 3,000 were appointed under fee-for-service contracts and 1,000 were appointed under fee-for-service contracts at facilities covered by the Rural Doctors Settlement Package. Some VMOs hold multiple appointments across Local Health Districts.

19. Contrary to suggestions by some stakeholders that VMO arrangements lack transparency, VMO appointments and contracts are governed under the *Health Services Act* 1997 (NSW) (***the Act***). VMO remuneration, and terms and conditions are determined by an independent arbitrator appointed by the Minister for Industrial Relations under the Act. Copies of the industrial instruments and applicable Ministry of Health policies are published on the NSW Health website.

20. VMOs are appointed under service contracts to provide services for monetary remuneration for on behalf of a Public Health Organisation (**PHO**). Service contracts include Sessional, Fee-for-Service and Honorary contracts.[10] A service contract must be in writing for an appointment to be valid.[11]

21. VMOs are subject to a detailed and competitive appointment process which, by virtue of the legislation, is undertaken on a regular basis.[12] There is the provision for short term VMO

[9] https://www.health.qld.gov.au/__data/assets/pdf_file/0036/395937/qh-pol-254.pdf
[10] Section 81 *Health Services Act* 1997 (NSW)
[11] Section 86 *Health Services Act* 1997 (NSW)
[12] NSW Health Visiting Practitioner Appointments in the NSW Public Hospital System PD2016_052 https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_052.pdf

appointments of up to six months to meet urgent service needs[13] but most are engaged on contracts of 5 years as is permitted under the legislation.[14]

22. AMA(NSW) does not support the practice of PHOs to provide some VMOs with rolling three- or six-month contracts rather than a quinquennial contract. This is not contemplated by the legislation and moreover leaves those working under those arrangements with no security. VMOs cannot commit to a hospital and local community when they cannot be certain they will be given contracts every three months. VMOs in regional communities are particularly concerned by this practice where they struggle to recruit and retain medical staff, and those offered rolling three-month contracts are unable to commit to relocating families, cannot commit to investing in establishing rooms and cannot secure finance to purchase a home. The same applies to quinquennial contracts provided with no specified hours or budget which again can create difficulties for VMOs in the same way as rolling short-term contracts.

23. If there is concern that regular reappointment processes are costly and / or add to uncertainty for the system, it may be appropriate to consider a review of the legislation and extend appointment terms beyond five years. VMO contracts are not fixed term contracts. There are termination provisions, annual performance review provisions, and annual budget review provisions in the VMO Determinations to regularly review performance and service needs and capabilities during the term of an appointment. Indeed, the annual review of budget provisions are provisions infrequently used by PHOs, and it is AMA(NSW)'s view that PHOs and VMOs may be the beneficiaries if these provisions were utilised.

24. The VMO Performance Review system provides PHOs with a discretion to reappoint VMOs who have had satisfactory annual performance reviews without the need to advertise and interview VMOs for seeking re-appointment.[15]

25. AMA(NSW) is very concerned by the claims made by the Australian Salaried Medical Officers' Federation (New South Wales) (**ASMOF**) in its submissions that it would be better to engage a salaried doctor than a VMO, and that VMOs contribute to cost inefficiencies and compromise patient care. There is no apparent basis for those claims. VMOs are consultant medical practitioners in the same way that Staff Specialists are consultant medical practitioners, and all have the same duty of care to the patients under their care. Attempts to diminish and undermine the role of VMOs in the system are unhelpful and divisive. All medical practitioners, regardless of the way they are engaged, are working to provide quality healthcare to patients.

26. The strength of the New South Wales Public Hospital System lies in the mix of VMOs and Staff Specialists.

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[13] Clause 5(4)(b) *Health Services Regulation* 2018 (NSW)
[14] Clause 7 *Health Services Regulation* 2018 (NSW)
[15] NSW Health *Performance Review Policy Directive* PD2011_010
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_010.pdf

27. AMA(NSW) supports a Public Hospital System that provides medical practitioners with choice about the arrangement under which they wish to work. Some will choose VMO arrangements and others salaried roles. In response to ASMOF's submission that VMOs should not replace salaried positions, AMA(NSW)'s position is that if a salaried position cannot be filled, and there is the option to offer a VMO appointment, the VMO appointment should be offered to ensure there is sufficient workforce to meet the needs of the hospital system.

28. Many AMA(NSW) Members say that unless they ask the question, or someone brings it to their attention for one reason or another, they are unable to distinguish between who a VMO is and who is a Staff Specialist. Of the 2023 survey respondents, 57% worked in a Department that was comprised of VMOs and Staff Specialists, 27% had only VMOs in their Department and 16% had only Staff Specialists in their Department.

