Public Accounts Committee

INQUIRY INTO THE USE OF VISITING MEDICAL PRACTITIONERS IN THE WESTERN AUSTRALIAN PUBLIC HOSPITAL SYSTEM

Report No. 2

In the Thirty-Sixth Parliament

2002

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State Law Publisher
10 William Street
PERTH WA 6000

Telephone: (08) 9321 7688
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Published by the Legislative Assembly, Perth, Western Australia 6000

Printed by the Government Printer, State Law Publisher

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Report No. 2
In the Thirty-Sixth Parliament

Presented by:

JOHN D'ORAZIO, MLA

Laid on the Table of the Legislative Assembly
on Thursday, 5 December 2002

COMMITTEE MEMBERS

Chairman	Mr John D'Orazio, MLA Member for Ballajura
Deputy Chairman	Hon. Monty House, MLA Member for Stirling
Members	Mr John Bradshaw, MLA Member for Murray-Wellington
	Mr Tony Dean, MLA Member for Bunbury
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Mr Andrew Young and Ms Jovita Hogan

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COMMITTEE'S FUNCTIONS AND POWERS

The Public Accounts Committee's establishment, powers and functions are provided for within Standing Orders Nos. 284–286 of the Legislative Assembly. Under its Standing Orders, the Public Accounts Committee is empowered to inquire into and report on any proposal, matter or thing it considers necessary, connected with the receipt and expenditure of public moneys, including moneys allocated under the annual Appropriation bills and Loan Fund.

Under Standing Order 285, the Public Accounts Committee may:

(1) Examine the financial affairs and accounts of government agencies of the State which includes any statutory board, commission, authority, Committee, or trust established or appointed pursuant to any rule, regulation, by-law, order, order in Council, proclamation, ministerial direction or any other like means.

(2) Inquire into and report to the Assembly on any question which:

  (a) it deems necessary to investigate;

  (b) is referred to it by resolution of the Assembly;

  (c) is referred to it by a Minister; or

  (d) is referred to it by the Auditor General.

(3) Consider any papers on public expenditure presented to the Assembly and such of the expenditure as it sees fit to examine.

(4) Consider whether the objectives of public expenditure are being achieved, or may be achieved more economically.

The general provisions for standing and select Committees (Standing Orders Nos. 248–281) also apply to the Public Accounts Committee.

INQUIRY TERMS OF REFERENCE

On 26 September 2001, the Public Accounts Committee resolved to adopt the following terms of reference:

That the Public Accounts Committee examine and report on the use of visiting medical practitioners (VMPs) for the provision of medical services in the Western Australian public hospital system, with particular reference to the:

- use of VMPs in the public hospital system;
- terms and conditions of engagement of VMPs; and
- compliance and accountability within an output based management framework.

CHAIRMAN'S FOREWORD

I am pleased to present to the Legislative Assembly of the Parliament of Western Australia, the second report of the Public Accounts Committee in the Thirty-Sixth Parliament.

The Public Accounts Committee would like to commend the world-class service provided to West Australians by the highly skilled and dedicated medical practitioners of this State. The Committee was impressed by the dedication and commitment demonstrated by Western Australian doctors to their patients. The Committee also recognises the tremendous impact on lifestyle and families and, as such, the significant personal sacrifice, that many of the State's doctors make, particularly those working in the country, in the delivery of services to their public patients.

The Committee would like to thank the Director General of the Department of Health, Mr Mike Daube, the former Acting Commissioner of Health Prof. Bryant Stokes and the staff of the Department of Health, particularly Mr Brian Troy, Mr Philip Aylward, Mr Neil Purdy, Mr Peter Bartlett and Ms Molly Abbott for their co-operation and assistance in providing information to the Committee throughout the course of its inquiry.

I thank my fellow Committee members; Hon Monty House, Mr John Bradshaw, Mr Tony Dean and Mr Martin Whitely, for their individual and collective contributions to this report. I also thank the Committee's staff, and in this regard I acknowledge the efforts of the former Principal Research Officer, Ms Stefanie Dobro, and former Research Officer, Ms Linlee Davies. I would also like to thank Mr Chris Johnson who was seconded from the Office of the Auditor General to assist with the inquiry.

The final report was prepared by Mr Andrew Young and Ms Jovita Hogan and I would like to pass on both my own and the Committee's appreciation for their diligent efforts, professional attitude and hard work, particularly over the past few months.

I commend the report to the House.

JOHN D'ORAZIO, MLA

CHAIRMAN

ABBREVIATIONS AND ACRONYMS

AA&IS	Account Assessment and Information System
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMA (WA)	Australian Medical Association (Western Australia)
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
CMBS	Commonwealth Medical Benefits Schedule
CPI	Consumer Price Index
FRACGP	Fellow of the Royal Australian College of General Practitioners
GP	General Practitioner
HARC	Health Administrative Review Committee
HCARe	Health Care and Related Information System
HIC	Health Insurance Commission
MHSB	Metropolitan Health Service Board
OTD	Overseas-Trained Doctor
PAC	Public Accounts Committee
PBS	Pharmaceutical Benefits Scheme
RACGP	Royal Australian College of General Practitioners
RACS	Royal Australasian College of Surgeons
RMO	Resident Medical Officer
TRD	Temporary Resident Doctor
UWA	University of Western Australia
VMO	Visiting Medical Officer
VMP	Visiting Medical Practitioner
WAGMSS	Western Australian Government Medical Services Schedule

GLOSSARY

Administrator	A person mainly employed in medical administration.
Clinician	A medical practitioner primarily involved in the treatment of individuals, including diagnosis and prevention action.
Committee	Refers to the Public Accounts Committee.
Consultant/Specialist	A medical practitioner with an appropriate qualification from a university or college, recognised by the Australian Medical Council.
Department of Health	Western Australian Department of Health.
General Practitioner (GP)	A medical practitioner whose practice is predominantly general practice, that is the provision of primary, continuing whole-patient care to individuals, families and the community, and who has appropriate training and experience in general practice.
GP Obstetrician	A general practitioner registered to practice medicine by a State or Territory, usually with the Diploma of the Royal Australian College of Obstetricians and Gynaecologists who provides maternity care. Part or all of antenatal, intrapartum and postnatal care may be provided by the general practitioner.
Inpatient	Any person formally admitted to a hospital.
Intern	A resident medical practitioner working in a hospital, (usually a tertiary hospital), usually in the first year of service after graduating from medical school.
Locum	A medical practitioner who acts as a substitute for another medical practitioner while that practitioner is temporarily absent from their practice.
Medicare	A national, government-funded scheme that subsidises the cost of personal medical services, and that covers all Australians to help them afford medical care.
Medicare Providers	Medical practitioners who billed Medicare for at least one private practice occasion of service during a given financial year.

Medicare Services	Services provided on a 'fee-for-service' basis for which Medicare benefits are paid.
Non-inpatient	Persons not requiring admission to hospital, but who receive admission in accident and emergency (casualty) departments or undergo short-term specialist treatment (such as minor surgery, radiotherapy or chemotherapy), receive care from a non-admitted patient service/ clinic of a hospital or are treated in their own homes through home nursing programs. Previously refer to as outpatients.
Overseas-Trained Doctor	A person who obtained an initial medical qualification in a country other than Australia. The qualification must be recognised as equivalent to an Australian medical qualification for the person to obtain registration as a medical practitioner in Australia.
Outpatient	*See non-inpatient*
Pharmaceutical Benefits Scheme	Commonwealth Government scheme which provides a comprehensive range of pharmaceuticals at a subsidised cost.
Private Patient	A person who elects to be responsible for fees charged by the hospital and medical professionals.
Privately-referred non-inpatient	In NSW, under certain conditions, doctors working in a public hospital can reasonably treat patients attending the hospital as private patients and subsequently raise charges accordingly. If a non-inpatient is privately referred to a specific doctor at a public hospital outpatient clinic or diagnostic service, there is scope for patient charges to be raised. The basis of private non-inpatient billing of outpatient and diagnostic services rests in the requirement for a private referral.
Public Patient	A person who elects to receive care as defined by the Medicare Agreements. or A patient in respect of whom a hospital or health service provides comprehensive care, including all necessary medical, nursing and diagnostic service by means of its own staff or by other agreed arrangements.
Registrar	A registered medical practitioner employed as a Registrar. A Registrar may be employed with or without the Part 1 Examination of an appropriate specialist qualification recognised by AMC.

Resident Medical Officer	A medical practitioner undergoing further training in a hospital after completing an internship but who has not commenced a recognised general practice or specialist practice training program.
Salaried Medical Officer	A full time medical doctor who is an employee of the hospital, receiving all employee-related entitlements.
Secondary Hospital	In Western Australia means, Armadale-Kelmscott Hospital, Bentley Hospital, Kalamunda Hospital, Osborne Park Hospital, Swan District Hospital.
Senior Registrar	A registered medical practitioner appointed as a Senior Registrar, who has obtained an appropriate specialist qualification acceptable to the AMC or recognised by the Director General of Health.
Session	Generally, 3.5 hours
Sessional	Salaried doctors engaged on a part-time basis who are paid per session worked.
Specialist	A medical practitioner with a qualification awarded by, or which equates to that warded by, the relevant specialist professional college in Australia. Specialist recognition is normally based on the completion of a program of appropriate supervised training covering a minimum of six years after initial medical graduation and an examination leading to the award of a higher qualification.
Teaching Hospital	In Western Australia, a hospital declared to be a teaching hospital pursuant to the provisions of the *University Medical School, Teaching Hospitals Act 1955* as amended.
Tertiary Hospital	In Western Australia means Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital or King Edward Memorial Hospital/Princess Margaret Hospital for Children.
Temporary Resident Doctor	A citizen of another country who has an immigration visa enabling them to be employed as a medical practitioner in Australia. The person's qualifications must be recognised for conditional registration by the relevant State medical board.

The State	State of Western Australia
Triage Category	The urgency of the patient's need for medical and nursing care in an Emergency Department. Patients are assessed and allocated a triage score from 1 to 5. Patients in category 1 are determined as being the most urgent cases, and patients with a triage score of 4 and 5 are typically patients seen by general practitioners.
Visiting Medical Officer	Term used, predominantly in the Eastern States, to refer to a medical practitioner appointed to provide medical services for hospital (public) patients on a fee-for-service basis. A VMO is an independent contractor regardless of whether payment made on a sessional or fee-for-service basis.
Visiting Medical Practitioner	Term used, predominantly in Western Australia, to refer to a medical practitioner (general practitioner or specialist) appointed to provide medical services for hospital (public) patients on a fee-for-service basis. VMP is an independent contractor.
Vocationally Registered GP	A primary care practitioner who has been registered by the Health Insurance Commission as a recognised general practitioner. The criteria for registration are certification from either the Royal Australian College of General Practitioners, a Vocational Registration Eligibility Committee, or the Vocational Registration Appeal Committee, that the practitioner's medical practice is predominantly general practice, and that the practitioner has appropriate training and experience in general practice.

FINDINGS

Chapter Three - Compliance and Accountability in the VMP System

Finding 1 p.16

The hospitals examined as part of the audit of Visiting Medical Practitioner (VMP) payments considered that the current VMP payment system – the Account Assessment and Information System (AA&IS) – was an improvement on the previous Doctor Accounting System.

Users of the AA&IS believe it is an effective tool for ensuring that most financial accountability requirements can be met, while also enabling VMP claims for payment to be processed in a timely manner.

Finding 2 p.20

Most hospitals examined were not undertaking procedures to verify that, prior to payment of a VMP's account, the fees claimed by the VMP were commensurate with the service provided. This impacts upon the capacity of hospitals to meet their statutory obligations under the *Financial Administration and Audit Act 1985* (FAAA), and reduces assurance that that the hospital has received value for money expended in the form of payment only for services delivered, and at the correct rate.

Finding 3 p.23

Where VMP claims for payment were verified, they were largely verified to the hospital's computerised Total Patient Admissions System (TOPAS) (metropolitan hospitals), Health Care and Related Information Systems (HCARe) (rural hospitals), or the theatre management system. However, as TOPAS, HCARe or the hospital's theatre management system only contain subsets of the information maintained in the hospital patient's medical record, there is not always detailed enough or sufficient information in these systems to facilitate verification of a VMPs claim for payment.

Finding 4 p.24

Where VMP claims are verified to Total Patient Admissions System (TOPAS), Health Care and Related Information Systems (HCARe) or the hospital's theatre management system, this involves a largely inefficient manual checking process.

Finding 5 p.26

The audit of the VMP payment system at four public hospitals revealed that:

- In 20 per cent of the claims examined, documentation on the hospitals' theatre management system or Total Patient Admissions System (TOPAS) did not support the level of fee claimed.
- Even when examining the hospital patient medical record, $2.8 million in payments could not be validated by any of the systems available.

VMP payments to the value of approximately $2.8 million have been made where there may have been either limited or no information available in TOPAS, HCARe, or the hospitals' theatre management system, to adequately substantiate these claims for payment.

Finding 6 p.28

There is little or no analysis of VMP payments performed to review trends and exceptions, with most reviews of VMP data generally being restricted to financial budgeting and reporting.

At the end of June 2002, not all public hospitals were using the Account Assessment & Information System (AA&IS), despite a directive from the Acting Commissioner of Health in September 2001 to do so.

Finding 7 p.29

The Department of Health has invested considerable resources into the development and ongoing operation of the Account Assessment & Information System (AA&IS), which has provided a system that may be suited to other Australian States that have similar types of medical service payments.

Finding 8 p.33

Approximately 25 per cent of all VMPs are currently employed by Public Health Services on both a salaried and VMP fee-for-service basis. However, contrary to the requirements of the *Public Sector Management Act 1994*, formal approval to undertake this dual employment has not been obtained in most instances.

Whilst Health Services may facilitate dual employment arrangements for operational reasons, these arrangements have the potential to create a number of issues that need to be considered carefully including:

- Possible adverse impacts upon the capacity of the employing hospital to effectively deliver quality of care to its patients.
- Cost inefficiencies associated with paying medical practitioners a dollar premium for providing the same, or similar service, at two different hospitals within the same health system.
- Possible conflict of interest scenarios.

Chapter Five - The VMP System: The Structure of the Metropolitan Health Services

Finding 9 p.43

The Committee supports the restructure of the Metropolitan Health Services into four Area Health Services, as recommended by the Health Administrative Review Committee.

Finding 10 p.45

The Department of Health was not aware of the scale of payments being made to some high earning Visiting Medical Practitioners.

Chapter Six - The VMP System: The Supply of Doctors

Finding 11 p.55

Western Australia has the lowest ratio of clinicians to population of any Australian State or Territory.

Finding 12 p.62

Funding for undergraduate places in Western Australia's medical school has significantly failed to meet the State's increasing demand for doctors.

Finding 13 p.64

Initiatives such as rural placements for medical students and the Rural Clinical School, are crucial first steps in encouraging doctors to practice in rural areas.

Finding 14 p.65

Use of secondary hospitals and privately managed public hospitals will increase training positions for training purposes.

Finding 15 p.66

The combined problems of training shortages, shortages of GPs and specialists, and areas of unmet need are not being adequately addressed across State and Federal levels.

Finding 16 p.70

The onerous hours involved in training for specialties has proved a disincentive for some medical school graduates to further their training.

Finding 17 p.70

Changes in lifestyle preferences and gender mix have resulted in a reduced number of working hours per doctor. The Australian Medical Association (AMA) 'safe hours' campaign is likely to exacerbate this trend.

Finding 18 p.72

There has been an increasing reliance on overseas-trained doctors in the Western Australian health system.

Finding 19 p.72

The importation of doctors into Australia is depriving countries like South Africa of much needed medical service and also prevents suitably qualified Australian students from becoming medical doctors.

Chapter Seven - The VMP System: Commonwealth State Relations in Funding Health

Finding 20 p.78

Medicare rebates have failed to increase in line with the Consumer Price Index (CPI).

There has been a corresponding increase in the number of attendances at emergency departments.

Chapter Eight - The VMP System: Fee Schedules

Finding 21 p.83

With the exception of New South Wales, other States predominantly employ salaried doctors in the metropolitan region and restrict their reliance on VMPs to the rural areas. Even in New South Wales the reliance on VMPs in the metropolitan area is minimal.

Finding 22 p.83

The Schedule of Fees contained in the July 2002 Medical Services Agreement provides for payments for most items at 9% premium above the Commonwealth Medicare Benefits Schedule. At 9% above the CMBS, this premium is higher than what is being paid for VMPs in other States.

RECOMMENDATIONS

Chapter Three - Compliance and Accountability in the VMP System

Recommendation 1 p.21

The Department of Health, in conjunction with the various Health Services, should review the current Visiting Medical Practitioner (VMP) payment arrangements, identify and resolve any impediments to hospitals' ability to satisfy the Incurring and Certifying Officers requirements of the FAAA 1985.

Recommendation 2 p.21

The Committee believes that, in addition to the requirements of the FAAA 1985, the VMP accounts for payment should be verified by an accountable process.

The Department of Health should implement a documented verification process for VMP claims.