VMO Arbitrations

29. The first VMO Arbitration was conducted in 1976. It was a private arbitration of the terms and conditions for VMOs providing services on a Sessional basis. A further private arbitration was held in 1978.

30. The first legislative provisions for arbitration were made in 1987 when the *Public Hospitals Act* 1929 (NSW) was amended by the *Public Hospital (Amendment) Act* 1978 (NSW). These provisions made allowance for the appointment of an arbitrator to determine the terms and conditions of work, and rates of remuneration for VMOs engaged on a Sessional basis.

31. Sessional VMO arbitrations were conducted in 1980, 1981, 1982, 1983, 1985, 1993, 1994, 2007 and 2014.

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

33. Annexed to this Statement is a copy of a document 'Overview of VMO Arrangements in NSW 1976 – 2011'.

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

35. In 2007 the most recent significant review of the Sessional Determination was undertaken. The most significant changes were the introduction of the regional support package and payments for cancelled lists.[16]

36. A Fee-for-Service Determination was made in 2007 for the benefit of the system and VMOs.[17] Prior to 2007, Fee-for-Service arrangements were set out in an agreement negotiated by AMA(NSW) and the then NSW Department of Health.

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

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

39. AMA(NSW) and / or the Ministry of Health can apply for the appointment of an arbitrator. AMA(NSW) is consulting with members regarding proposed amendments to the Sessional and Fee-for Service VMO Determinations so to modernise the Determinations to reflect the current ways in which VMOs work and want to work.

40. Following representation to the Ministry of Health from as early as February 2024, in May 2024 AMA(NSW) wrote to the Minister for Health and the Minister for Industrial Relations seeking legislative amendments to ensure the next VMO Arbitration takes place within the NSW Industrial Relations system. Prior to the dissolution of the NSW Industrial Court in 2016, the arbitrator was to be appointed from the Commission. In 2007 and 2014 Justice Walton was appointed as arbitrator. When the Industrial Court was dissolved in 2016, the legislation was amended to provide the arbitrator was to be a former Supreme Court judge or a legal practitioner of at least 7 years' experience. As of 1 July 2024, the Industrial Court in NSW has been re-established and while the interpretation of the VMO Determinations has been returned to the Industrial Court, AMA(NSW) was informed by the Ministry that it was an oversight that the provisions regarding the qualifications of the arbitrator were not amended.

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

[17] *Ibid.*

STATEMENT OF DOMINIQUE EGAN

Sessional and Fee-for-Service Arrangements

41. The features of the *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination* 2014 are as follows:[18]

    (a) VMOs are engaged to provide clinical services to public patients, participate in teaching and training as may be required by the PHO, participate in committees as may be reasonably be required, and participate in the on-call roster;
    (b) Ordinary hours for service provision are to be agreed between the VMO and PHO;[19]
    (c) One of three remuneration options will apply;
    (d) A review of ordinary hours is to take place each year and agreement is to be reached regarding service provision for the coming year;
    (e) Annual performance review;
    (f) Payments will be made for cancelled operating times in prescribed circumstances;
    (g) Remuneration at the established hourly rate for each ordinary hour specified in the contract, an allowance is payable for background practice costs, superannuation as per the *Superannuation Guarantee (Administration) Act* 1992, an on-call allowance is payable when the VMO is rostered to be on-call, and payment for services provided pursuant to a call-back is determined by reference to when the service is provided;
    (h) Additional payments may be made to Regional VMOs;
    (i) Leave is unpaid;
    (j) VMOs must keep a record of services provided and submit claims within defined times;
    (k) Treasury Managed Fund Indemnity Cover;
    (l) A dispute resolution process.

42. VMOs providing services under the Sessional Determination are required to be engaged under the applicable Model Service Contract for Sessional VMOs either as an individual or with the VMO's service entity. [20] As noted above, the terms of the Determination form part of the terms and conditions of the contract.[21]

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

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

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

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

43. The features of the *Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination* 2014 are as follows:[22]

    (a) VMOs are engaged to provide clinical services to public patients, participate in teaching and training as may be required by the PHO, participate in committees as may be reasonably be required, and participate in the emergency after-hours roster;
    (b) A services plan is to be agreed between the VMO and PHO;
    (c) VMOS are remunerated by reference to a percentage of the relevant Commonwealth Medicare Benefits Schedule (***CMBS***);[23]
    (d) A review of the services plan is take place each year and agreement is to be reached regarding service provision for the coming year;
    (e) Annual performance review;
    (f) Payments will be made for cancelled operating times in prescribed circumstances;
    (g) Additional payments may be made to Regional VMOs;
    (h) Leave is unpaid;
    (i) VMOs must keep a record of services provided and submit claims within defined times;
    (j) Treasury Managed Fund indemnity cover;
    (k) A dispute resolution process.

44. VMOs providing services under the Fee-for-Service Determination are required to be engaged under the applicable Model Service Contract for Sessional VMOs – either as an individual or with the VMO's service entity. [24] As noted above, the terms of the Determination form part of the terms and conditions of the contract.[25]

45. Contrary to claims made by some stakeholders, VMOs teach and train DiTs in the Public Hospital System. Many do so for little or no remuneration. As noted above, VMOs are entitled to be remunerated for teaching, but many are discouraged from claiming, or are told there are only limited hours available to be claimed. While not isolated to teaching, VMOs also tell AMA(NSW) that when claims are rejected, the time involved in trying to address the queries of PHOs and resubmit claims is such that many often simply decide not to press claims.

46. VMOs can, and do, hold leadership positions in the New South Wales Public Hospital System. For example, Head of Department positions. The remuneration paid to VMOs for these roles is usually for a set number of hours that does not accurately reflect the time spent. The required

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[22] *Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination* 2014 https://www.health.nsw.gov.au/careers/conditions/Awards/feeforservicedetermination.pdf
[23] NSW Health Information Bulletin Remuneration Rates for Fee-for-Service Visiting Medical Officers IB2019_026 https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2021_054.pdf
[24] NSW Health Policy Directive, Model Service Contracts – VMO and HMO https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_008.pdf
[25] *Health Services Act* 1997 (NSW) Section 98

administrative support provided to Staff Specialist who perform these roles is often not provided to VMOs.

47. The following table sets out the key elements of the Sessional and Fee-for-Service Determinations. Some are by virtue of legislation, for example, Sessional VMO arrangements fall within the Superannuation Guarantee Act and Fee-for-Service arrangements do not, others are historical and are a result of the different origins of the arrangements, for example, Fee-for-Service VMOs are not currently paid an on-call allowance or an allowance for background practice costs.

Component	Sessional	Fee-for-Service
Rates	Hourly rates	Percentage of Commonwealth Medicare Benefits Schedule
Background Practice Costs	Yes	No
After-Hours	Payment of on-call Allowance and call backs	Payment of loadings for after-hours emergency services
Superannuation	Yes	No
Cancelled Lists	Yes	Yes – sessional rates
Teaching, Committees and Meetings	Yes	Yes – sessional rates
Regional incentives	Yes	Yes
Leave	Unpaid	Unpaid

48. Until Fee-for-Service arrangements were arbitrated in 2007, the two arrangements co-existed but were determined under separate pathways.

49. Sessional arrangements are more commonly found in larger quaternary and tertiary referral hospitals where more teaching and training is undertaken as these are facilities where the requirements of Colleges for training, including the required numbers of consultants to supervise trainees, can be met.

The need for reform

50. Regardless of the arrangement under which members work, the need for modernisation of the arrangements is critical. As one respondent to the AMA(NSW) 2023 survey stated:

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

conditions and remuneration, otherwise we will lose more to the private sector or interstate/overseas.'

51. The following addresses aspects of VMO arrangements that AMA(NSW) has identified as needing to be addressed. This is not an exhaustive list.

On-call arrangements

52. AMA(NSW) is acutely aware of the on-call burden on VMOs providing on-call services particularly in regional and rural hospitals. VMOs are not contracted to, remunerated for, or prepared to provide on-call services 24/7 in regional and rural communities.

53. Fee-for-Service remuneration remains an attractive and viable option for many VMOs. Indeed, they can promote efficiency. That said, when it comes to on-call, these arrangements result in a situation where VMOs are making themselves available to provide on-call services but are receiving no compensation for doing so, and when they are called to provide a service, be it in regional / rural or even metropolitan hospitals, the remuneration they receive (if any) does not reflect the time spent and the service provided.

54. Additionally, it has recently been brought to AMA(NSW)'s attention that many VMOs are not being paid the stipulated loadings for services provided when on-call.

55. The above is one example of the way the VMO Determinations do not meet the expectations of the workforce when it comes to modern working arrangements. The last substantive review of the VMO Determinations was in 2007[26] and for the Staff Specialist State Award, 2006[27]. The terms and conditions under both arrangements are overdue for review. The New South Wales State Government's Wages Policy effectively ensured no reform for over 10 years.

Remote service provision

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

57. When Sessional VMOs are on-call they are paid an on-call allowance (currently $14.90 per hour). Fee-for-Service VMOs are not paid an on-call allowance. The on-call allowance is not and was never intended to compensate VMOs for the provision of services.