Recommendation 3 p.23

The Department of Health should implement a system that combines the Total Patient Admissions System (TOPAS), Health Care and Related Information Systems (HCARe), or the hospitals' theatre management system, and the patient's medical record, so that reconciliation of VMP payments can occur.

Recommendation 4 p.24

The Department of Health, in conjunction with the various Health Services, should automate the authentication process of VMP payments.

Recommendation 5 p.28

The Department of Health should implement a process that identifies excessive or exceptional VMP payment trends.

Recommendation 6 p.29

- The Department of Health should immediately implement the Account Assessment and Information System (AA&IS) in all hospitals in accordance with the directive from the Acting Commissioner of Health in September 2001.
- Overall coordination of audit and best practice review of VMPs should be placed with the Department of Health, with relevant input from the various hospitals concerned.
- After two years in operation, the Department of Health should seek input from the AA&IS users in relation to the functionality of the system and areas for improvement or enhancement.

Recommendation 7 p.30

The Department of Health should actively pursue on-sale opportunities of the Account Assessment and Information System (AA&IS) to external buyers, while having due regard to relevant Government policies.

Recommendation 8 p.33

Where VMPs are referring patients to hospitals for the VMP themselves to provide procedures, an audit or approval process to ensure the efficacy of such procedures should be implemented.

Recommendation 9 p.33

The Department of Health should implement a process to ensure that, where VMPs are employed as salaried doctors at teaching hospitals, patients are not sent to other hospitals and treated by the same doctors in their role as a VMP.

Recommendation 10 p.33

The Department of Health should ensure that approvals are obtained for all medical practitioners currently undertaking dual employment arrangements.

The Department of Health should advise the relevant Health Services of the requirements of the *Public Sector Management Act 1994* and, in conjunction with the Health Services, develop appropriate policies and procedures to ensure that approvals are obtained where dual employment arrangements are being undertaken.

Chapter Four - The VMP System: Overview of Issues

Recommendation 11 p.40

In country areas VMP services are an appropriate method of delivering cost-effective health services to the community and be should be continued.

Recommendation 12 p.40

In the metropolitan area VMPs should be phased out as and when constraints surrounding the structure of the Metropolitan Health Services, the supply of doctors, and Commonwealth-State relations allow.

Recommendation 13 p.40

The Department of Health should conduct a comprehensive cost-benefit analysis of all employment models to determine which model is best suited in each circumstance, both metropolitan and rural.

Chapter Five - The VMP System: The Structure of the Metropolitan Health Services

Recommendation 14 p.43

In implementing the recommendations of the Health Administrative Review Committee there should be greater use of the metropolitan non-teaching hospitals and privately managed public hospitals for training purposes.

Recommendation 15 p.43

The Committee recommends the Metropolitan Health Service should be a fully integrated system under the direct control of the Director General of Health.

Recommendation 16 p.43

As a consequence of the restructure of the Metropolitan Health Services, the Department of Health should encourage clinical appointments to Area Health Services, or joint appointments at teaching and non-teaching hospitals within a given Area Health Service.

Recommendation 17 p.43

The Department of Health should review the role of each hospital within a given Area Health Service to ensure that the current structure is an efficient means of providing quality of care.

Recommendation 18 p.45

The Department of Health should introduce financial accountability controls that prevent and detect over-servicing by VMPs.

Recommendation 19 p.47

The Department of Health should introduce co-located GP clinics at public hospital sites.

Recommendation 20 p.48

The Department of Health should introduce bulk billing for privately referred non-inpatients in the State's public hospitals.

Recommendation 21 p.48

The Department of Health should establish clear guidelines for the billing of patients for outpatient services.

Recommendation 22 p.49

The Committee recommends that consideration be given to the establishment of centres of excellence by the Department of Health.

Recommendation 23 p.52

The Department of Health should implement the use of secondary hospitals, and privately managed public hospitals, as a means of increasing the capacity of teaching hospitals. This should be done in conjunction with the establishment of centres of excellence.

Chapter Six - The VMP System: The Supply of Doctors

Recommendation 24 p.55

The ratio of clinicians to population in Western Australia should be increased to at least the national norm by year 2010.

Recommendation 25 p.57

The Department of Health should insist that the Australian Medical Workforce Advisory Committee (AMWAC) give consideration to the special circumstances in Western Australia when forecasting medical labour force requirements.

The State Government should insist that there be a representative from Western Australia on the AMWAC board.

Recommendation 26 p.59

The VMP fee schedule should continue to attract a premium in areas where medical practitioners do not have back up, such as in rural areas.

Recommendation 27 p.59

The Department of Health should establish a locum pool of practitioners to relieve doctors in rural areas. This should be done in conjunction with the teaching hospitals, the Federal Government and the Australian Medical Association.

Recommendation 28 p.59

The Department of Health should further examine the current fly in – fly out surgical specialist service based at the University of Western Australia and Sir Charles Gairdner Hospital with a view to expanding the service to areas of unmet need.

Recommendation 29 p.60

The State Government should negotiate with the Federal Government to ensure that area specific provider numbers, which are currently in operation for a period of five years before portability, be further restricted to their current locations, or at least restrict portability to other areas of unmet need.

Recommendation 30 p.62

The State Government should consider funding extra undergraduate medical positions, which would be in addition to Commonwealth funded positions, and use the commitment of funds to bond students to practicing in areas of unmet need.

Recommendation 31 p.62

The State Government should negotiate with the Federal Government to increase training places to the University of Western Australia's stated capacity of 180 entry-level medical students.

Recommendation 32 p.62

The State Government should support Notre Dame University's application to the Federal Government to establish a medical school for undergraduates, in addition to expanding the number of places at the University of Western Australia.

Recommendation 33 p.64

The State Government should provide scholarships to eligible medical school entrants on the proviso that, upon graduation, a certain period be served in areas of unmet need, as defined by the State.

Recommendation 34 p.64

The State Government should approach private industry and give local government the opportunity to provide scholarships to eligible medical school entrants on the proviso that, upon graduation, a certain period be served in specified locations.

Recommendation 35 p.66

The State Government should consider providing financial incentives to encourage doctors to train as specialists in exchange for a period of service in the State public health system after qualification.

Recommendation 36 p.66

The State Government should immediately call on the Federal Government to hold a national summit on medical training and workforce requirements.

Recommendation 37 p.70

The Department of Health, in conjunction with the colleges, should devise strategies to provide all graduates, regardless of gender, with opportunities to specialise.

Recommendation 38 p.70

The State Government should encourage the Federal Government to recognise the reduced number of doctors' working hours due to both lifestyle and gender trends, and to factor this into medical student entry-level intake numbers.

Chapter Seven - The VMP System: Commonwealth State Relations in Funding Health

Recommendation 39 p.72

The State Government should urge the Federal Government to increase university places to train Australian medical students in order to reduce the dependence on overseas-trained doctors.

Recommendation 40 p.78

The State Government should negotiate with the Federal Government to increase the Medicare rebates to a level that will encourage doctors to return to bulk billing.

Recommendation 41 p.79

The State Government should investigate the establishment of co-located GP clinics at appropriate public hospital sites, including the teaching hospitals.

Recommendation 42 p.79

The State Government should investigate the Victorian pilot program with a view to implementing 'pharmaceutical benefits scheme' prescribing by doctors working in Western Australian public hospitals.

Recommendation 43 p.80

The State Government should negotiate with the Federal Government to provide sufficient aged care beds to overcome the current shortage.

Recommendation 44 p.80

The State Government should make provision for alternative services to aged care patients who are currently occupying public hospital beds.

Chapter Eight - The VMP System: Fee Schedules

Recommendation 45 p.83

The 109% fee should be further negotiated in the next round of negotiations with the Australian Medical Association.

MINISTERIAL RESPONSE

Standing Order 277(1) of the Standing Orders of the Legislative Assembly states that:

> *A report may include a direction that a Minister in the Assembly is required within not more than three months, or at the earliest opportunity after that time if the Assembly is adjourned or in recess, to report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.*

Accordingly, the Public Accounts Committee directs that the Minister for Health respond to the recommendations.

CHAPTER 1 INTRODUCTION

1.1 REASONS FOR THE INQUIRY

The Department of Health (DOH) has budgeted to spend $68 million in the current financial year 2002-03 on Visiting Medical Practitioners (VMPs) for the provision of general practitioner and specialist medical services. To put this figure into context, the State spends in excess of $160 million on sessional and salaried doctors.[1]

In 1998 the Auditor General's Audit of Payments to VMPs found that public hospitals were paying doctors' invoices without verifying the payments. The audit also revealed that almost half of the payments could not be substantiated.[2]

In a hearing conducted on 29 August 2001, the then Acting Commissioner for Health, Professor Bryant Stokes, informed the Committee that one visiting medical practitioner working in rural Western Australia was earning $460,000 from his work for the public hospital system, and that one VMP working in the metropolitan area was earning $355,000. Professor Stokes also told the Committee that the average payment to a VMP in the metropolitan area is $31,000 and in the non-metropolitan area is $36,000.

In subsequent evidence the Committee was informed that the highest paid metropolitan VMP earned $770,000 by working across four different health services.[3]

In September 2001, the after hours closure of Swan Districts Hospital's emergency department, caused by an inability to engage a senior registrar, highlighted the difficulty in engaging medical practitioners at non-teaching hospitals in the metropolitan area.

1.2 TERMS OF REFERENCE

On 26 September 2001, the Public Accounts Committee (the Committee) resolved to inquire into the use of VMPs in the public hospital system of Western Australia.

The following terms of reference were adopted:

That the Public Accounts Committee examine and report on the use of visiting medical practitioners (VMPs) for the provision of medical services in the Western Australian public hospital system, with particular reference to the:

- use of VMPs in the public hospital system;
- terms and conditions of engagement of VMPs; and
- compliance and accountability within an output-based management framework.

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1 Prof. Bryant Stokes, Acting Commissioner of Health, Transcript of Evidence, 29/08/01, p.5

2 Office of the Auditor General Western Australia; *Controls, Compliance and Accountability Audits*, Report No 8, October 1998, p. 25-29

3 Transcript of Evidence, 5/11/01, p.6

1.3 SUBMISSIONS

The Committee received 26 written submissions from a range of organisations, including the Department of Health and the Australian Medical Association, as well as other key stakeholders including many medical specialists. (Appendix Three)

1.4 HEARINGS AND EVIDENCE

The Committee held a total of 42 hearings with 77 witnesses. Of the 42 hearings, 25 were held in regional Western Australia. Transcripts of all public formal evidence hearings are available on the Parliament's website: www.parliament.wa.gov.au/committees.

1.5 INVESTIGATIVE TRAVEL

In November 2001, the Committee travelled to Broome, Geraldton, Kalgoorlie, Albany and Bunbury to improve the Committee's knowledge and understanding of issues facing health authorities and medical practitioners in rural and remote Western Australia. The Committee held formal evidence hearings with health administrators, medical practitioners and other concerned organisational representatives and authorities. (Appendix Two)

The Committee sought to understand the VMP system and other related health expenditure issues in Western Australia by considering them in comparative perspective. Accordingly, in late April, the Committee travelled to Melbourne, Bacchus Marsh and Bendigo in Victoria and Wagga Wagga and Sydney in New South Wales to hear first hand from health administrators and medical practitioners the strengths and weaknesses of the models of service delivery operating in those States. (Appendix One)

The Committee also took the opportunity while in Sydney to meet with the Executive Officer and a Senior Policy Analyst at the Australian Medical Workforce Advisory Committee. AMWAC is the Federal and State funded body responsible for assessing the current medical workforce requirements and predicting the medical workforce needs of the future.

CHAPTER 2 BACKGROUND

2.1 THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

Health systems are a highly complex and expensive area of government. In Western Australia, the State budget for health is in excess of $2 billion and increasing every year. As society changes and consumers' health requirements evolve, the health system must also evolve through review and restructure.

The Western Australian public health system provides a world-class health service. However, like health care systems throughout the developed world, the WA health system has become increasingly strained. Advances in medical technology, combined with increasing demands and expectations of consumers increase the pressure on a health system predicated on being publicly funded and universally accessible.

The models of service delivery for the State's public hospitals and health services differ both within the metropolitan area, between tertiary and secondary hospitals, as well as between the metropolitan and country hospitals. The models of service delivery range from –

- the overwhelming use of salaried doctors in metropolitan teaching hospitals;
- a hybrid model of VMPs and salaried positions in most secondary and outer metropolitan hospitals; and
- the overwhelming use of VMPs in most rural health services.

2.2 VISITING MEDICAL PRACTITIONERS

A Visiting Medical Practitioner (VMP) is either a general practitioner (GP), or a specialist, engaged to provide medical services to public patients in non-tertiary public hospitals.

Public hospitals usually pay VMPs on a fee-for-service basis, though some are paid on a daily or sessional rate.

In effect, VMPs are independent contractors to the public system and are therefore not entitled to the normal benefits associated with being an employee. VMPs are responsible for all of their own overheads, administrative costs, leave-associated costs, superannuation, etc. VMPs are also required to provide their own medical indemnity coverage, workers compensation coverage and any other costs associated with running a business.[4]

VMPs are responsible for providing total health care service in relation to their patients. Once admitted, the VMP takes full responsibility for any treatment or post-operative care in relation to his or her patients.

[4] Department of Health, Submission, p.1

2.3 SALARIED DOCTORS

A salaried medical officer is a medical practitioner who is a public sector employee, entitled to receive the normal benefits associated with employee status: annual leave, sick leave, study leave, superannuation benefits and professional indemnity coverage. The salaried doctor is not paid on a throughput basis and receives no additional payment for the number of patients treated in a session.[5] Salaried medical practitioners can be engaged by WA health services either on a full time or sessional basis.[6] Some doctors choose to be engaged on a full time basis, while others may work a number of sessions at a public hospital but also have private practices that they run outside of their sessional hours at the public hospital.

The Department of Health explains the Salaried Medical Officers as follows:

> *Salaried Medical Officers range from the most junior, the intern, to the highly skilled and experienced specialists. There are 23 salary levels to reflect the range of knowledge, skills and experience of the doctor. The top specialist at Level 23 will have spent at least 6 years as a junior doctor and no less than 13 years as a specialist consultant.*[7]

2.4 SESSIONAL DOCTORS

Sessional doctors are employees of the health system who are remunerated on a sessional basis. In addition to receiving a sessional salary for public work, sessional doctors receive a 14% loading. Throughout the report the Committee will use the terms salaried and sessional doctors interchangeably unless otherwise explicitly stated.

2.5 EMPLOYMENT ARRANGEMENTS

Medical services can be provided at public non-teaching hospitals under two engagement models:

- salaried (full-time or sessional) staff; and
- Visiting Medical Practitioners (fee-for-service).

In Western Australia, VMPs have historically been employed to provide services where the employment of medical practitioners as salaried doctors was not deemed to be feasible or viable, most notably in rural and remote areas. The same argument has been made for the historical engagement of VMPs in the outer metropolitan hospitals, in that outer metropolitan areas were less attractive places to work and therefore more difficult to recruit to.[8]

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5 A session is typically 3.5 hours and could be an outpatient clinic, a theatre operating list, administrative duties, teaching duties etc. A full time doctor's salary is based on working ten sessions. Sessional doctors are employed part-time employees whose remuneration is calculated on the number of sessions worked, ie three sessions ($3/10^{th}$ of a full time salary).

6 Department of Health, Submission, p.1

7 Department of Health, Submission, p.5

8 *Ibid,* p.6

As statutory authorities under the *Hospitals and Health Services Act 1927*, WA hospitals have the ability, on a hospital by hospital basis, to determine what mix of salaried and fee-for-service staff they would prefer to employ.

There are a variety of factors that will determine the employment model that an individual health service will choose, which include:

- the level and range of services provided by the hospital;
- historical arrangements;
- demographics;
- geographical location of hospital; and
- the availability and willingness of doctors to provide services under those arrangements.

2.6 CONDUCT AND SCOPE OF THE INQUIRY

The Committee was interested to determine –

- whether the State is getting value-for-money from the VMP model of health service compared to other models, such as salaried and sessional doctors;
- whether the VMP system is being administered effectively and efficiently; and
- the compliance and accountability of the VMP system.

The Committee examined the issue of compliance and accountability by auditing records of payments to the ten VMPs receiving the highest payments from the public health system (see Chapter 3). The Committee obtained the services of a seconded officer from the Office of the Auditor General to assist its examination.

The issue of 'over-servicing' was considered by the Committee. In a fee-for-service system the risk of over-servicing is greater, but should not be inevitable. A difficulty in assessing 'over-servicing' is that there is rarely agreement on what constitutes over-servicing in any particular case of medical treatment. This is why the compliance and accountability procedures analysed in Chapter 3 are so important, given the difficulty in otherwise determining whether over-servicing has taken place. Consistent with the Committee's findings in Chapter 3; that there is insufficient analysis of VMP payments, and the evidence outlined in Chapter 5; that the Commissioner for Health, and the then Metropolitan Health Services Board, were not even aware of the size of VMP payments, the public cannot be reasonably confident that over-servicing is not happening.

In the course of inquiring into the various models of service delivery, the Committee found a range of complex issues that are inextricably linked to why different models are used by the different hospitals. These issues may be regarded as forming part of the environment in which the health system operates. As such, an assessment of the merits of the VMP system has to be made in conjunction with analysis of the environmental factors. An analysis is contained in the following chapters.