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

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

58. VMOs rostered on-call under Sessional and Fee-for-Service arrangements will be paid for the provision of a service if they attend the hospital but if they do not physically attend the hospital, they are not remunerated.

59. Under existing arrangements, Sessional VMOs are entitled to claim 20 minutes travel time each way, and then for the time or service provided when they arrive at the hospital. Fee-for-Service VMOs are not paid for travel.

60. VMOs, acting in the best interests of patients and their colleagues, increasingly provide review from home or their rooms rather than traveling to the hospital unless this is warranted or specifically requested. They are not remunerated for these services.

61. There are some specialities where the provision of services from a location other than the hospital is not possible in most cases, for example anaesthesia and obstetrics. However, there are other specialities where this is possible. In the recent AMA(NSW) 2023 Senior Medical Officer Survey, 497 survey respondents answered the question about whether they able to provide services that directly involve patient management from a location other than the hospital, namely, services that involve the review of a patient record, test results other clinical information, the making of decisions regarding the management of the patient and documenting same without attending the hospital, and of those 497, 72% responded in the affirmative.[28]

62. When survey respondents were asked about advances in technology and service provision, 33.4% of survey respondents said that advances in technology had reduced the need for them to attend the hospital to provide services. Of the 501 respondents, 295 said they were and 208 were not able to access the eMR (electronic medical record), results and other clinical information when not physically present at the Hospital. This is a matter that needs to be addressed as a matter of priority.[29]

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

64. Yet the industrial instruments for VMOs and Staff Specialists in New South Wales make no provision for the payment for the provision of services from locations other than the hospital.

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

In contrast, in the Australian Capital Territory VMOs are paid for 'digital call back'. [30] Under the ACT Determination, a VMO who is on-call and called-back to provide a service and can do so using appropriate digital resources without the need to leave their residence or other location remote to the hospital. AMA(NSW) is advocating for the inclusion of the same or similar provision in the VMO Determinations in New South Wales.

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

66. A General Surgeon working under VMO arrangements at two public hospitals told AMA(NSW) that he provides services from locations other than the Hospital and documents his clinical decisions in the patients' medical records. He gave the example of being contacted by a consultant for a second opinion. The VMO was able to access the radiology and blood results immediately and discuss the patient's care with the consultant. A decision was made, the VMO documented same in the medical record and the patient's management proceeded much more quickly than if the team had to wait for him to get to the hospital. The VMO was not paid for this service.

Attendance at Virtual Meetings

67. VMOs are paid for attendance at meetings under the VMO Determinations. During the COVID-19 pandemic, many meetings such as Department meeting and Morbidity and Mortality Meetings were held virtually. Many VMOs expressed the view that this meant they were able to attend more meetings than they could when they were all held in person as it could be difficult when meetings were scheduled on days when the VMO was working elsewhere.

68. Following the return to business as usual, there continues to be a mechanism in many cases for persons to attend in person or virtually. While PHOs will pay for in person attendance, they will not pay for virtual attendance. AMA(NSW) acknowledges concerns of PHOs that it can be difficult to measure engagement when persons attend virtually, however, there are ways to measure it and there should not be a standing refusal to pay all of those who attend virtually as opposed to in person.

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

After-hours and weekend work

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

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

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

71. Other health professionals in the New South Wales Public Hospital System who are required to work evenings and / or weekends are paid a loading for doing so. So too should medical practitioners.

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

Growing discrepancy between public and private earnings

73. The growing discrepancy between earnings in the private and the public needs to be addressed. AMA(NSW)'s survey conducted in 2023, demonstrates that if this is not addressed more practitioners will spend more time in the private and less in the public or leave the public altogether.

> *As an anaesthetist the NSW Public Hospital system is way behind the mark in the offering they currently have. Private work has expanded enormously in terms of sessions and more importantly, hours available each week. The pay differential is too great to make the public offering worth considering in any great quantity - especially given the maximum working capacity and ideal work mix for most anaesthetists.*
>
> *As an example...the Private sessions per month have increased from $450/month a decade ago, to $950/month currently. The public sessions have grown from $600/month to $750/month. Each day the morning private and public sessions are 5*

hours, but the afternoon session is 5 hours public and 8 hours private. This means that a "full" private day is worth 1.5 public days in terms of hours…This means that a 3-day per week anaesthetist with 1:2 split public : private works 36 hours a week, but to earn the same would have to work a 7 day public week!...The landscape is diabolical for the public hospitals trying to staff Anaesthetic departments (not because the anaesthetists are lazy and good for nothing, as they would have you believe) but because the public system is littered with inefficient middle managers … who further disincentivize our natural instinct to give back to the system which trained us.

Outpatient services and background practice costs

74. In circumstances where VMOs are frequently providing outpatient services from their rooms, the payment of an allowance for background practice costs should be extended to Fee-for-Service VMOs.

Rising costs of medical indemnity

75. In the past few years, AMA(NSW) has been contacted by many members concerned about the rising cost of their medical indemnity premiums. In the early 2000s, VMOs were granted indemnity by the Treasury Managed Fund for medical negligence claims arising from the treatment of public patients. In regional areas, VMOs may be indemnified for private inpatients, and there is also an option of cover for private paediatric inpatients. In metropolitan areas there is no Treasury Managed Fund cover for private adult inpatients. In circumstances where many patients on VMOs' emergency lists are classified as private and the VMO is not provided with the opportunity to accept the patient, and these patients are frequently high risk patients, VMOs have told AMA(NSW) they are considering withdrawing from the public system, because the risk of an adverse outcome is greater and a claim made under the medical indemnity cover will negatively affect future premiums. If PHOs wish to assert an obligation on VMOs to treat private patients, Treasury Managed Fund cover should be extended to private inpatients at all facilities.

Locums

76. Locums are a critical part of the NSW Public Hospital System. The term locum is derived from the Latin 'locum tenens' which means placeholder. A 'true' locum is a person who temporarily fills the duties of another.

77. Locums have historically been, and continue to be, engaged to meet short-term service needs including cover for periods of leave (planned and unplanned) or an uptick in service demands. That said, the use of locums has, in some locations, become a part of 'business as usual' in the NSW Public Hospital System.

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

79. In 2023 AMA(NSW) made an application under the *Government Information (Public Access) Act* 2009 (***GIPA***) to the Hunter New England Local Health District (***HNELHD***) for contracts for locums engaged to provide services in the Anaesthetic Department at Tamworth Rural Referral Hospital. In circumstances where the HNELHD was in agreement with the VMOs that reliance on locums needed to be reduced and greater efforts made to attract and retain permanent workforce, the HNELHD representatives were unable to provide information about how much money it had spent on locums in recent years, and in response to the GIPA application, AMA (NSW) was advised the scope was too broad and it was not possible to distinguish between contracts issued to locums and contracts issued to VMOs appointed under standard arrangements.

80. There is no easy answer or answers to how the reliance on locums can be 'fixed' but the answer is not to stop locum arrangements altogether. It may be possible to reduce current rates of locum use by engaging more VMOs or Staff Specialists, but it is a struggle to recruit to these roles due to the out-dated nature of the industrial arrangements and remuneration. The challenge is that many communities in regional and rural areas, to one extent or another, rely on locums to meet business-as-usual service provision because the current industrial instruments are out-dated, and the remuneration and other terms and conditions are not such to attract and retain specialist medical practitioners to live and work in those communities.

81. In 2023 AMA(NSW) was involved in a dispute under the VMO Determination at a regional hospital. Given an ageing workforce and an inability to recruit and retain new consultants who were will willing to participate in an onerous on-call roster, and to reduce the reliance on locums who not infrequently either did not attend or would leave before the end of their placement, and in any case, where not available to provide ongoing care to patients, the VMOs asked the PHO to consider a non-standard remuneration arrangement to recruit new consultants. There was no willingness on the part of the PHO or the Ministry of Health to consider such a proposal. While non-standard arrangements have limitations (see below), it was a matter that at the very least should have been considered.

82. AMA(NSW) is aware that there are hospitals where locums have been engaged to provide services when consultants at those hospitals could have undertaken the work, but they were not offered the additional work. Not only was no effort made to identify local capacity, but the remuneration also offered to locums (plus accommodation and travel) meant the work was done at a higher cost than it would have if done by existing VMOs. Of additional concern is that at these same hospitals, when VMOs request locum cover so they can take much needed leave, their requests have been refused.

83. In 2007 when the Professional Support Payment was introduced for Sessional and Fee-for-Service for VMOs providing services at regional hospitals, one of its specified purposes was to help VMOs cover locum costs. It was not to the cover the costs of engaging a locum to provide cover in the public hospital as this is cost neutral because the VMO is not paid when on leave and the public hospital pays the locum for services that may otherwise have been provided by the VMO. The payment was and is intended to contribute to the costs of having a locum provide cover for the VMO in their rooms. Most regional VMOs provide outpatient services from their private rooms because there is no public clinic at the hospital. These are services provided at the VMO's cost.

84. Over time, it has become increasingly difficult for VMOs to access the Professional Support Payment for locum expenses. The Ministry of Health refuse to pay claims for locum expenses when a VMO is on anything other than conference leave and stipulates that costs can only be claimed when the VMO is at the conference and for the net costs of engaging the locum. This is not what is provided for in the Determinations, and not what was contemplated in 2007.