Chapter 4, 'The VMP System: Overview of Issues', provides an introduction to the assessment of the effectiveness of the VMP system. The Committee was disappointed to find that there has not been anything other than occasional, ad hoc, attempts to undertake cost-benefit analysis in order to determine the benefits of the various models. A comprehensive cost-benefit analysis that considers all environmental factors is required.

Chapters 5 to 7 examine the issues that effect the assessment of the health service models under the headings of 'The Structure of the Metropolitan Health Services', 'The Supply of Doctors', and 'Commonwealth-State Relations in Funding Health'. Some of the issues discussed under these headings help to explain the reason that rural and remote health services have to rely almost solely on the VMP system, rather than the reason simply being one of geography.

Within the metropolitan area the structure of health services is a fundamental issue, as examined in Chapter 5. Each of the five tertiary metropolitan hospitals and the six non-tertiary metropolitan hospitals are operated individually, rather than as an integrated hospital system. Consequently, the Department of Health is unable to aggregate important information, such as the various employment arrangements across the health system. A further consequence is that the health system lacks flexibility to respond to staffing, training and resource requirements of the overall health system. Further, the Committee identifies alternative structures for teaching to be conducted across a larger number of hospitals and for specialist medical services to be better planned and delivered by different hospitals becoming centres of excellence for different specialist medical services.

The supply of doctors emerged as a significant and complex issue during the inquiry. In Chapter 6, the Committee examines the reasons for shortages of GPs and specialists across the State. The training of medical students and postgraduate training of specialists is not addressing current and future health service needs, particularly in terms of training intake numbers. Changes in the gender balance amongst doctors, and lifestyle issues more generally, are also underlying factors recognised by the Committee as influencing the supply of specialists and the ability to attract doctors to particular regions. Accreditation and employment of overseas-trained doctors has been an effective means of addressing the shortage of doctors in the short term, and further encouragement of overseas doctors will be required until a longer term solution to the supply of locally trained GPs and specialists takes effect.

Commonwealth-State relations on the provision of public health services is a matter made complex and political in nature due to policy or administrative decisions at State and Federal level effecting the delivery of health service at each level. With two levels of government being responsible for the funding of the system, there is also the ability to cost shift between the two levels of government and for each level to blame the other for service deficiencies. Chapter 7 examines the extent to which changes to levels of Medicare funding can effect the State's delivery of health services. In light of the failure of Medicare funding to keep pace with Consumer Price Index (CPI) increases since 1991, the Committee identifies potential cost savings to the State health budget via a restructuring of outpatient arrangements at public hospitals. Other Commonwealth funding responsibilities such as aged care also make it more difficult for the State to provide adequate health service, due to hospital beds being taken up by elderly patients, who should be in aged care facilities.

The Committee examines all of the above issues in order to properly analyse the effectiveness of current arrangements and what the system should look like in the future, as detailed in the report's recommendations. With a restructured metropolitan health system, an increasing ratio of GPs and specialists to general population, and recent changes to training provided in rural areas,

there will be increased scope for the public health system to choose its preferred model of employment of doctors in the metropolitan area and some larger rural regions. The Committee acknowledges that many rural and remote areas have and will have little option but to continue to be well served by the VMP system.

CHAPTER 3 COMPLIANCE AND ACCOUNTABILITY IN THE VMP SYSTEM

3.1 OVERVIEW

Payments to Visiting Medical Practitioners (VMPs) are a significant expense for hospitals. In the 2000/01 financial year, it is estimated that the WA public health system made payments approximating $63 million to VMPs for services ranging from general consultations through to complex surgery.

Engagement of medical practitioners on a fee-for-service versus salaried basis, is a management resourcing decision designed to address the Outcome of the hospital concerned, in the most efficient and effective manner. Overlaying this decision are the systems and processes that the hospital develops to ensure that management objectives are met, whilst also satisfying key stakeholder requirements, including legal obligations.

In the case of hospitals that employ VMPs to meet their service obligations, most currently utilise a state-wide computer system to vet medical practitioner claims for payment. This Account Assessment and Information System (AA&IS), was developed on behalf of the Western Australian Department of Health (DOH), to assist hospitals to meet a number of obligations concerning payment of accounts under the *Financial Administration and Audit Act 1985 (FAAA).*

The AA&IS has been in operation at a number of public hospitals in Western Australia for a relatively short time – since June 2000.

As part of the inquiry, the Committee undertook an examination of aspects of this system and the VMP payment process in general. In addition, a number of VMP payments made in 2000/01 were selected for detailed testing. This testing focussed on the ten medical practitioners earning the highest payments from the VMP fee-for-service system and included a selection of metropolitan hospitals and a large rural hospital.

This chapter of the report details information concerning aspects of the VMP system when considered in light of legislative requirements entailed in the FAAA 1985 and accountability relationships between stakeholders to this system. This section also provides background information that the Committee considered when undertaking an audit concerning some aspects of the VMP system and the findings from this investigation, along with recommendations for future consideration.

3.2 PREVIOUS AUDIT REPORTS

Two reports were of interest to the Committee when examining the accountability arrangements associated with the VMP system. The first report was undertaken by the Victorian Auditor General in 1993, and involved a detailed review of Visiting Medical Officer (VMO) arrangements within the Victorian public hospital system. The second report was undertaken by the Western Australian (WA) Auditor General in 1998 and focussed on the system by which VMPs were paid, with an emphasis on the verification and management of VMP payments within the WA public hospital system.

Both reports were found to be key reference points when the Committee was considering auditing some VMP payments and aspects of the WA VMP system. In particular, the following key findings were considered by the Committee when undertaking its audit process:

3.2.1 The Victorian Auditor General's Report Into Visiting Medical Officer Arrangements 1993

- Hospitals had not established appropriate monitoring mechanisms and accountability processes to manage VMO payments. In turn, this rendered the fee-for-service system vulnerable to manipulation and inefficiency.
- Hospitals had not undertaken cost-benefit analysis to confirm that their existing out of hours remuneration arrangements were cost effective.
- There was prima facie evidence of over servicing of public patients in certain fee-for-service hospitals.
- Annual cost savings in the order of $8 million were available if medium sized public hospitals abandon inefficient fee-for-service VMO arrangements.
- Suitable cross-checking mechanisms were not in place to curtail the potential for VMOs to receive reimbursement from both Medicare and public hospitals, for the provision of the same medical service.

3.2.2 The Western Australian Auditor General's 1998 Report Into Payments to Visiting Medical Practitioners for Professional Attendances

- There was little or no analysis of VMP payments performed to review payment trends and exceptions. In general, hospital management was unlikely to be aware of significant trends and exceptions in VMP payments and accordingly, could miss opportunities for improvements in the provision of medical services.
- There were generally no verification procedures undertaken to determine whether the fee claimed by the VMP was commensurate with the service provided. The verification procedures undertaken were also relatively *ad hoc* as they had not been documented.
- Detailed testing of a sample of payments found that in approximately 45 per cent of these cases, it could not be satisfactorily substantiated from the VMP notes in the medical record, that the appropriate fee had been claimed and paid. For a further 11 per cent, there was no notation by the VMP on the medical record to indicate that the patient was seen on that date. This means that it was often difficult, if not impossible to substantiate the fees being claimed by VMPs, based on the notes by these doctors on the medical file.

3.3 HEALTH SYSTEM AGENCIES' LEGISLATIVE RESPONSIBILITIES

VMP payments are made by public hospitals. These hospitals are established under the *Hospital and Health Services Act 1927* and are governed by Boards. These Boards are ultimately accountable for the management of the agencies.

In the metropolitan area the Commissioner for Health has been delegated the functions and powers of all public hospitals comprising this area. In most rural areas individual Boards were controlling many health service areas until the recent decision of the Government to replace boards with a new regional administrative structure.

The FAAA 1985 provides the legislative framework governing the financial administration and reporting practices of government agencies funded through the OBM process. In addition to annual reporting requirements, this Act contains a number of provisions that prescribe specific obligations for key members of government agencies and regulate the ongoing financial practices of these entities.

At an operational level, the FAAA 1985 requires under Section 33 that:

> *(1a) No payment shall be made from a bank account maintained by a statutory authority unless certified as correct by a certifying officer; And that*
>
> *(2) A certifying officer shall not certify as correct the payment of an account for the purposes of subsection (1a) unless —*
>
> *(i) satisfied that money is lawfully available for the payment of that account;*
>
> *(ii) satisfied that such account is correct and the expenditure or transfer of moneys is correctly classified;*
>
> *(iii) payment of the account is authorised by the person incurring the expense in accordance with the Treasurer's Instructions; and*
>
> *(iv) any other prescribed requirements relating to the payment of the account have been complied with.*[9]

In addition, when making VMP payments, there needs to be consideration of the authorisation requirements of Treasurer's Instruction 305, which states that:

> *The Incurring Officer shall not certify to the payment of an account unless satisfied that:*
>
> *i. the creditor's name and address is correctly recorded on the payment record;*
>
> *ii. the accounts to be charged are correct and expenditure or transfer of moneys is correctly classified;*
>
> *iii. any recoverable expenditure is clearly indicated on the payment record;*
>
> *iv. rates of charges and calculations are correct; and*
>
> *v. (a) goods have been satisfactorily supplied or services have been satisfactorily performed, except where payment in advance is required as a condition of purchase; or*

[9] Extracted from Western Australian Financial Administration Bookcase, *Western Australia Financial Administration And Audit Act 1985*

> *(b) where the transaction is not of the nature of a payment for goods or services, such as payment of a grant or travel advance, the payment has been properly authorised.*[10]
>
> *For the purpose of this paragraph, an Incurring Officer to be satisfied that the above requirements have been met, need not have personal knowledge of each transaction but is required to do all that a reasonable person would do in the circumstances. This could include placing reliance on the systems operating in the department or statutory authority and on the attestation of other officers when giving a certification, eg. a storeman's signature on a delivery docket stating that the goods have been received.*[11]

The requirements of the Act and the Treasurer's Instructions, are framed to provide assurance that the principles governing the payment of moneys by public sector agencies are central in the day to day operations of these entities.

The key principles that these legislative requirements aim to address are that:

i. there is legal authority to make the payment.

ii. the payment has been authorised by officers with legal authority to do so.

iii. payments are made promptly and correctly.

iv. duplicate payments are not made.

v. adequate management and audit trails are produced.

vi. transactions are recorded in sufficient detail to enable discharge of statutory reporting requirements.

The Committee reviewed the discharge of these legislative responsibilities when examining a sample of VMP payments made (see Section 3.6).

3.4 THE VMP PAYMENT SYSTEM IN WA

Key stakeholders in the VMP payment system include those agencies primarily charged with delivering on health outcomes (Department of Health and public hospitals) and those individuals providing the medical services on a fee-for-service basis (the VMPs). Central to the relationship between the hospitals, the Department of Health and VMPs, is the Account Assessment and Information System (AA&IS).

The AA&IS has only been in operation at a number of hospitals for approximately two years. According to the Department of Health, this system was largely developed in response to the shortcomings identified by the Auditor General of Western Australia's 1998 report into payments to visiting medical practitioners (see Section 3.2) and replaced the former Doctor Accounting System (DAS). Regard was also had to those matters raised in the 1993 Victorian Auditor General's Report.

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10 Extracted from *Western Australian Financial Administration Bookcase, 305 Incurring Officers*

11 *Ibid.*

In their submission to the Committee, November 2001, the Western Australian Department of Health stated that:

> *It was concluded that a centralised service provider should be contracted to complete a software payment system for use at all health services. The provider recommended was the Health Insurance Commission (HIC) who are a Commonwealth Government funded institution responsible for processing Medicare payments and who keep details of doctors able to practice throughout Australia. A contract was signed (with the HIC) and is scheduled to expire on 21st June 2002.*

The Committee was advised at the time of reporting that the contract was recently renewed for a period of three years. The Department of Health submission further commented on the initial contract that:

> *The contract required the HIC to provide:*
>
> - *an improved system of payments to VMPs, expected to result in savings up to $6 million per year.*
> - *effective verification and assessment procedures to ensure appropriate categories of payment.*
> - *improved management information about VMP fee-for-service payments.*
> - *implement professional review activities to encourage 'best practice' health delivery.*
>
> *A phased approach was agreed with the HIC with*
>
> *Phase 1 being the development of a VMP payment and information system (excluding radiology items). This system was introduced in early 2000.*
>
> *Phase 2 will incorporate radiology items in the payment system.*
>
> *Phase 3 will be integration with hospital processing information systems.*
>
> *Phase 4 will introduce professional review activities.*
>
> *The new software system was called the Account Assessment and Information System (AA&IS) and has been in operation since June 2000. The system incorporates a number of checks for the validity of payment claims made by a practitioner. The business rules within the system include validation of the VMP as being able to deliver services within the hospital and that the schedule item number quoted in the claim for payment is valid.*[12]

[12] Department of Health, Submission, p.9-12

As at the end of June 2002, phase 1 was largely completed. Consideration was being given as to whether it was still appropriate to proceed with Phase 2 and 3 of the system, or if progressed, in what from this might take. Phase 4 of the project is expected to be completed by the end of 2002, subject to relevant contractual approvals being obtained under the *State Supply Commission Act 1991*.

In practice the interaction between VMPs, hospitals and the AA&IS is illustrated in this simplified example:

Patient A presents to their local GP with a hernia complaint. The GP refers the patient to a surgeon specialising in general surgery for assessment. The surgeon, who is a VMP at a public hospital, books the patient into this hospital for a hernia repair operation.

Prior to the procedure, the anaesthetist responsible for the operation also assesses the patient. This anaesthetist is also registered with the relevant public hospital and HIC as a VMP.

On the designated date, the patient is admitted to hospital, the operational procedure is performed and the patient is subsequently discharged. Details of the patient's stay are recorded in the hospital's computerised patient management system. In the case of metropolitan hospitals, the system concerned is the Total Patient Admissions System (TOPAS), while in rural hospitals, it is largely the Health Care and Related Information System (HCARe).

Details of the operating theatre procedure(s) are also recorded in the hospitals computerised theatre management system.

Following on from this process, both the VMP surgeon and anaesthetist submit their claims for payment. The VMP clerk enters the claim for payment details into the AA&IS. The clerk undertakes some preliminary checks of the claim details against data in the TOPAS or HCARe systems. This check focuses on confirming that the:

- patient is a public patient;
- doctors claim date(s) correlate to the patient's date(s) of stay; and
- patient claim details are correct.

After all claim details are entered by the VMP clerk, the AA&IS validates the data utilising a number of business rules programmed into the system. Checks performed by the system include:

- *the patient is a public patient;*
- *the patient can be identified with a valid Medicare number;*
- *the age and gender of the patient are appropriate for the services rendered;*
- *the VMP is eligible to render the services claimed on the date of service involved;*
- *the item number of the service is valid within the WA Government Medical Services Schedule (WAGMSS) or the Commonwealth Medicare Benefits Schedule (CMBS);*
- *the item number claimed is valid on the date of service;*
- *the date of service is within the admission and discharge dates specified;*

- *the services being processed have not been processed previously;*
- *the required information is provided for the service involved; and*
- *multiple procedure groups and derived fee groups have been identified.*[13]

Following this assessment, the system confirms that this invoice should be transmitted to the HIC for further assessment (where necessary), or if correct, stored in the hospitals database.

When the invoice has been finalised, the invoice can be certified for payment in accordance with Section 33 of the FAAA 1985. A certification facility is available within the AA&IS to certify invoices:

- up to a specified monetary amount;
- for a particular payment mode;
- up to a particular receipt date; and
- for a particular VMP.[14]

After this certification phase a payment run is scheduled on a regular basis to select invoices that have been certified for payment. The end results of a payment run are:

- *for hospitals that have elected for the HIC to release payments on their behalf:*
  - *a report is sent to the Reserve Bank detailing the payments to be made to VMPs who have elected to be paid via EFT.*
  - *a report is sent to the hospital involved detailing the payments to be made to their VMPs who have elected to be paid by cheque.*
- *for hospitals that have elected to make their own payments (i.e. by cheque or EFT), a report is sent detailing the payments to be made to their VMPs and the hospital makes the relevant EFT or cheque payment to the VMPs.*
- *statements are sent to the VMPs detailing the services that have been paid or rejected.*
- *information to update the General Ledger is sent to each hospital.*[15]

The hospitals run an interface job, which extract VMP payment data from the AA&IS and post the relevant payment and accounting entries to their accounts payable and general ledger systems. Database reports from the AA&IS are available on request from the Department of Health's AA&IS representative.

By and large, the hospitals examined as part of the audit of VMP payments (see Section 4.6) felt that the current VMP payment system was an improvement on the previous Doctor Accounting System. Whilst there were areas of concern and suggestions for improvement and enhancement, users of this system felt that it formed a solid platform for ensuring that most financial accountability requirements could be met, while also enabling VMP claims for payment to be processed in a timely manner.