Fee-for-Service Remuneration

85. AMA(NSW) does not advocate for the abolition of Fee-for-Service arrangements, indeed, the arrangement can benefit VMOs and PHOs. That said, there needs to be a review of the arrangements to ensure VMOs are appropriately remunerated. I have addressed above the anomalies of on-call remuneration for Fee-for-Service VMOs.

86. The remuneration paid to Fee-for-Service VMOs is based on the CMBS fee schedule. If there is no applicable CMBS item for the service provided then no claim can be made. There is no payment for being up for hours at night awaiting the arrival of a critically ill patient being transferred in from a remote location and liaising with the retrieval team about the care of the patient on route to the hospital, or coming in for an emergency case and waiting for an available theatre.

87. The CMBS was agreed upon as the fee schedule for payment for Fee-for-Service VMOs. The CMBS was not and is not designed for the delivery of all services in a public hospital. It was intended to provide a reference point for fees, but has since become a means of restricting the remuneration that can be claimed and paid to a VMO.

88. In the past, there was flexibility provided in terms of items claimed for services, for example, in relation to a patient who underwent a procedure in a rural hospital, a VMO could claim and would be paid for a 104 consultation later the same day as the surgery to avoid the need for the patient to travel into the regional centre for the consultation at another time. Now those claims are rejected because they do not strictly meet the requirements of the CMBS which provides a 104 cannot be claimed on the same day as a procedure.

VMoney

89. The VMoney system for VMO Claims requires review. It has been suggested on a number of occasions that claims cannot be paid as provided for in the Determination because that is not how VMoney is set up. VMoney should reflect the requirements of the Determination.

90. Concerns have recently been raised with AMA(NSW) by Fee-for-Service VMOs that it is very difficult to identify whether they are being paid at the correct rate. Further, claims for loadings appear not to be recognised by VMoney.

91. The system for checking of claims frequently means VMOs are paid more than one month after the submission of claims. Most manage to pay within the 45 days before interest accrues. The latitude granted to PHOs is disproportionate to the scrutiny to which VMOs are subjected. While there is no objection to an audit process, it must be more efficient and respectful of VMOs. For claims to be checked by an administrative officer and rejected without consultation with the VMO is unsatisfactory. Feedback provided to PHOs from VMOs is that once a claim is rejected, the time it takes to identify the issue, address the issue, and resubmit the claim, often months after the service was provided, is prohibitive and often VMOs do not pursue the claim.

92. The Ministry policies on the auditing of claims are framed in such a way that suggests VMOs are often submitting inflated claims to maximise income with little or no acknowledgement that VMOs and PHOs can make honest errors in the submission and / or processing of claims.

Non-standard arrangements for medical practitioners in the NSW Health System

93. In a system where there are workforce shortages either based on region and / or specialty, coupled with a need for reform of arrangements, there is a place, for consideration of non-standard arrangements, be this for VMOs or Staff Specialists or DiTs.

94. It is critical that there be transparency about any non-standard arrangements that are in place, the rationale for each arrangement and that the application and scope are clearly defined. It is a lack of transparency and consistency that can undermine the benefits that a non-standard arrangement may serve in addressing an urgent workforce need.

95. At paragraph 81 above I referred to an example where a non-standard arrangement could have been considered, but the PHO and Ministry of Health declined to do so.

96. The reasons why DiTs are not taking up places in regional and rural areas is an issue which must be explored to ensure these can be meaningfully addressed. For example, this year Dubbo was only able to place 2 interns, with 10 positions unfilled. In the interim, non-standard remuneration arrangements for those hospitals which are struggling to fill positions should be an option that is put on the table for discussion.

Complaints Processes

97. AMA(NSW) has made a submission to the Special Commission of Inquiry regarding NSW Health Complaints Processes. The submission addresses the lengthy delays in the progress of investigations, the lack of transparency such as the refusal to provide the risk assessment to the medical practitioner who is the subject of the assessment, a failure to afford medical practitioners to right to be heard before determining to suspend the practitioner or place restrictions on their practice, and the failure to have regard to the impact of a complaint on the well-being of the medical practitioner, as well as the delivery of clinical care to patients.

98. AMA(NSW) has consulted with the Medical Defence Organisations (**MDOs**) who are often contacted by medical practitioners seeking advice and representation. Observations made by the MDOs included the following:

    - While NSW Health has very clear policies in place regarding the management of complaints, grievances, misconduct and bullying, the experience of MDOS and their members was that the very broad confidentiality requirements may prevent practitioners from reaching out to peers for support and that this can adversely affect the medical practitioner's mental health and well-being;

    - Concern about the length of time taken to complete investigations. The average length of time taken to complete investigations was reported to be 8 months by two MDOs.

Processes and procedures for lodging complaints and disputes

99. Under the VMO Determinations there is a Disputes Mechanism. The Disputes Mechanism originated from the mediation directed by the Full Bench of the Commission in 1994 when it was determining the appeal from the Hungerford Determination. The disputes mechanism was intended to provide an efficient and cost-effective means for VMOs to raise concerns with PHOs.

100. In 2007 the process was streamlined to address concerns that there were too many steps in the process.

101. Dispute resolution processes are now commonly found in many contracts, providing parties with efficient and cost-effective pathways to resolve disputes.

102. It is my experience that despite the disputes process forming a part of the VMO's contract with the PHO, some PHOs are reluctant to engage or refuse to engage in the process, or otherwise do not comply with the timeframes provided. This further adds to angst or disillusionment on the part of the VMO who has notified the dispute, or on whose behalf a dispute was notified. For example, a dispute was lodged at one hospital in July 2023 and the VMOs could not secure a meeting with the PHO until May 2024. Under the disputes process, meetings are to occur within 2 weeks of notification of the dispute. In another case, the PHO, having engaged in the initial stages of the Dispute process now refuses to engage in mediation

and have threatened the VMOs against pursuing the matter advising they will seek costs from the VMOs and / or AMA(NSW) should they do so.

103. That said, there are other examples where PHOs have complied with the disputes process has resulted in resolution to the satisfaction of both parties.

104. The difficulty with non-compliance on the part of a PHO is that while a VMO could pursue the PHO for non-compliance with the contract, most are reluctant to do so for all the obvious reasons.

105. If PHOs do not wish to engage in alternative dispute resolution, then consideration must be given to providing VMOs with other avenues to raise and resolve disputes.

106. The Disputes process does not extend to disputes about decisions of PHOs to suspend, terminate or reduce the clinical privileges of VMOs. VMOs have a right of appeal regarding these decisions under the *Health Services Act*. A Committee of Review is established to determine appeals. Over time, the Committee of Review process has become increasingly legalistic, pre-hearing processes and hearings are lengthy, and costs are not insignificant. AMA(NSW) was pleased to engage with the Ministry as a part of a review of the process and concerns regarding same in 2023. The review process resulted in a draft Practice Note to try to better manage the process, so it is more efficient and cost-effective. AMA(NSW) hopes that once the Practice Note is finalised, improvements will be realised (with or without accompanying legislative reform). It is essential that there are improvements in this process.

107. It is of concern to AMA(NSW) that in some cases PHOs do not progress their investigation processes once an appeal is lodged. The two should continue side by side. If a PHO should decide at the conclusion of its own investigation that, for example, a decision to suspend should be withdrawn, then the appeal can be withdrawn.

Medical Staff Councils

108. Having had the opportunity to review the Commission's Issues Paper 1/2024, AMA(NSW) convened a meeting of the Medical Staff Council Chairs on the evening of 27 June 2024 to discuss their views on whether the Medical Staff Council at their hospital provides an effective mechanism for communication with the Executive and Administration at their hospitals. As one might expect given the size of the NSW Health System, there were differing views. Some expressed the view that the Executive regularly attended meetings and engaged with the Medical Staff Council. Others expressed quite a different perspective: that the relationship between the Medical Staff Council and the Executive was strained and, in some cases, almost combative.

109. The consensus from attendees was that, even where there was reasonable engagement and communication, there needed to be work done to engage medical practitioners in the hospital and service delivery planning and service delivery. All acknowledged the health system has finite resources and said that there was a need to make sure medical staff were a part of the

conversation about resource allocation. Medical staff are increasingly feeling marginalised from decision-making, and while the Medical Staff Council could provide the forum, there was a need to perhaps revisit the By-Laws and the role of the Medical Staff Council.

110. AMA(NSW) would like to see VMOs remunerated for attendance at Medical Staff Council Meetings. This would help VMOs (and PHOs) to recognise the valuable contribution that can be made by participating in the Medical Staff Council.

111. Having spoken at a number of Medical Staff Council meetings recently and noting that some of those were held specifically on the issue of the VMO Determinations, I make the observation that attendance and engagement varies considerably across hospitals.

Doctors-in-Training

112. It is not only the arrangements of Senior Doctors that need reform. The Public Hospital Medical Officers Award has not been the subject of meaningful reform for many years.

113. The remuneration paid to DiTs in New South Wales continues to fall behind other States and Territories, as does the payment for benefits such as study leave.