13 Health Department of Western Australia VMP Payment and Information System User Guide, p.3-1 and 4-1

14 *Ibid*, p.9-1

15 *Ibid.*

Finding 1

The hospitals examined as part of the audit of Visiting Medical Practitioner (VMP) payments considered that the current VMP payment system – the Account Assessment and Information System (AA&IS) – was an improvement on the previous Doctor Accounting System.

Users of the AA&IS believe it is an effective tool for ensuring that most financial accountability requirements can be met, while also enabling VMP claims for payment to be processed in a timely manner.

3.5 AUDIT OF THE VMP PAYMENT SYSTEM

As part of its inquiry, the Committee was interested in establishing that payments being made to VMPs were legitimate with an emphasis on payments to the ten medical practitioners earning the highest payments from the VMP fee-for-service system. The Committee was also interested in establishing that there were sufficient safeguards within the VMP payments system to detect and prevent unauthorised or fraudulent transactions from being processed.

3.5.1 Potential Risks

The key risk associated with VMP payments centres on the potential for payments to be made to medical practitioners, where a corresponding service has not been delivered. The focus of the audit into VMP payments largely concerned this risk.

Other matters considered when examining VMP payments were:

- that payments were only for eligible (public) patients;
- no duplicate payments were made for the same service;
- that payments for services performed were made at the correct rate for those services; and
- all payments were in accordance with relevant legislative requirements.

3.5.2 Background to Testing

The focus of the Committee's testing was on the ten medical practitioners receiving the highest total payments from the VMP fee-for-service system. Combined, these medical practitioners delivered services over four hospitals – three metropolitan and one large rural hospitals. An extract was received from the Department of Health, of all VMP payments that had been made by hospitals utilising the AA&IS. This extract covered payments made since the AA&IS's inception - May 2000, up to December 2001.

From this extract, a random sample of payments was selected for the ten medical practitioners earning the highest total payments from the VMP fee-for-service system. The payments covered the financial year July 2000 to June 2001.

There are approximately 1000 VMPs supplying medical services to WA hospitals. The extract received from the Department of Health included payments made to 876 of these VMPs. Of those payments, total payments made to the ten highest earning VMPs are shown as follows:

Provider	*Number of procedures or attendances claimed*	*% of total VMP claims*	*Total payment*	*% of total VMP payments*
1	2690	0.872%	766,801.92	1.780%
2	2344	0.760%	575,714.55	1.337%
3	1457	0.472%	550,911.61	1.279%
4	1602	0.519%	440,825.82	1.023%
5	1335	0.433%	437,603.47	1.016%
6	2523	0.818%	428,247.32	0.994%
7	1240	0.402%	379,483.67	0.881%
8	3210	1.041%	369,158.57	0.857%
9	1350	0.438%	356,051.45	0.827%
10	1541	0.500%	354,022.36	0.822%
TOTAL	**19292**	**5.89%**	**$4 658 820.74**	**9.76%**

The 10 medical practitioners receiving the highest payments for services provided under the fee-for-service model, while comprising only 1% of all VMPs, received $4,658,821 and claimed for 19,292 procedures or attendances performed. This represented 9.76% of all VMP payments made and approximately 6% of all claims made.

Total VMP payments at the four hospitals examined varied from $2.5m through to $5.1m and represented approximately 30% of all VMP payments made.

3.6 THE VERIFICATION PROCESS

3.6.1 Current Process

When considering the payment process, a key requirement of this process is that agencies discharge their legislative responsibilities under the FAAA 1985.

Importantly, there is the requirement under Treasurer's Instruction 305 that each hospital establish prior to payment that in relation to each claim for payment, the… *rate of charge* (for the service claimed) *is correct* and… *the service has been satisfactorily performed.* This requirement is mandatory and verification of services performed and appropriateness of the fee charged, must be undertaken prior to payment of an account.

This Instruction, and the subsequent certifying of the payment under Section 33 of the FAAA 1985, provides assurance that, amongst other things, there is legal authority to make the payment, the payment is correct and satisfies the various legal requirements, and that the hospital has received value for money. Ultimately, these checks and balances provide assurance to the taxpayers that fund the provision of health services, that funds expended on their behalf are *bona fide* and in accordance with the purposes for which Parliament appropriated them.

Central to the verification process is the hospital patient's medical record. A hospital patient's medical record contains all key information concerning that patient's episode of care in a hospital. It is a manual record and contains information such as:

- the patient's personal details;
- admission, transfer and discharge details; and
- information and records pertaining to the patient's diagnosis and treatment.

In turn, some of a patient's information concerning their episode of care is also recorded in the hospital's computerised patient management systems. As noted in Section 3.4, in the case of metropolitan hospitals TOPAS is the relevant system, while in most rural hospitals it is the HCARe system.

Details of the operating theatre procedure(s) are also recorded in the hospital's computerised theatre management system.

Each of these sources of information provide a reference point to which VMP claims for payment can be verified, to differing degrees. The hospital patient's medical record provides a complete record of all information concerning a patient, whilst TOPAS, HCARe and the hospital's theatre management system provide subsets of information contained in the medical record.

Section 2.4 of the Department of Health's W.A. Government Medical Services Schedule (WAGMSS) emphasises the importance and primacy of the hospital patient's medical record, when considering documentation by a VMP evidencing his/her provision of a service. This section states that:

> *Claims for medical services rendered must be supported by adequate notation/documentation in the hospital's patient medical records to support the claim.*

If sufficient documentary evidence in the patient's medical record is not provided by the medical practitioner, the account will be returned unpaid or if already paid, an adjustment note issued.

When entering VMP claim for payment details into the AA&IS, hospital staff undertake some preliminary checks of the claim details to data in the TOPAS, HCARe or theatre management system. These checks focus on confirming:

- that the patient is a public patient;
- that the doctor's claim date(s) correlate to the patients date(s) of stay; and
- that the patient claim details are correct.

By and large, most hospitals examined were not undertaking procedures to verify that, prior to payment of a VMPs account, that the fees claimed by a VMP were commensurate with the service provided. In one of the hospital's visited, a small sample of payments made to each of the hospital's VMPs were verified to the relevant patient's medical record, as part of its post payment checking process. In each of the other hospitals, verification of the service provided by the VMP varied, but was in general limited.

Where verification of a VMP claim for payment did take place, it was usually confirmed to TOPAS (where possible), or to the hospitals theatre management system. Due to its time consuming nature, verification of a claim to a patient's file usually only happened in instances where the hospital's VMP clerk believed there was a potential or obvious error with the claim details.

There were a number of reasons provided for not undertaking checks to ensure that the fee claimed by the VMP was commensurate with the service provided, which included:

- the hospital's VMP clerks were not considered to possess the relevant clinical knowledge to undertake this assessment;
- the large volume of claims that require processing and the time required to verify each claim;
- the need to maintain a harmonious working relationship with the hospital's various VMPs through prompt processing of claims for payment;
- the fact that hospitals can undertake post payment checks of VMP claims where necessary, as a result of historical payment data being stored on the AA&IS's database; and
- over time VMP clerks develop a knowledge of the typical claim patterns associated with each of the hospitals VMPs and through this knowledge, are able to readily identify potential erroneous claims.

Clearly, the current limited verification process means that officers charged with the responsibility to incur payments in accordance with Treasurer's Instruction 305, are not always in a position to fulfil their responsibilities under the FAAA 1985. In turn, the limited verification process impacts upon the capacity of the Certifying Officer to discharge their responsibilities under Section 33 of the FAAA 1985.

For the taxpayer funding the health service, the current processes result in reduced assurance that all VMP claims for services performed have been verified prior to payment and that the fee paid for this service is appropriate.

In response to the issues raised, the DOH considered that:

> *there are procedures and systems in place that support the incurring and certifying functions sufficiently to comply with the requirements of TI 305 and TI 304.*

These included that:

> *health services conduct random post payment audits as a further check and will be able to pinpoint problem area's through the use of (future developments of) the AA&IS system.*

In addition they felt that:

> *it was not practicable and therefore not reasonable to check every line item in a VMP invoice with the relevant patient medical record and to expect non-medical staff (who are not medically qualified) to ascertain whether a VMP performed the duties satisfactorily.*

The DOH believed that:

> *the current procedures are a practicable and reasonable position to take.* [16]

Whilst it is accepted that the nature of claims by VMPs present challenges in meeting the requirements of the FAAA 1985, nevertheless, these requirements are enshrined in legislation and are therefore mandatory. Further, where there is significant public expenditure, in this case in excess of $60 million, greater accountability is required.

Treasurer's Instructions 104 enables the Treasurer to exempt persons from the provisions of Treasurer's Instructions. The DOH advised that no exemption was being considered at this stage.

Finding 2

Most hospitals examined were not undertaking procedures to verify that, prior to payment of a VMPs account, the fees claimed by the VMP were commensurate with the service provided. This impacts upon the capacity of hospitals to meet their statutory obligations under the *Financial Administration and Audit Act 1985* (FAAA), and reduces assurance that that the hospital has received value for money expended in the form of payment only for services delivered, and at the correct rate.

[16] Letter, Department of Health, 14 June, 2002, p.3

Recommendation 1

The Department of Health, in conjunction with the various Health Services, should review the current VMP payment arrangements, identify and resolve any impediments to hospitals' ability to satisfy the Incurring and Certifying Officers requirements of the FAAA 1985.

Recommendation 2

The Committee believes that, in addition to the requirements of the FAAA 1985, the VMP accounts for payment should be verified by an accountable process.

The Department of Health should implement a documented verification process for VMP claims.

3.6.2 Verification Systems

Where VMP claims are verified, these are largely verified to TOPAS, HCARe or the hospital's theatre management system. A hospital patient's medical record is largely ignored for the purposes of verifying payments, primarily because of the time consuming nature of this process when considered in light of the volume of claims to be processed and need to process these claims in an expeditious manner.

The Committee found however that as TOPAS, HCARe or the hospital's theatre management system only contain subsets of the information in the hospital patient's medical record, there is not always sufficient information in these systems to facilitate verification of a VMPs claim for payment.

Discussions with DOH officers highlighted that the above systems were never designed to be detailed clinical management systems, or to hold all data currently maintained on the hospital patient's medical record. In general, the capacity of TOPAS, HCARe or the hospitals theatre management system to facilitate verification of a VMP claim for payment varied.

In addition TOPAS, HCARe or the hospital's theatre management system do not always contain information at a detailed enough level to enable verification of a VMPs claim for payment. This is mainly because fees claimed by VMPs are specific in their nature, while information held in TOPAS, HCARe or the hospitals theatre management system is often not at the same level.

Fees claimed by VMPs for services performed are based on item numbers specified in the WA Government Medical Services Schedule (WAGMS). These item numbers contain a description of the service provided, the description of which is often precise.

> ***Item Number 31200*** *Tumour – other than viral verrucae (common warts) and seborrheic keratoses, cyst, ulcer or scar (other than a scar removed during the surgical approach to an operation) – removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane – not being a service to which another item in this Group applies*
>
> *FEE: $28.60*

Item Number 31205 *Tumour – other than viral verrucae (common warts) and seborrheic keratoses, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation) – lesion size up to 10mm in diameter – removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane – including excision to establish the diagnosis of tumours covered by items 31300 to 31335 – where specimen sent for histological examination – not being a service to which item 30195 applies.*

FEE: $80.20

Item Number 31210 *Tumour – other than viral verrucae (common warts) and seborrheic keratoses, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation) – lesion size more than 10mm and up to 20mm in diameter – removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane – including excision to establish the diagnosis of tumours covered by items 31300 to 31335 – where specimen sent for histological examination – not being a service to which item 30195 applies.*

FEE: $103.50

Item Number 31215 *Tumour – other than viral verrucae (common warts) and seborrheic keratoses, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation) – lesion size more than 20mm in diameter – removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane – including excision to establish the diagnosis of tumours covered by items 31300 to 31335 – where specimen sent for histological examination – not being a service to which item 30195 applies.*

FEE: $120.60

Whilst the fees claimed by VMPs are based on the WAGMSS and are often related to specific services, this level of detail is not always available in TOPAS, HCARe or the hospitals theatre management system.

Hospital officers felt that in general, TOPAS, HCARe or the hospitals theatre management system contained sufficient details to verify medical procedures performed at hospitals, but not necessarily other medical services such as second and third consultations with the same patient. This was mainly because hospital staff recorded patient medical procedure details into both the hospitals theatre management system and TOPAS or HCARe.

Coding of patient medical procedures in TOPAS or HCARe often utilised the same item numbers contained in the WAGMSS, enabling a simple cross matching of VMP claim details to that in TOPAS or HCARe. However, as the examination of VMP claims highlighted, this same level of detail was not always evident with other medical services.

Finding 3

Where VMP claims for payment were verified, they were largely verified to the hospital's computerised Total Patient Admissions System (TOPAS) (metropolitan hospitals), Health Care and Related Information Systems (HCARe) (rural hospitals), or the theatre management system. However, as TOPAS, HCARe or theatre management system only contain subsets of the information maintained in the hospital patient's medical record, there is not always detailed enough or sufficient information in these systems to facilitate verification of a VMPs claim for payment.

Recommendation 3

The Department of Health should implement a system that combines the Total Patient Admissions System (TOPAS), Health Care and Related Information Systems (HCARe), or the hospitals' theatre management system, and the patient's medical record, so that reconciliation of VMP payments can occur.

3.6.3 Enhancement Opportunity

Of note to the Committee was the fact that verification of VMP claims to TOPAS or the hospitals theatre management system was largely a manual checking process. Where VMP claims were checked, this involved the hospital's VMP clerk visually cross checking claim details against the relevant system. The Committee is of the view that prima facie, this is an inefficient means of verifying the legitimacy or otherwise of claim data.

The DOH and various hospitals have invested considerable resources in the development of computer systems and processes to capture data concerning a patient's episode of care with a hospital and details concerning VMPs that have provided this care. Given this investment and the need to accurately verify claims for payment in a time efficient manner, an opportunity exists to more fully realise the potential of the current systems, by automating the verification process.

The Committee believes that there are a number of inherent benefits to be obtained by automating this verification function including:

- greater assurance that Incurring Officer responsibilities under the FAAA 1985 are able to be met;
- reduction in potential for verification errors; and
- potential for reduced processing of payment times.

The success of automating the verification function would depend on a number of factors including defining and recording all necessary data, the capacity to match data from one system to another and resources available to undertake this development. However, given the potential benefits that could be derived from automating this function, the Committee believes that the DOH, in conjunction with the various hospitals, should explore this option.

Finding 4

Where VMP claims are verified to Total Patient Admissions System (TOPAS), Health Care and Related Information Systems (HCARe) or the hospital's theatre management system, this involves a largely inefficient manual checking process.

Recommendation 4

The Department of Health, in conjunction with the various Health Services, should automate the authenticating process of VMP payments.

3.6.4 Effectiveness of Current Process

Given the limitations of the verification processes, the Committee's examination of VMP payments paid particular attention to ascertaining whether there was:

- documentary evidence on the patient's medical record to support the level of fee claimed by the VMP; and
- documentation on the hospital's theatre management system or TOPAS, adequate enough to enable the hospital's VMP clerk to assess whether a VMP had delivered the service specified and hence that the fee claimed was correct.

A sample of 903 claims for payment were selected for testing across the four hospitals. The results of testing are summarised in the table below.

Summary of results from verification of VMP claims for payment.

		Documentation on Patient File Supported Level of Fee Claimed		Documentation on TOPAS/Theatre System Supported Level of Fee Claimed	
Hospital	**Claims Examined**	**Yes**	**No**	**Yes**	**No**
Hospital 1	207	**99%**	**1%**	**79%**	**21%**
Hospital 2	200	**99%**	**1%**	**88%**	**12%**
Hospital 3	254	**96%**	**4%**	**81%**	**19%**
Hospital 4	242	**99%**	**1%**	**71%**	**29%**
Total	**903**	**98%**	**2%**	**80%**	**20%**

In summary, the results indicate that in the majority of cases there was adequate documentation on the patient's file to support the level of fee claimed and paid. Of concern, however, was that

approximately 20% of the claims for payment could not be substantiated from information contained in TOPAS or the hospital's theatre management system.

Documentation on Patient File Did Not Support Fee Claimed

Of those claims for payments where the documentation on the patient file did not support the fee claimed, in approximately 75% of these cases it was because there was no documentation on the patient's file evidencing the service being claimed.

In those instances where there was no documentation on the file to support the payment, this was also the situation in the hospital's theatre management system or TOPAS.

The fact that claims were paid where there was inadequate evidence supporting delivery of the medical service highlights the risk associated with limited verification of services being claimed.

If extrapolated across all VMP payments made for 2000/01, the 2% error rate could mean that payments totalling approximately $1.2m may not in fact reflect services delivered, or should not have been paid without further supporting documentation from the VMP concerned.

Documentation on the hospitals theatre management system or TOPAS did not support the level of fee claimed.

In approximately 20% of the claims examined either:

1. the amount paid to the VMP should have been less based on information in those systems;

2. there was insufficient information in the hospitals key verification systems to assess the appropriateness of the VMP claim; or

3. there was no information in the systems to assess the appropriateness of the VMP claim.