114. Doctor-in-Training are employed on fixed term contracts, in some cases of only one- or two-years duration. The need to apply for positions over many years is a cause of stress. The need to submit detailed applications and all supporting documentation each time creates an administrative burden on DiTs and presumably PHOs.

115. The short-term contracts are a very real problem for many, including unaccredited registrars. Many training programs are very competitive, and many medical practitioners work as an unaccredited registrar for several years to gain experience and set them apart from their peers before being accepted on to a training program. It is more often the case than not that unaccredited registrars will be employed on one-year contracts and must apply for a position each year.

116. As noted above at paragraph 93 the reasons why DiTs are not taking up regional and rural places should be explored as a matter of urgency. If incentives are indicated, then these should be considered. While not determinative of the matter, there at least a better chance that a DiT who has completed one or more regional rotations and had a positive experience will consider returning to the regional or rural area in the future to work.

117. AMA(NSW) is often contacted by DiTs who are on rotation to a regional or rural area only to find themselves in accommodation that is not clean and / or unsafe. Rising costs of living and a shortage of accommodation in regional and rural areas means there are often few if any viable alternative options for DiTs beyond the hospital-provided accommodation.

118. AMA(NSW) supports the role of Colleges as the providers of high quality training and maintain professional standards. It is important for PHOs to work with the Colleges to ensure employment arrangements are sufficiently flexible to align with training programs.

STATEMENT OF DOMINIQUE EGAN

119. As with VMOs and Staff Specialists, Award reform for DiTs is critical. The Award needs to reflect the ways in which DiTs work. Recently negotiated amendments to the Award arising from the settlement of the DiT class action, has seen an increase in on-call payments which is welcomed, but at the same time, removed the mechanism for DiTs to claim for services provided from home. While not privy to the negotiations, it is critical that Awards provide for all medical practitioners to be fairly remunerated for services they provide in the Public Hospital System, be they provided in person or able to be provided from locations others than the hospital.

120. Remote service provision does not replace the need to attend a patient, but can complement the provision of care, and indeed, assist to meet service delivery needs at locations where recruitment and retention is a struggle.

Dated: 25 July 2024

Dominique Egan

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Dominique Egan

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

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

VISITING MEDICAL OFFICER DETERMINATIONS

1. Legislative Provisions regarding Arbitrations

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

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

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

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

2. Sessional Arrangements

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

(a) The basis and rates of remuneration;

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

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

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

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

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

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

2.5. The features of the Determination were as follows:

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

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

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

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

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

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

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

(h) long service leave was granted to VMOs;

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

The 1978 and 1980 Determinations

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

1981 Determination

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

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

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

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

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

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

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

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

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

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

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

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

1982 Determination

2.9. In 1982 the main changes were as follows:

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

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

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

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

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

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

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

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

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

1983 Determination

2.10. The significant changes were as follows:

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

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

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

1985 Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hungerford Arbitration

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

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

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

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

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

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

$$\frac{11 \times 100}{41} = 26.83\%$$

(e) As a consequence of the effect of the *Superannuation Guarantee (Administration) Act* 1992 and its consequences for State Government employment, superannuation was excluded;

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

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

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

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

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

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

(l) Hourly rates:

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

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

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

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

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

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

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

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

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

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

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

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

2.18. In terms of call backs:

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

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

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

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

The decision of the Full Bench in 1993

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

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

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

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

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

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

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

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

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

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

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

1994 Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) Disputes mechanism.

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

The 2007 Determination

2.28. The features of the Determination were as follows:

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

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

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

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

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

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

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

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

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

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

3. Fee for Service Arrangements

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

1985 Doctors' Dispute

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Fee-for-Service arrangements;

(b) Sessional arrangements; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Rural Doctors arrangements

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

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

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

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

Attachments

1. Visiting Medical Officers case 1991 - 1993: Hungerford J's Reasons for Determination
2. Visiting Medical Officers case 1991 – 1993: Appendices to the Reasons for Determination
3. Orders made by the Full Commission dated 24 December 1993
4. Reasons for the decision of the Full Commission
5. Full Commission's Speaking to Minutes of Determination and Order Statement dated 25 March 1994
6. 1994 Sessional Determination
7. Sessional Determination Contextual Overview
8. Sessional Standard Form Contract dated 1994
9. Public Hospitals (Sessional Contracts) Determination 2007
10. Terms of Settlement of the NSW Doctor's Dispute
11. Agreement between the NSW Branch of the Australian Medical Association and the NSW Department of Health
12. Fee-for-Service Standard Form Contract
13. Fee-for-Service Contextual Overview
14. Public Hospitals (Fee-for-Service Contracts) Determination 2007