Of the exceptions noted, approximately 95% related to points 2 and 3 above. Where there was insufficient information concerning the claim in the hospital's key verification systems, these largely related to:

- whether a hospital had initiated an attendance to a patient by a VMP;

- where an anaesthetist attendance to a patient was a referred consultation or involved a call back from home or other location; and

- whether the patient being attended to by an anaesthetist had a systemic disease or required emergency surgery.

Where there was no information in the hospital's key verification systems, these mainly centred on:

- VMP claims for pre-anaesthesia consultations prior to administering an anaesthetic; and

- attendances to patients by VMPs involving two or more occasions of service.

An extract of all payments that had been made to VMPs in 2000/01 that matched the profile of the exceptions noted above, highlighted that these payments amounted to approximately $2.8 million. Accordingly, this indicates that VMP payments to the value of approximately $2.8 million have been made, where there may have been either limited or no information available in TOPAS, HCARe or the hospital's theatre management system, to adequately substantiate these claims for payment.

In large part, the issues noted in points 2 and 3 concern the nature of TOPAS, HCARe or the hospitals theatre management systems as verification systems (See Section 3.6.1.2). In essence, whilst Treasurer's Instruction 305 requires each hospital to establish prior to payment that in relation to each claim for payment, the …rate of charge (for the service claimed) is correct and… the service has been satisfactorily performed, the systems to which claims are checked do not always facilitate discharge of this obligation.

Finding 5

The audit of the VMP payment system at four public hospitals revealed that:

- In 20 per cent of the claims examined, documentation on the hospitals' theatre management system or Total Patient Admissions System (TOPAS) did not support the level of fee claimed.
- Even when examining the hospital patient medical record, $2.8 million in payments could not be validated by any of the systems available.

VMP payments to the value of approximately $2.8 million have been made where there may have been either limited or no information available in TOPAS, HCARe, or the hospitals' theatre management system, to adequately substantiate these claims for payment.

3.7 THE ACCOUNT ASSESSMENT AND INFORMATION SYSTEM (AA&IS)

3.7.1 Future Developments

The AA&IS has only been in operation for approximately 2 years. At the time the Committee reviewed the System, not all phases had been implemented, including the phase concerned with reviewing the professional activities of VMPs.

The importance of reviewing the professional activities of VMPs was highlighted in the Agreement between the HIC and the DOH to develop this phase. In this Agreement the HIC stated that:

> *In the health care delivery, as in many other areas, a range of human behaviour is evident from fraud, through to unacceptable professional behaviour, to inefficient or ineffective practice and finally to best practice.*

> *Indications are that relatively few practitioners (approximately 2%) engage in fraud, with an additional 7-8% engaging in behaviour that would be unacceptable to the bulk of the medical profession. The majority of the medical profession however does engage in inefficient or ineffective treatment to varying degrees. The reason for this are multiple and include poor communication between practitioners, lack of processes enabling doctors to review their own performance and lack of appropriate access to the latest evidence regarding best practice.*
>
> *To ensure that a health care system is as efficient as possible, all factors need to be addressed.*[17]

Part of this phase will involve analysis of claims data in the AA&IS to identify possible fraud or unacceptable behaviour by VMPs. Of equal importance will be the utilisation by WA health sector agencies of HIC developed best practice programs and indicators. Utilisation of current and future programs and indicators is expected to provide the following benefits:

- *clearly focussed health outcomes.*
- *considerable potential cost savings.*
- *support from the medical profession concerning best practice.*[18]

The Committee's examination of management practices in the hospitals visited found that in general, there was little or no analysis of VMP payments performed to review trends or exceptions. Most reviews of VMP data were generally restricted to financial budgeting and reporting purposes. In large part there was a lack of awareness of the potential usage of this data and expertise to fully utilise it.

In addition, the Committee was advised that as the end of June 2002, not all Health Services were utilising the AA&IS to process their VMP payments, despite a directive from the Acting Commissioner of Health in September 2001 to do so. Those Health Services not utilising the AA&IS comprised a significant portion (approximately 15%) of all VMP payments made in 2000/01.

The directive clearly highlights the following concerns associated with Health Services not utilising the AA&IS including:

- *the use of processed account information for Departmental management information is significantly handicapped by the lack of data from non participating hospitals.*
- *the increasing complexity of the business rules cannot be managed without a statewide system.*
- *adherence by non participating hospitals to the business rules and fee schedule cannot be guaranteed by the Department.*[19]

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17 Agreement Between Health Insurance Commission and the State of Western Australia for the Development and Implementation of a Visiting Medical Practitioner Fee-For-Service Payments and Information System; Appendix A – Phase 4, p.8

18 *Ibid*, p.9

19 Western Australia Department of Health Operational Circular - Number OP 1463/01; Subject: Fee-for-service Payment of Visiting Medical Practitioners (VMPs); Date: 13 September 2001

The DOH advised that in relation to the above situation that a number of the non-participating Health Services were *committed to starting on 1 July 2002.*[20] In addition they stated that *the revised arrangements for managing Country Health Services to apply from 1 July 2002, will facilitate further implementation of the AA&IS.*[21]

Given the potential for inappropriate or fraudulent practices, weaknesses highlighted in 3.6 and the possible cost savings through adoption of better practice indicators and programs, the Committee considers that roll out of the professional activities review phase should be expedited as soon as practical. This roll out should be in conjunction with renewed efforts to ensure that all hospitals making VMP payments are utilising the AA&IS for this purpose.

In addition, as VMPs may provide services at more that one hospital, the Committee believes that overall coordination of audit and best practice reviews would be best placed with the DOH, with relevant input from the various hospitals concerned.

The Committee believes that part of future development of the AA&IS should also involve formal consultation with those individuals primarily responsible for its usage. As the AA&IS has now been in operation for two years, it may be an opportune time for the DOH to seek the system users' input into the current functionality of the AA&IS and areas that may require improvement or enhancement.

Accessing this valuable information resource could potentially further improve the current system and its capabilities, which in the long run may further enhance the system's usefulness and marketability to external buyers.

Finding 6

There is little or no analysis of VMP payments performed to review trends and exceptions, with most reviews of VMP data generally being restricted to financial budgeting and reporting.

At the end of June 2002, not all public hospitals were using the Account Assessment & Information System (AA&IS), despite a directive from the Acting Commissioner of Health in September 2001 to do so.

Recommendation 5

The Department of Health should implement a process that identifies excessive or exceptional VMP payment trends.

20 Letter, Department of Health, 14 June 2002, p.1

21 *Ibid.*

Recommendation 6

- The Department of Health should immediately implement the Account Assessment and Information System (AA&IS) should be immediately implemented in all hospitals in accordance with the directive from the Acting Commissioner of Health in September 2001.
- Overall coordination of audit and best practice review of VMPs should be placed with the Department of Health, with relevant input from the various hospitals concerned.
- After two years in operation, the Department of Health should seek input from the AA&IS users in relation to the functionality of the system and areas for improvement or enhancement.

3.7.2 Sale Opportunities

The Department of Health has invested considerable resources into the development and maintenance of the AA&IS. The DOH advised that:

> *Development costs for the system to date were (approximately) $1.2m. Further development costs primarily related to the development of professional review procedures by the HIC for the DOH were estimated at $0.5m.*
>
> *The annual outgoing expenditure to the HIC for 2001/02 was estimated at (approximately) $1m.*[22]

This system, while providing a tailored solution to the management of VMP payments for the WA health sector, is considered to be suited to other Australian States that have like type medical services payments. The Committee is of the opinion that in light of the significant development and ongoing expenditure on the AA&IS, that on sale opportunities of this system to external buyers should be actively pursued, in accordance with relevant Government policies.

Finding 7

The Department of Health has invested considerable resources into the development and ongoing operation of the Account Assessment and Information System (AA&IS), which has provided a system that may be suited to other Australian States that have similar types of medical service payments.

[22] *Ibid.*

Recommendation 7

The Department of Health should actively pursue on-sale opportunities of the Account Assessment and Information System (AA & IS) to external buyers, while having due regard to relevant Government policies.

3.7.3 Modes of Employment

As part of its inquiries the Committee focussed its attention on the modes by which medical practitioners are employed within the WA Government Health System. Largely this concentrated on medical practitioners employed in the metropolitan area.

Advice received from the Department of Health highlighted that:

> *medical practitioners are engaged by WA Government Health Services as both employees and independent contractors. The independent contractors – VMPs, provide services in the non-teaching (secondary) hospitals and may be General practitioners or Specialists. The majority of medical staff in the teaching (tertiary) hospitals, as well as the Kimberley, Pilbara and the Gascoyne are employees.*

Salaried employees range from the most junior, the intern, to the highly skilled and experienced specialist.[23] Until April 1, 2002 metropolitan employees have been employed under the Metropolitan Health Service Board (MHSB) AMA Medical Practitioners Agreement 1999. Employees engaged under this Agreement enjoy traditional benefits associated with a contract of personal service (employment) arrangement including:

- salary or equivalent remuneration;
- standard hours of duty;
- annual, long service and sick leave entitlements;
- employer superannuation contributions; and
- employer workers compensation coverage.

These salaried employees are also considered to be employees in the Public Sector and therefore, are subject to the requirements of the Public Sector Management Act (PSMA) 1994.

This contrasts to VMPs in that *VMPs are engaged on a fee-for-service basis at individual Health Services. The contracted VMP takes full responsibility for any services delivered by them, or on their behalf.*[24]

Prior to employment, each contracting practitioner is required to sign the Medical Services Agreement between the Minister for Health and the Australian Medical Association (AMA) and is paid via a schedule of fees defined in that Agreement. In practice this has meant each contracting practitioner signing a one-page contract, which incorporates through reference, the terms and conditions of the 'Head Agreement'.

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23 Department of Health, Submission, p.4 - 5

24 *Ibid,* p.6

The DOH advised that *a private ruling from the Australian Taxation Office has held that fee-for-service VMPs are not employees for the purpose of the Commonwealth superannuation guarantee legislation (Superannuation Guarantee (Administration) Act 1992).*[25] Similarly, VMPs are considered to be employed on a contract for the provision of services (independent contractor) basis, for the purposes of the Pay As You Go (PAYG) tax system.

Of interest to the Committee was the fact that in the 2000/2001 financial year there were 243 medical practitioners (approximately 25% of all VMPs) employed by Health Services on both a salaried and VMP basis. Pursuant to the Medical Practitioners Agreement 1999, these medical practitioners were employed in one or more of the following modes:

- Sessional
- Arrangement A
- Arrangement B
- Medical Officer

Section 102 of the PSMA 1994 states that:

Except with the written permission of his or her employing authority, which permission may at any time be withdrawn, an employee shall not —

(d) engage or continue in the private practice of any profession; or

(e) accept or engage in any employment for reward other than in connection with the functions of his or her office, post or position under the State.[26]

In relation to those medical practitioners employed by Health Services on both a salaried and VMP basis, the DOH advised *that there is little evidence of written permission having been obtained.* [27]

Correspondence from the Department of the Premier and Cabinet highlighted that the Section 102 requirements of the PSMA 1994 stemmed largely from the issues raised in the 1992 Report of the Royal Commission Into Commercial Activities of Government and Other Matters. In part this provision was included in the PSMA 1994 to improve the integrity of appointments within the Public Sector, by ensuring that agencies were fully informed as to any outside employment activities of individuals currently employed, or where they were being considered for employment.[28]

Advice from the Crown Solicitor noted that Section 102 of the PSMA 1994 applied to salaried medical practitioners employed under the under Medical Practitioners Agreement 1999, regardless of whether they were full time or part time employees. Accordingly, the Crown Solicitor advised that in regard to those 243 medical practitioners noted above *that permission should be obtained under Section 102 for employees undertaking VMP fee-for-service work.*[29]

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25 *Ibid*, p.8
26 Public Sector Management Act 1994; Section 102
27 Letter, Department of Health, 14 June 2002, p.2
28 Letter, Ministry of the Premier and Cabinet, 20 June, 2002
29 Letter, Crown Solicitor's Office, 28 May, 2002, p.2

Whilst there are a number of reasons why Health Services may facilitate dual employment arrangements, these arrangements can create a number of issues that need to be considered carefully in light of the requirements of Section 102 of the PSMA 1994 and effective and efficient delivery of health services. Some of these issues include:

1. Quality of Care

Health Services that are unaware of their salaried medical practitioners outside employment arrangements could be employing medical practitioners who are working excessive hours, contrary to the Australian Medical Associations 'Safe Hours' Campaign. This has the potential to impact adversely upon the capacity of the agency to deliver effective quality of care to its patients and in turn may increase the risk of potential exposure to actions for negligence in instances of adverse events for patients.

2. Costs of Employment

Health Services engaging medical practitioners on dual employment arrangements may in fact be paying a dollar premium for the same service. The current arrangements can result in a medical practitioner undertaking salaried sessional work in his/her field of expertise for $300 a session at one hospital, then undertaking VMP fee-for-service work at another hospital, in the same Health Service and earn $3 000 for that sessional work.

Whilst it is accepted that this is not the scenario for all dual employment arrangements, it nevertheless highlights the cost inefficiencies that can exist with these arrangements.

3. Conflicts of Interest

A potential conflict of interest associated with these dual employment arrangements, is the possibility for medical practitioners employed on a salaried basis at one hospital, to refer a patient seen by them at that agency to another hospital where they may be treated by them in their capacity as a VMP.

Where Health Services are unaware of their salaried medical practitioners outside employment arrangements, they may also be unaware of any potential conflicts of interest associated with these practitioners' external business arrangements. In the case of the example above, Health Services that are unaware of this potential conflict of interest are unable to make informed decisions concerning the engagement of medical practitioners, or adoption of strategies to minimise risks associated with this employment.

In response to this matter the Department of Health has advised that, "*the Department will issue an appropriate instruction detailing procedures to ensure written permission is obtained when required.*"[30]

[30] Letter, Department of Health, 14 June 2002, p.3

Finding 8

Approximately 25 per cent of all VMPs are currently employed by Public Health Services on both a salaried and VMP fee-for-service basis. However, contrary to the requirements of the *Public Sector Management Act 1994*, formal approval to undertake this dual employment has not been obtained in most instances.

Whilst Health Services may facilitate dual employment arrangements for operational reasons, these arrangements have the potential to create a number of issues that need to be considered carefully including:

- Possible adverse impacts upon the capacity of the employing hospital to effectively deliver quality of care to its patients.
- Cost inefficiencies associated with paying medical practitioners a dollar premium for providing the same, or similar service, at two different hospitals within the same health system.
- Possible conflict of interest scenarios.

Recommendation 8

Where VMPs are referring patients to hospitals for the VMP themselves to provide procedures, an audit or approval process to ensure the efficacy of such procedures should be implemented.

Recommendation 9

The Department of Health should implement a process to ensure that, where VMPs are employed as salaried doctors at teaching hospitals patients are not sent to other hospitals and treated by the same doctors in their role as a VMP.

Recommendation 10

The Department of Health should ensure that approvals are obtained for all medical practitioners currently undertaking dual employment arrangements.

The Department of Health should advise the relevant Health Services of the requirements of the *Public Sector Management Act 1994* and, in conjunction with the Health Services, develop appropriate policies and procedures to ensure that approvals are obtained where dual employment arrangements are being undertaken.

CHAPTER 4 THE VMP SYSTEM: OVERVIEW OF ISSUES

4.1 COST-BENEFIT ANALYSIS

The Government of Western Australia, through its departments and agencies, is responsible for the efficient and accountable management of the State's resources. Good management involves the regular assessment of established practices. However there is no way of knowing if the current system of visiting medical practitioners is the most cost-efficient and effective, if no cost-benefit analysis is undertaken.

The Committee was concerned to find that no real effort has been undertaken to objectively assess the benefits of retaining the current structure of employing doctors, which includes visiting medical practitioners, and salaried or sessional staff.

The Canning Division of General Practice Ltd submitted that any deliberations about fee-for-service versus sessional rates need to consider the real cost of alternatives.[31] The Committee concurs with this statement and further suggests that an assessment be made in the form of a cost-benefits analysis by the Department of Health, on all regional and secondary hospitals in the State.

The cost-benefit analyses that the Committee has been made aware of, appear to have been ad hoc, undertaken as a result of a dispute, or the inability of a hospital to retain sufficient cover in the accident and emergency department. They have not been undertaken as a comprehensive form of review or as a management practice.

4.2 OVERVIEW OF THE ADVANTAGES AND DISADVANTAGES OF THE VMP SYSTEM

In evidence to the Committee on 28 November 2001, former Commissioner of Health, Mr Alan Bansemer, told the committee that, in the past, metropolitan health administrators argued "that we should phase out the fee-for-service arrangements in the metropolitan area" on the basis of cost-effectiveness.[32]

Mr Bansemer told the Committee he believed that some of the large payments to VMPs were not appropriate but they were permissible under the agreement. He told the Committee that he did not know about them, because they were under the control of the Metropolitan Health Service Board:

> *during the period I was on the Metropolitan Health Service Board I did not know about it. In fact, the figures I was given were substantially lower than the figures now being discussed.* [33]

In contrast to Mr Bansemer's evidence, the Department of Health submission to the Committee outlined the basis for the argument in favour of fee-for-service. The Department did this by doing an exercise on cost comparison between:

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31 Canning Division of General Practice Ltd, Submission, p.1

32 Transcript of Evidence, 28/11/01, p.2

33 *Ibid.*

- a Level 22 Arrangement A Doctor; (total cost $407,460 p.a.);[34]
- a sessional specialist obstetrician at a non-teaching hospital ($336,000 p.a.);[35] and
- a specialist obstetrician on a fee-for-service basis ($250,000 p.a.).[36]

The Department of Health's view is that even though their comparison is simplistic, it does emphasise the difference between the models, particularly in view of the fact that fee-for-service is on a needs basis.[37]

The Australian Medical Association (WA) put to the Committee that the VMP model, by its competitive nature, is a best practice model:

> *Referrals are based on the referring doctors (sic) judgement as to whom is the most appropriate specialist thus exerting pressure on specialists to perform. In many such instances, the patient will be treated at the specialist's own rooms, again at no cost to the State. In others, admissions will be required either by the specialist to the local community hospital or if need be, arrangements would be made to admit them to a tertiary facility. Again it is a very cost effective, clinically appropriate system. Clinically VMP arrangements reflect best practice.*[38]

The AMA also argued that:

> *Under the VMP Arrangements the State doesn't meet the costs of outpatients, diagnostic and various other services provided by the VMP but has full access to the breadth of medical expertise of doctors who compete for work on a pay as you go basis and receive no on call payments.*[39]

In some cases the AMA's explanation may apply, but in some secondary hospitals this may not be the case because patients requiring surgery at these centres will be treated by the VMP working at that hospital, with little option of who they are treated by.

Mrs Helen Morton, General Manager, Armadale Health Service, told the Committee that:

> *The decision on whether the medical services are to be provided on a fee-for-service or a salaried basis is taken by management. The decision takes into account cost, and the need for flexibility. We need to be able to stop and start, or increase and decrease the levels of service. With a salaried person in place, this flexibility is often not available.*[40]

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34 This total did not include other costs for support staff, facilities, vehicles etc.

35 Based upon the most senior specialist level completing on 3.5 hour session each weekday and one session per weekend.

36 Assuming one caesarean section (one of the most expensive obstetrics procedures is conducted every day of the year.

37 Department of Health, Submission, p.17-18

38 Australian Medical Association, WA, Submission, p.10

39 *Ibid.*

40 Transcript of Evidence, Second Session, 05/11/01, p.3

All the work of an outpatient clinic in a salaried hospital is picked up by the health service or the State. In fee-for-service arrangements, all the costs of the pre-hospital work on those patients is done in the private rooms of the doctors. Therefore, all the costs of pre-hospitalisation:

- the costs of the outpatient clinics;
- the receptionists;
- the capital costs of the building;
- the electricity;
- the diagnostic work contained in the pre-hospitalisation work-up of patient; and
- the pharmaceutical costs

are not borne by the health service.

Many other costs are absorbed by the fee-for-service doctor, including:

- staffing costs of annual leave, sick leave, superannuation, workers' compensation and study leave;
- reception staff;
- nursing staff associated with the clinics;
- the capital cost of buildings, as well as any interest on borrowed money;
- the fit and furniture;
- technology;
- own vehicle costs;
- maintenance bills;
- insurance and litigation costs; and
- building insurance.[41]

The AMA (WA), in its submission to the Committee, emphasised that it was not possible to equate the sessional payments with VMP work:

> *A lot of services are provided on behalf of the State through the VMP's rooms at no cost to the State, as well as various other services which are embraced by the fee-for-service payment. In addition for operative procedures the fee-for-service payment includes normal after care within the Hospital consequent upon surgery.*[42]

41 Mrs Helen Morton, General Manager, Armadale Health Service, Transcript of Evidence, Second Session, 05/11/01, p.4

42 Australian Medical Association, WA, Submission, p.10

Mr Kim Snowball, General Manager, Geraldton Health Service, told the Committee that at the Geraldton Health Service Board meeting of 17 January 2000, in relation to the staffing of the accident and emergency service, the "option of salaried doctors versus continuing with fee-for-service VMPs was discussed…" and that a "financial comparison between salaried doctors and VMP arrangements" had been carried out.[43] The Committee was provided with comparative figures of $756 000 for the provision of a 24 hour a day emergency service versus $526 000 for the current VMP fee-for-service arrangement.

While it is appropriate to say that based on those calculations the VMP service appeared to be $230 000 "cheaper", it is the Committee's view that the cost comparison failed to take into account other factors, including the difference in 24 hours a day, on-site, clinical coverage provided under the salaried model.

Although the Committee received evidence in support of the VMP model the Committee's analysis is that in certain circumstances, especially in the metropolitan area, it is a very expensive method of providing medical services. The Committee's audit of a sample made up of the top 10 earning VMP's showed that it is possible for a VMP to earn approximately $4000 for performing up to 6 procedures in one day or less.[44] Such high amounts are possible if the VMP has a full list for the session. In the case of high-income earners this is clearly the case.

Based on the information received by the Committee in relation to the amounts that could be received for the most highly qualified specialist, it is the Committee's view that a salaried sessional specialist could perform the same work more cheaply, even when allowing for the associated costs of employing a salaried doctor. However this comparison is inexact and highlights the need for the Department of Health to undertake an accurate, objective cost benefit analysis.

The VMP model, however, works very well in rural areas where it is difficult to recruit doctors. Even where there is a specialist available, the problem becomes one of generating enough work and having support structures in place to encourage the specialist to remain in the location. The Committee acknowledges the fact that specialist practices require much larger catchment populations to be viable than do GP practices.[45]

In the metropolitan area it is more difficult to justify the use of VMPs. However in some circumstances it may be a valid option. In the Eastern States, most metropolitan health services have moved away from VMPs because they have found that it is expensive way of providing health services. More importantly it appears that having salaried staff provides more flexibility and better health outcomes in the long term. These outcomes include the ability to share knowledge between doctors and better equipping the health system to provide a broader range of health services.

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43 Transcript of Evidence, Second Session, 20/11/01, p.2-3

44 This can be compared to a sessional salaried doctor who, under the terms of the new Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2002 (PSAAG 39 of 2002), would be paid a base rate of $288-58 for the same 3.5 hour session.

45 AMWAC and AIHW, *Medical Workforce Supply and Demand in Australia: A Discussion Paper*, 1998, p.17

4.3 ADVANTAGES AND DISADVANTAGES OF THE SALARIED MODEL

Whilst the advantages and disadvantages of the VMP model as put to the Committee can be more readily expressed in dollar terms, the advantages of the salaried model in terms of total health care are far more difficult to quantify.

Some of the known benefits are:

- greater responsiveness - immediate availability of doctor for emergencies and after-care;
- certainty of coverage - not relying on the VMPs (as subcontractors) to provide services, as in some circumstances they may have their own private work which takes priority;
- better ability for health system to ensure a balance of medical skills in the workforce employed;
- imparting of knowledge or skills to other health professionals, including other doctors;
- flexibility in relation to rostering of procedures - this can be beneficial both to the hospital and patients;
- greater accountability - better accountability and support processes can be put in place for salaried professionals than is the case for VMPs, whose primary interest is in their private practice.

In terms of the difficulties facing a salaried model of employment, the Committee is aware that there are factors that cannot be ignored; particularly in relation to rural and outer metropolitan areas and the fact that many clinicians prefer to work in the inner urban areas. Similarly, it would be impractical and inefficient for the health system to have salaried doctors in those specialities with less patient demand staffing the public hospitals in rural and remote areas. These services are better provided by the VMP model.

The Committee also acknowledges that there is a propensity for a slower throughput of cases with a salaried model, but this can equally be seen as a benefit for the support staff and patients.

The Committee is also aware that the income earning ability of salaried staff is somewhat lower to the earning potential in a private practice, but suggests that a salaried lifestyle may suit those practitioners who may not care for the sometimes onerous responsibility of operating their own business.

4.4 ENVIRONMENTAL ISSUES

Whilst the Committee has been provided with anecdotal evidence of the advantages and disadvantages of different models of employment, no assessment has been done which takes all of the environmental issues into consideration. A proper assessment cannot be done in isolation from these issues, which the Committee has identified under 3 headings –:

- Structure of the Metropolitan Health Services;
- The Supply of Doctors; and
- Commonwealth - State Relations.

Each of these headings constitutes a different chapter of the report in which the Committee highlights the substantial range of factors that influence the need for, and effectiveness of, models of employment of doctors and specialists.

Recommendation 11

In country areas VMP services are an appropriate method of delivering cost-effective health services to the community and be should be continued.

Recommendation 12

In the metropolitan area VMPs should be phased out as and when constraints surrounding the structure of the Metropolitan Health Services, the supply of doctors, and Commonwealth-State relations allow.

Recommendation 13

The Department of Health should conduct a comprehensive cost-benefit analysis of all employment models to determine which model is best suited in each circumstance, both metropolitan and rural.

CHAPTER 5 THE VMP SYSTEM: THE STRUCTURE OF THE METROPOLITAN HEALTH SERVICES

5.1 ACCOUNTABILITY STRUCTURES

Under the *Hospital and Health Services Act 1927*, public hospitals are established and given the status of autonomous corporate bodies. This Act prescribes the powers and functions of these hospitals, however the Government of the day still sets the broad policy directives by which hospitals manage their activities.

The health system currently operates under an Output Based Management (OBM) funding and accountability mechanism. Agencies' relationship to their Minister, and ultimately to Parliament, is inextricably governed by this funding process and the operation of the *Financial Administration and Audit Act 1985*.

In simple terms, under the OBM system, the Minister, on behalf of the Government, 'purchases' outputs from the relevant government agency. The Treasurer, through the Parliamentary process, allocates the 'funding,' and the government agency 'provides' or delivers the outputs necessary to achieve the government desired outcome.

In turn, the FAAA 1985 provides the legislative framework governing the financial administration and reporting practices of government agencies funded through the OBM process. This Act requires government agencies to account for monies received from Parliament through yearly annual reports, which include financial statements and performance indicators.

In the case of the health system, Parliament appropriates to the Western Australian Department of Health funding in the order of $2.3 billion on an annual basis. The Government of the day stipulates the outcome that it desires to be achieved by expenditure of this money on specified outputs. In turn, the Department of Health negotiates with relevant public hospitals to deliver on the outputs specified, to a desired quality standard and acceptable price.

On an annual basis, the Department of Health reports to Parliament through its financial statements on its stewardship of funds appropriated to it. On the same basis, it also reports to Parliament on the extent to which it has achieved the Governments desired outcome and the efficiency with which it has produced its relevant outputs.

The Department of Health, as the key representative for the Minister of Health, has prime responsibility for ensuring the effective delivery of Government-desired outcomes through the:

- coordination and setting of clear strategies and performance targets for hospitals, which are clearly linked and directed towards achievement of the whole of health outcome;
- promulgation of health sector-wide directions and guidelines to assist in the management of public hospitals;
- development of health sector-wide systems to assist in the identification of emerging health sector issues and to aid in the development of corrective action; and

- monitoring of the operations of public hospitals in the delivery of their services.

This responsibility is reflected in the recent *Health Administrative Review Committee (HARC) Report - 2001* and in its subsequent implementation. The HARC review was initiated by the Minister for Health following dissolution of the Metropolitan Health Services Board (MHSB) and was driven by weaknesses that were considered to be evident in the administrative structure of the health system.

Specifically, the HARC report noted that:

> *the Minister for Health requested the Committee to provide recommendations that will ensure there is:*
>
> - *coordinated management and planning of health services across the public health system.*
> - *a high level of managerial and administrative accountability in the provision of an effective and efficient health service for the Western Australian community.*[46]

This report made it clear that the Department of Health is the key agency responsible for the overall management of the health system. The HARC proposed:

> *A new structure for the Health Department of Western Australia be established, based on the desirability of a single, unified Government health system working in partnership with others directly and indirectly involved in the provision of health services.*[47]

The HARC envisaged that:

> *The central office (the Department) to carry roles in policy, strategy, resource allocation, standard setting and such statutory and other functions as are appropriately carried out centrally.*[48]

With the demise of the MHSB, the Director General of the Department of Health, in his role as the Commissioner of Health, has been delegated the functions and powers of the former MHSB. In its place, the HARC report recommended:

> *Four Metropolitan Areas or Services be established, reporting through Boards and CEOs to the Minister and Director General on the health status and delivery of health services within their areas. The Areas to be described as East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Women and Children's Health Service.*[49]

At the time of writing these Metropolitan Health Services were in the process of being established. However, the overall focus is on establishing lines of accountability and supporting management structures that will deliver a unified and coordinated health system.

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46 Health Administrative Review Committee Report June 2001; p.1

47 *Ibid*, p.14

48 *Ibid.*

49 *Ibid*, p.16

Finding 9

The Committee supports the restructure of the Metropolitan Health Services into four Area Health Services, as recommended by the Health Administrative Review Committee.

Recommendation 14

In implementing the recommendations of the Health Administrative Review Committee there should be greater use of the metropolitan non-teaching hospitals and privately managed public hospitals for training purposes.

Recommendation 15

The Committee recommends the Metropolitan Health Service should be a fully integrated system under the direct control of the Director General of Health.

Recommendation 16

As a consequence of the restructure of the Metropolitan Health Services, the Department of Health should encourage appointments to Area Health Services or joint appointments at teaching and non-teaching hospitals within a given Area Health Service.

Recommendation 17

The Department of Health should review the role of each hospital within a given Area Health Service to ensure that the current structure is an efficient means of providing quality of care.

5.2 THE MANAGEMENT OF THE STATE'S HOSPITALS

Throughout the course of the inquiry, the Committee found that the State's hospitals were run individually, with little evidence of any integration. The Committee also found there to be a lack of aggregated information at HDWA level regarding employment and other arrangements at hospitals. These factors then contribute to a lack of flexibility for the health service as a whole to respond to immediate needs in different hospitals.

Recent changes to the metropolitan health services have resulted in the creation of three area health services in the eastern, western and southern metropolitan areas; and the creation of the Women's and Children's Health Service. The Committee is pleased to note that this initiative has been expedited due to the Committee's inquiry and believes that, as the hospitals will no longer be working in isolation, there should be improvements throughout the health system in terms of

flexibility and accountability. These benefits include better use of human resources, improved purchasing power and better control of finances and accountability processes.

Prof. Bryant Stokes, former Acting Commissioner for Health, told the Committee that:

> *Developing the regional system gives us the opportunity of being able to do that in the state system – the northeast and southern region, etc. That is a way, I am hoping, that we will be able to do it. We will also be able to have new appointments made to the health service, not the individual institution.* [50]

The Committee was initially concerned to learn that some doctors were receiving such high payments for working as independent contractors to the public health system. However, the Committee's concern in relation to the VMP system itself, and the Department of Health's oversight of that system, grew dramatically when it was revealed, in a subsequent formal evidence hearing, by the then Acting Commission of Health, Professor Bryant Stokes, that the information previously provided to the Committee had been incorrect.

Mr Brian Troy, General Manager, Health Workforce, advised the Committee of both the revised figures and the reason for the revisions:

> *I must first explain the background to the variation in the figures. Professor Stokes was provided with a briefing note based on individual sites and we did not take into account doctors who worked across a number of sites. Taking into account doctors working across a number of sites, the highest-paid metropolitan doctor is a specialist in obstetrics and gynaecology who earned $770,000 by working across Armadale, Bentley, Swan and Kalamunda.*
>
> *The highest paid non-metropolitan doctor is a general surgeon operating from Bunbury and Warren who earns $570,000 a year. The average individual payment to each visiting medical practitioner was $48,000 in the metropolitan are and $48,500 in non-metropolitan areas.*[51]

Further to this, Mr Alan Bansemer, former Commissioner of Health, made the following comment:

> *I did not know about it. I was Commissioner of Health. It was run by the former Metropolitan Health Service Board and I did not know about it. During the period I was on the Metropolitan Health Service Board I did not know about it. In fact, the figures I was given were substantially lower than the figures now being discussed*".[52]

Of immediate concern to the Committee were the issues of oversight and accountability, but also of quality of care and clinical or medical safety. Clinical safety was also of concern to the Department of Health:

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50 Prof. Bryant Stokes, Acting Commissioner for Health, Transcript of Evidence, 29/08/01, p.6

51 Transcript of Evidence, First Session, 5/11/01, p.6

52 Transcript of Evidence, 28/11/01, p.2

> *Anecdotally, the guy receiving $770,000 is working incredible hours that we, as an employer, would not allow an employed doctor to do. I guess that leads to the clinical aspects, but they are controlled by the clinical committees…*[53]

The Committee agrees that clinical safety issues are raised by practitioners working extraordinarily long hours and, further, that such situations should be investigated by the clinical committees. However the danger is when the health system cannot identify an individual doctor working at more than one site and in some cases, private practice as well. There are potential dangers in relation to patient welfare.

When the Committee commenced the inquiry, each health service was responsible for the administration of its hospital, which includes the staffing structure and staffing of the services provided by the health service. As a consequence, VMPs have been contracted to provide services, not by the Department of Health, but by each individual health service, with many VMPs providing services at more than one site.

The Committee also recognises that many of the specialists who are receiving very large payments from the public health system are performing services because of the clinical need and community expectations that these services will be provided by the public health system.

Finding 10

The Department of Health was not aware of the scale of payments being made to some high earning Visiting Medical Practitioners.

Recommendation 18

The Department of Health should introduce financial accountability controls that prevent and detect over-servicing by VMPs.

5.3 EMERGENCY DEPARTMENT / OUTPATIENT SERVICES PROVIDED BY HOSPITALS

One of the issues in the media at the time that the Committee decided to inquire into the use of visiting medical practitioners was the closure of the Swan District Hospital emergency department after hours because of an inability to find a senior registrar to work those hours.

The Committee heard in Geraldton that, due to problems with access to GP services and limited bulk billing for the community, there were a higher number of presentations at the accident and emergency department, particularly individuals who were clinically in need of GP services.

The Committee considers that the failure of the Commonwealth Medical Benefits Schedule (CMBS) schedule to keep pace with inflation is having an impact on the emergency service resources at hospitals across the State. (A copy of recent CMBS schedule changes is contained in Chapter 7.)

[53] Mr Brian Troy, General Manager, Health Workforce, Transcript of Evidence, First Session, 5/11/01, p.7

Anecdotally, the reality is that there had been an overwhelming reduction in the number of private general practitioners bulk billing and that there are not many GP practices that open outside normal working hours of 8 am – 7 pm.

As the table below indicates, there has been a steady increase in emergency department attendances in every public hospital from 1998 – 2001.

Emergency Department Attendances 1998 – 2001[54]

Hospital Name	1998 - 99	1999 - 00	2000 -01
Royal Perth Hospital	52453	53821	53881
Fremantle Hospital	39018	39988	39013
Princess Margaret/ King Edward Hospitals	51333	51651	51965
Sir Charles Gairdner Hospital	34549	35830	37343
Armadale/Kelmscott Memorial Hospital	20735	23473	26544
Swan District Hospital	21021	23243	24635
Bentley Hospital	855	1060	1367
Rockingham/Kwinana Hospital	22523	26058	27749
Wanneroo/Joondalup Health Campus	35507	39957	38451
Mandurah/Peel Health Campus	19505	22235	23636
TOTALS	**297499**	**317316**	**324584**

5.3.1 Co-located GP Clinics

The Committee heard that co-located GP clinics had been established at Frankston Hospital in Victoria. The same initiative was to commence at Sunshine Hospital, also in Victoria. It is happening on a smaller scale in Armadale WA.[55] A co-located GP clinic is where private doctors operating under Medicare are located adjacent to or near the emergency department of a State hospital. Patients attending emergency department are then given the option of being treated immediately at the clinic or having to wait longer to receive treatment at the hospital emergency department. The idea of this arrangement is to reverse the trend of patients presenting to emergency departments because services there are free and because of the reductions in bulk billing by GPs. Co-located GP clinics are not for the purpose of treating patients who are classified as triage 1, 2, or 3; that is genuine emergency patients, but triage 4 and 5; patients that would normally attend a doctor's surgery.

The advantages of a co-located clinic are that patients receive more immediate attention; resources are better utilised; State funds are not used for functions that should be more appropriately the responsibility of the Federal Government; and other ancillary hospital health services are better utilised. In other States, especially Victoria, co-located GP clinics in one form or another are common place. The Committee was told that the cost savings to those State health systems are significant. It is the Committee's understanding that the Department of Health is currently looking at the possibility of implementing such a policy in Western Australia.

54 Information supplied by Department of Health, 09/07/02

55 Though initially funded by the State in 1998, the current clinic was established in 2001 and is managed by the Canning Division of General Practice. The clinic pays a nominal rent to the hospital for the facility.

Recommendation 19

The Department of Health should introduce co-located GP clinics at public hospital sites.

5.3.2 Privately referred non-inpatients

A privately referred non-inpatient is a term used to describe private patients who have been referred to a nominated specialist operating an outpatient clinic at a public hospital.

In the course of its inquiry, the Committee was made aware of a quality of care initiative operating in New South Wales, whereby private doctors were permitted to operate their outpatient clinics from the hospital premises. Practitioners have access to those rooms for a charge. The consequence of this is that those initial costs are no longer funded by the hospital, but are covered by Medicare instead. Moreover, there is a flow-on effect in that all diagnostic tests, prescriptions etc are also covered by Medicare, thereby reducing the burden on the State for the provision of those services.

The Committee is aware that Dr Bill Beresford, in the capacity of Director Clinical Services at Royal Perth Hospital, lead a team that prepared a report on the 'Feasibility of Privatising of Outpatient Services in Western Australia,' by looking at three teaching hospitals in Victoria and New South Wales.

Dr Beresford's report recommended, "That the Metropolitan Health Service Board endorse the move to introduce bulk billing for privately referred non-inpatients rather than consider privatisation of outpatients."[56]

The matter of bulk billing at public hospitals was raised on several occasions with the Committee. Dr Robert Jarvis, General Practitioner, and Dr Kim Pedlow, the then President of the Rural Doctors Association in WA, highlighted in their submissions to the Committee, that there was confusion in the profession about what constituted legitimate billing practices for out-patients.[57] Dr Jarvis wrote, "There were no clear guidelines produced by the HDWA and there has been a huge variation in practice regarding billing for out-patients."[58]

The Committee found that it is unacceptable that doctors do not have clear guidelines in relation to the treatment of outpatient services. It is also important to make sure that the appropriate level of government is made responsible for the cost of these services.

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56 W Beresford, *Report to the Metropolitan Health Services Board on the Feasibility of Privatising Outpatient Services in Western Australia*, August 1999, p.4

57 Rural Doctors Association, Submission, p.6

58 Dr R B Jarvis, Submission, p.2

Recommendation 20

The Department of Health should introduce bulk billing for privately referred non-inpatients in the State's public hospitals.

Recommendation 21

The Department of Health should establish clear guidelines for the billing of patients for outpatient services.

5.4 SPECIALIST MEDICAL SERVICES PROVIDED BY SECONDARY HOSPITALS

5.4.1 Current Model of Specialist Service Provided by Secondary Hospitals

Under the current system each of the secondary hospitals try to provide the full range of specialist services. An example of a specialist services being offered across most secondary hospitals is obstetrics. The result is that hospitals need to employ VMPs, as there may not be enough work to substantiate salaried specialist services. This can also result in inefficient use of resources.

Mr Peter Baulderstone, former General Manager, Peel and Rockingham-Kwinana Health Services, told the Committee:

> *My primary recommendation would be to have four or five hospitals in Perth doing all of the obstetrics, not the eight or nine that are currently doing it. If you did that, you could organise rosters that were not as demanding on these people and you could potentially pay them less.*

Mr Baulderstone went on to say that a reduction in the number of obstetric units would produce significant economic and safety gains. [59]

5.4.2 Centres of Excellence in Secondary Hospitals

The Committee was in agreement with Mr Baulderstone's opinion that consideration should be given to rationalising specialist services in secondary hospitals. The creation of 'centres of excellence' would be a possible solution to this rationalisation. A centre of excellence would result in a specialist medical service being concentrated in a location. For example, the Osborne Park Hospital has in recent years specialised in obstetrics, which has resulted in better health outcomes for expectant mothers at the location.

There is scope for all secondary hospitals to follow this example in relation to the provision of specialist health services. Clearly, this should be co-ordinated by the Department of Health, so that the spread of specialist medical services across the various centres of excellence achieves the right balance. This cannot be achieved without the support and development by the specialists themselves.

[59] Transcript of Evidence, Third Session, 05/11/01, p.7

Centres of excellence in secondary hospitals would achieve:

- The improved ability to have salaried specialist staff at specific locations;
- Ability to have a large number of professionals from the same discipline working together, providing a more collegiate outcome of professional development, support and knowledge sharing;
- Flow on effects for the more efficient allocation of specialist ancillary and support staff, who can be targeted at specific specialities resulting in improved health outcomes;
- Provide patients with a wider choice of specialist services;
- Economies of scale;
- Safety in relation to hours worked;
- Better training outcomes (further developed in the following section of the Report); and
- Cost savings in terms of rationalising equipment use and purchase for a lesser number of sites.

The Committee recognises that any such rationalisation and establishment of centres of excellence is a politically complex matter, given that the public is used to having a larger number of hospitals providing the full range of specialist services. It is inevitable that some health users would have to travel further within the metropolitan area to access certain specialist services than is currently the case. However, the trade off for health consumers and the Government are the many benefits outlined above.

A qualification to the recommendation to rationalise specialist services is the recognition that at any hospital where an emergency department is operating, there will be an ongoing requirement for some specialist services. This would be an important message for the Government of the day to communicate to the public, so that people's concerns are placed in context.

Recommendation 22

The Committee recommends that consideration be given to the establishment of centres of excellence by the Department of Health.

5.5 TEACHING IN HOSPITALS

5.5.1 Current Structure of Teaching Hospitals

Currently there are five public teaching hospitals in the metropolitan area:

- Sir Charles Gairdner Hospital;
- Royal Perth Hospital;
- Fremantle Hospital;
- King Edward Memorial Hospital for Women; and
- Princess Margaret Hospital for Children.

Four of the above are very centrally located around the central business district of Perth. The Committee was informed that the concentration of training in these centrally located hospitals resulted in some resistance by specialists to work in secondary hospital locations once their training is completed.

Dr Ian Skinner, an orthopaedic surgeon based in Kalgoorlie said, "A mind shift must occur to allow people to realise that Perth is not the only place in Western Australia to have an orthopaedic practice."[60] Mr Michael McGushin a general surgeon also from Kalgoorlie made the comment, "We need an educational change. Doctors who take up a specialty need to let go of the apron strings and move away from the teaching hospitals."[61]

The Committee recognises that the difficulty experienced by secondary and country regional hospitals in attracting specialists may not only be the result of the training locations, but of other factors, such as the overall shortage of specialist numbers.

Each area of specialist medical training is under the control of a 'Royal College'. The College provides accreditation for that speciality. The training required for each speciality is undertaken at the five teaching hospitals. The number of training position is therefore limited.

The evidence received by the Committee maintained that the restrictions on the accreditation of training posts imposed by Colleges were motivated by the assurance of quality standards alone, and that the most significant restriction on the accreditation of additional training posts was funding. Professor Lou Landau, Executive Dean, Faculty of Medicine and Dentistry, University of Western Australia, stated:

> *the numbers that colleges admit into a training program depend upon the positions that are available, and they will accredit positions only if they have adequate experience in that speciality.*[62]

60 Transcript of Evidence, Fourth Session, 21/11/01, p.6
61 Transcript of Evidence, Second Session, 21/11/01, p.3
62 Transcript of Evidence, 10/04/02, p.5

Mr Philip Fisher Chairman, State Committee of RACS, told the Committee that:

> *the problem from the point of view of the college is the quality of training. The problem for the higher level of surgical training goes back to basic numbers of patients that junior doctors need to operate on to learn the skills… we need to provide that number of patients for them to be taught on, the appropriate nursing staff and everything else that goes with it.*[63]

Generally, training posts are reviewed in accordance with documented guidelines by College Fellows and granted accreditation provided that the College is assured that the trainee will:

- be subject to sufficient supervision;
- receive exposure to the sufficient range and quality of clinical scenarios required for complete training;
- participate in a structured teaching / education program;
- have access to sufficient training facilities such as medical libraries, clinical meetings, and conferences; and
- be required to comply with adequate administrative procedures.

Mr Kingsley Faulkner, President, RACS, told the Committee that he supported the expansion of the number of training positions in our colleges, provided the standard does not drop and there is sufficient clinical material for training purposes:

> *For a proper training program to function there must be exposure to a certain number of cases otherwise people will only be half trained in the time available. There must also be the funding to do that…* [64]

5.5.2 Teaching In Secondary Hospitals

The possibility of incorporating the 'peripheral' or secondary hospitals into training programs was suggested to the Committee, a number of times, as a means of increasing the capacity of the system to provide more training positions, while simultaneously improving the quality of training. Prof. Landau told the Committee that although capacity exists in the current system for the recognition and accreditation of training posts, it would require change in the way that services are provided. He indicated the need to:

> *…integrate the community-based services, the secondary hospitals and the tertiary hospitals, because the tertiary hospitals are becoming more specialised, and a lot of other care is occurring at the secondary hospitals and also within the community. Once we can integrate that, we can then organise the teaching positions that are now not available because there are limited numbers in the teaching hospitals, and we can then have them spread throughout the whole of the health service so that they are in the secondary hospitals and also in the community, and we would then have more positions and be able to train more specialists.* [65]

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63 Transcript of Evidence, First Session, 15/04/02, p.4-7

64 Transcript of Evidence, Third Session, 15/04/02, p.6

65 Transcript of Evidence, 10/04/02, p.4

Mr Fisher, concurred with the view that it would be appropriate to develop the State's secondary hospitals into centres of excellence where registrars and specialist surgeons could conduct training on public patients.[66]

This would involve the possible use of secondary hospitals and privately managed public hospitals (such as Joondalup) for training of specialists. This would require major changes, including revision of the use of VMPs. VMPs do not perform training tasks and the Committee is mindful of the Colleges' requirements that trainees receive appropriate levels of supervision and structured instruction. The use of secondary hospitals as teaching hospitals is already occurring in Victoria and New South Wales and has proven very successful in training specialists. Furthermore Mr Robert Aitken, Consultant Surgeon, told the Committee that in the United Kingdom a vast majority of training takes place at non-teaching hospitals.[67]

Centres of excellence may assist in accommodating teaching at secondary hospitals. The centre of excellence model, previously outlined in this report, would provide an adequate number of salaried specialists at the secondary hospital capable of providing the level of supervision and structure to the training of the trainee specialist. Furthermore, having been trained at the secondary hospital, the specialist may be more likely to take on working at the hospital in which he or she was trained. Any of this change would of course require the support of, and development by, the Colleges.

In line with the Committee's view that training should be extended to privately managed public hospitals, Mr Aitken, told the Committee that:

> *…the college has grave reservations about the volume of training that the trainees are getting at teaching hospitals because of the restriction of work. It is inevitable that training must take place in the private sector.* [68]

Recommendation 23

The Department of Health should implement the use of secondary hospitals, and privately managed public hospitals, as a means of increasing the capacity of teaching hospitals. This should be done in conjunction with the establishment of centres of excellence.

66 Transcript of Evidence, First Session, 15/04/02, p.11-12
67 Transcript of Evidence, 22/05/02, p.9
68 *Ibid,* p.5

CHAPTER 6 THE VMP SYSTEM: THE SUPPLY OF DOCTORS

6.1 THE SHORTAGE OF GENERAL PRACTITIONERS AND SPECIALISTS

In December 1995, the number of medical practitioners in Western Australia was below the national norm.[69] Queensland and Western Australia were well below the other States, with 88.8% and 86.6% of the national norm respectively.

As the table below indicates, Western Australia continues to have the lowest ratio of clinicians to population of any State or Territory in Australia at 220.3 clinicians per 100,000 of population. The shortage is even more pronounced in the case of general practitioners involved in primary care. This is even more astounding when the size of the State is taken into consideration, along with the geographic spread of population, and the special needs of remote Aboriginal communities.

Employed Clinicians per 100 000 population by State and Territory [70]

Occupation	All clinicians	Primary care	Specialists
NSW	255.1	111.0	90.2
Vic	243.4	113.5	96.9
Qld	225.6	104.5	72.6
SA	273.4	120.7	99.7
WA	220.3	98.7	78.0
Tas	233.5	125.9	72.0
NT*	239.1	115.1	59.9
ACT	279.4	124.5	96.0
Total	**244.5**	**110.6**	**87.5**

*It should be noted that the ACT provides a significant number of medical services to residents of south eastern NSW. In addition, the ACT has no significant rural areas and therefore comparing its level of clinicians per population with that of other States is not meaningful. Comparison of clinicians per population for capital cities shows Canberra having a lower supply than other cities.

The Committee received anecdotal evidence from a number of sources indicating severe shortages of GPs in metropolitan Perth and country Western Australia. These shortages are particularly evident in the fringe metropolitan area and smaller regional towns. In some cases local authorities are going to extraordinary lengths to attract GPs to their areas.[71]

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69 In Australia in December 1995 there were 253.8 practicing clinicians per 100,000 population. AMWAC and AIHW, *Medical Workforce Supply and Demand in Australia: A Discussion Paper*, 1998, p.23. See also p.36. In December 1998 there was a 26.8% difference between the States and Territories with the lowest and highest supply. The lowest rate was 220.3 clinicians per 100,000 population in WA. AIHW, *Medical Labour force* 1998, Canberra, p.3

70 Department of Health and Aged Care, *The Australian Medical Workforce Occasional Papers* New Series No.12, August 2001, p.42

71 For example, the City of Kalgoorlie-Boulder, in conjunction with other key stakeholders, have formed a group and produced a video to promote the area. Transcript of Evidence, Second Session, 21/11/01, p.3

There comes a point where the shortage of GPs in the metropolitan area and regional centres creates additional pressures on emergency departments of teaching and local hospitals with the associated implications. Where emergency departments are using VMPs as service providers, this can lead to increased human resource and financial cost implications for the State health system.

6.1.1 Supply Profile

Throughout the inquiry, the Committee repeatedly heard that Western Australia suffers not only a maldistribution of doctors but also from a general shortage in supply.[72]

Providing an adequate number of appropriately trained and skilled doctors against a population ratio is fundamental to the provision of quality health care to that population. Workforce shortages result in:

- reduced access to health care;
- unmet need;
- poorer health outcomes;
- overworked doctors; and
- expensive responses to the shortages by government.

In keeping with international developments which have seen a growth in medical workforce planning since the 1980s, the Australian Medical Workforce Advisory Committee (AMWAC) was established in 1995 by the Australian Health Ministers Advisory Council (AHMAC). It was envisaged that the formation of such a body would "enable action to be taken to better match the supply of medical practitioners with the demand for medical services in Australia."[73]

According to the research undertaken by AMWAC, Australia is considered to have a shortage of doctors in some specialities, the hospital workforce, the locum and deputising workforces, and in many rural and remote areas.

Maldistribution is a greater problem in some States than others, notably Queensland, the Northern Territory and Western Australia. As indicated in the table above, Western Australia has a comparatively low ratio of 78 specialists per 100,000 population, compared to the highest ratio of 99.7 specialists per 100,000 population in South Australia. Specialties known to AMWAC with either overall shortages, emerging shortages or localised shortages include:

- Anaesthesia;
- Dermatology;
- Ear nose and throat surgery;
- General surgery;

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72 The Chairman "We need some more specialists." Mr Graeme Clarke, General Surgeon, "Absolutely… There is a problem with supply." Transcript of Evidence, 13/03/02, p.18

73 AHMAC, *Tomorrows Doctors: A Review of the Australian Medical Workforce Advisory Committee*, 2002, p.xxiv

- Geriatric medicine;
- Intensive care;
- O&G;
- Ophthalmology;
- Orthopaedic surgery;
- Psychiatry;
- Radiation oncology;
- Rehabilitation medicine; and
- Urology.

Evidence presented to the Committee by Mr Robert Aitken, Consultant Surgeon, indicated that there were 28 general surgeons operating in the State health system in Western Australia. On 1 July 2002, that figure was to reduce to 26 surgeons and by the end of the year it was expected be only 22.[74] Only one general surgery trainee is due to come out of the system between now and 2005.[75]

Recent reviews undertaken by AMWAC have recommended increases in the number of trainees undertaken by the various, relevant specialties. However it appears that some of these recommendations have not been acted upon.

In 1999 it was reported that most of the OECD countries for which data are available are showing a continuing growth in the number of practicing doctors per 100, 000 population, with the exception of Canada and Australia, which has shown slight decreases since a peak in 1996.[76]

Finding 11

Western Australia has the lowest ratio of clinicians to population of any Australian State or Territory.

Recommendation 24

The ratio of clinicians to populations in Western Australia should be increased to at least the national norm by year 2010.

74 Mr Aitken explained that Joondalup Health Campus have four general surgeons; two of whom were due to retire at the end of June. One of the retiring surgeons had agreed to stay on until the end of the year. Transcript of Evidence, 22/05/02, p.3

75 Transcript of Evidence, 22/05/02, p.9

76 AMWAC & AIHW, *Medical Workforce Supply and Demand in Australia :A Discussion Paper*, 1998, p.23

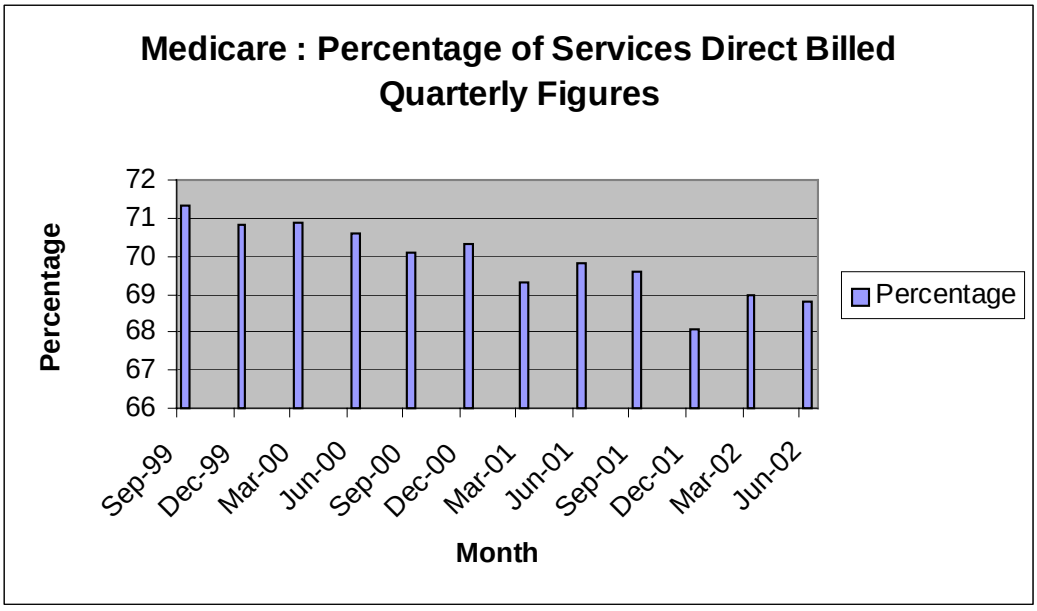
6.1.2 Growing Demand

One of the significant factors shaping demand for doctors includes population growth.[77] However, growth in patient demand for medical services has occurred faster than national population growth.[78] This growth in demand is evidenced by the number of hospital patients treated, and the rising average numbers of Medicare services per person.[79] Generally, health expenditure has accounted for a growing percentage of GDP over time.

Although illness and injury are the major factors determining patient demand for medical services, their respective levels and types of incidence are related to the characteristics of the relevant population such as age, ethnicity, Aboriginality, socioeconomic status, lifestyle and environmental risk factors.

However, in relation to the operation of these factors on doctor demand in Western Australia specifically, it is important to note that:

- using any of the three ABS projections for population growth between 1999 – 2101, Western Australia is one of the fastest growing States in Australia;[80]
- the population of those over 65 years is increasing rapidly;
- there are large itinerant Aboriginal population living in remote areas of Western Australia; and
- there are a larger number of small rural towns in WA compared to the national average.



77 University of Western Australia Faculty of Medicine and Dentistry, Background Analysis of Future Directions for Medical Education, August 2001, p.4

78 *Ibid*, p.18

79 AMWAC & AIHW, *Medical Workforce Supply and Demand in Australia :A Discussion Paper*, 1998, p.xi

80 University of Western Australia Faculty of Medicine and Dentistry, Background Analysis of Future Directions for Medical Education, August 2001, p.18

As the table above indicates in Western Australia, the percentage of services directly billed has decreased from 71.3% in 1999 to 68.8% in 2002.[81]

Recommendation 25

The Department of Health should insist that the Australian Medical Workforce Advisory Committee (AMWAC) give consideration to the special circumstances in Western Australia when forecasting medical labour force requirements.

The State Government should insist that there be a representative from Western Australia on the AMWAC board.

6.1.3 Rural and Remote Barriers

The population of Western Australia is 1.8 million with approximately 580,000 people living in rural areas. The Committee heard repeatedly of the difficulties of attracting and retaining doctors in the country areas; whether they are private practitioners, salaried doctors, or VMPs. A number of factors were identified as barriers to doctors working in the country:

- professional and personal isolation;
- on call 24 hours a day, 7 days a week and subsequent burn out;
- tremendous responsibility with limited hospital, specialist, technological and allied health back up;
- higher medical insurance premiums relative to patient throughput;
- higher costs of establishing private practices where economies of scale are not as readily available;
- fewer opportunities to fund their public work through private practice work; and
- lifestyle preferences and family /social commitments.

The difficulties of attracting doctors to regional and rural Western Australia led the Committee to canvas with many of its witnesses the concept of requiring specialist doctors, including general practitioners, to practice in the public system in the country in exchange for their training.

Mr Aitken told the Committee:

> *A better option would be have a salary package that tempts people to stay in the system…you should be saying that you will make it worth their while to work in the system by giving them a decent salary. Part of this is not just about salaries, but about lifestyle. That is why most of the juniors give up and why there are problems recruiting into general surgery.* [82]

81 Information sourced from Australian Department of Health and Ageing; Medicare Statistics; Table A7.

82 Transcript of Evidence, 22/05/02, p.12

Mr Kingsley Faulkner, President, RACS, told the Committee that attracting doctors to country areas does not usually work without:

> *a fair bit of pain and opposition. I would rather take the carrot approach if at all possible in which it is made attractive enough for people to want to do it. I do not mean monetarily attractive, but providing all the support mechanisms.* [83]

The Committee is in favour of any increased support mechanisms that can be practically provided but acknowledges that financial incentives remain the most obvious means to attracting doctors to rural areas.

Additionally the Committee learned of the adoption of a scale of rurality and remoteness implemented in New South Wales in the determination of the remuneration rates required to attract practitioners to areas of need. In light of the development of many of Western Australia's rural towns into significantly urbanised areas, the Committee recommends that categories of rurality and remoteness be adopted in the provision of incentives.

When the Committee visited the south-west to conduct hearings, it was presented with evidence that one of the most notable issues to affect the region was that of the partial withdrawal of services to the Busselton District Hospital by private General Practitioners in the area. Mr Noel Carlin, General Manager, Vasse Leeuwin Health Service, told the Committee that, though he believed the VMP service was very good, Busselton had been characterised by several years of tension and difficulty in the provision of emergency medical services. Towards the end of year 2000, the doctors were increasingly unwilling to treat out-of-town patients at the hospital.

The Committee heard that the dispute arose as a result of the heavy private workload of the general practitioners in their own practices, coupled with the influx of tourists to the area requiring treatment through accident and emergency. Though happy to attend to their own patients to provide continuity of care, the practitioners were concerned that their continued attendance at the hospital to attend to emergency patients, other than their own, affected their ability to effectively operate their own surgeries the next day. As a means of compensating any cancellation of private practice appointments the following day, the general practitioners proposed a "facility guarantee" fee.[84]

This fee was not agreed to by the health service and the final outcome was to move to a salaried system for the accident and emergency department, with one doctor being on call at all times.[85] The operating costs for the accident and emergency have increased from $330,000 a year under the previous fee-for-service arrangement to $698,000 for the provision of a 24 hours-a-day salaried staff.

However the Committee's view is that this cost comparison does not factor in:

- That the provision of fee-for-service medical services to the A & E section would only have continued if a facility guarantee fee had been agreed to, thus increasing the cost of the VMP model;

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83 Transcript of Evidence, Third Session, 15/04/02, p.9

84 Mr Noel Carlin, Transcript of Evidence, Fourth Session, 23/11/01, p.3-4

85 Mr Carlin also added that that, due to the geographical isolation of Busselton, only senior doctors were employed.

- The provision of services by salaried doctors provided benefits such as certainty of 24 hours a day coverage and immediate response, and various other benefits that are not easily quantifiable in dollar terms.

Another factor contributing to the shortage of doctors in rural WA is the increasing medical indemnity costs. The lower throughput of patients in rural and remote areas means that the cost of insurance per patient for the doctor is greater in those areas than in the metropolitan area and may consequently act as a disincentive for specialists to practice in country areas.

Medical indemnity insurance premiums have increased dramatically over the last year. The Committee heard that such increases are a disincentive for general practitioners to continue to provide obstetrics and anaesthetics care. The Department of Health currently provides a subsidy to rural general practitioners in relation to their medical indemnity insurance. That subsidy is considerably lower than the subsidies paid in other States.

However, and somewhat paradoxically, the alarming increases in indemnity insurance premiums for specialist and general practitioners areas may have the effect of encouraging more GPs and specialists towards salaried employment, where the health system picks up the indemnity cover.

Where a doctor works on a salaried basis, either as a full-time or sessional employee, the public hospital bears the cost of the medical indemnity insurance for that doctor. By contract, VMPs, working as independent contractors bear the cost of their own medical indemnity insurance. The Committee heard from Dr Gary Hastwell, Obstetrician/Gynaecologist, that this may be an incentive to attracting doctors to work on a sessional basis in the public hospital system

> *If the insurance premiums get very high, I think that is what will happen because it will price itself out of the market. The young guys especially will not have the money. I think in time insurance premiums may solve your problem, but the State must pick up the cost.*[86]

Recommendation 26

The VMP fee schedule should continue to attract a premium in areas where medical practitioners do not have back up, such as in rural areas.

Recommendation 27

The Department of Health should establish a locum pool of practitioners to relieve doctors in rural areas. This should be done in conjunction with the teaching hospitals, the Federal Government and the Australian Medical Association.

Recommendation 28

The Department of Health should further examine the current fly in/fly out surgical specialist service based at the University of Western Australia and Sir Charles Gairdner Hospital, with a view to expanding the service to areas of unmet need.

86 Transcript of Evidence, 20/02/02, p.16

Recommendation 29

The State Government should negotiate with the Federal Government to ensure that area specific provider numbers, which are currently in operation for a period of five years before portability, be further restricted to their current locations, or at least restrict portability to other areas of unmet need.

6.2 UNDERGRADUATE AND POSTGRADUATE TRAINING

6.2.1 Undergraduate Admissions to Medical School in Western Australia

Western Australia currently has only one undergraduate medical school located at the University of Western Australia (UWA). Completion of a Bachelor of Medicine and Bachelor of Surgery (MBBS) requires at least six years of full time study.

The number of students commencing the course in 2002 decreased to 137, from 146 the previous year. Over the past 12 years, from 1990, the intake for medical students at the University of Western Australia had risen on average at a rate of less than 1%. During the past eleven years 84% of students have completed the course, of which the evidence indicates 96% undertook full time employment in their first year.

The number of places available in the MBBS program each year is controlled by Federal funding; as explained to the Committee by Professor Bryant Stokes, former Acting Commissioner for Health:

> *The Commonwealth controls the higher education contribution scheme fees and how many places will be available in the various faculties. Through that the Commonwealth is controlling the number of medical schools and the numbers of places in the medical schools.*[87]

In formal evidence Mr Paul Boyatzis, Executive Director, AMA told the Committee of the situation in Western Australia:

> *Western Australia has more overseas-trained doctors per head of population than any other State in the country. A lot of them are in the rural sector. The AMA tries very hard – because it sponsors doctors to Western Australia and it works with the Department of Health to do this - to get the broadest skills it can so that those doctors can go to remote areas and practise their craft, whether it is obstetrics, anaesthetics or whatever. However, it is very difficult. Similarly, as a matter of interest, we have something like 280 overseas-trained doctors in our teaching hospitals because they are understaffed. When we look at the problems in our teaching hospitals, we cannot go past the fact that we cannot even get Australian graduates to man the hospitals within our State. The medical profession is hopelessly understaffed, our medical school is not graduating the numbers we need and we cannot keep Western Australian graduates in WA. This is a big issue on which we are more than happy to work with the Government.* [88]

87 Transcript of Evidence, 29/08/01, p.20-21

88 First Session, 10/12/01, p.19

Having completed the six-year MBBS, the graduate must complete a one-year intern course at a tertiary hospital, followed by a continued period of salaried employment as a junior doctor in one of the hospitals, as part of the hospital non-specialist workforce. The hospital non-specialist workforce comprises:

- doctors in training as interns and resident medical officers;
- career medical officers;
- hospital medical officers; and
- other salaried hospital doctors who are not specialists.

As the following table indicates, University places for medical undergraduates in Western Australia have only very slightly increased in the past decade. In fact, when the number of overseas fee-paying students who will return home after graduating is taken into consideration, the situation is even worse.

To demonstrate this problem and how it continues to result in shortages of doctors now and into future years, the intake of students in 1995-96 can be examined, as those students would be coming into the system in 2003 and the immediate years after. In 1996, 130 students commenced medicine at University of Western Australia (UWA), but only 123 of these students were Australian, with the remaining seven being overseas, fee-paying students. In 1990, 120 Australian students commenced at UWA; thus six years later, the number had increased by just three. Furthermore, in 1990, only 340 eligible students identified medicine as their first choice of study, of which 120 were accepted, whereas in 2001, 1020 eligible students identified medicine as their first preference, but only 141 were a accepted.

TISC Applicants[89]

Year	Number of Applicants with Medicine as their First Preference	No. of Applicants Commencing		
		Australian	*Fee Paying*	*Total*
1990	340	120	0	120
1991	492	125	5	130
1992	579	120	5	125
1993	668	125	5	130
1994	518	124	6	130
1995	493	123	5	128
1996	503	123	7	130
1997	487	123	9	132
1998	807	122	11	133
1999	949	126	4	130
2000	1051	127	5	132
2001	1020	141	5	146
2002	1040	134	3	137

89 Information supplied by the Faculty of Medicine and Dentistry, UWA, 22/3/02

Finding 12

Funding for undergraduate places in Western Australia's medical school has significantly failed to meet the State's increasing demand for doctors.

Between 1999 and 2002 the number of overseas-trained doctors in Western Australia with conditional registration has increased from 484 to 726, an increase of fifty per cent.[90]

The cost of training undergraduate medical students is approximately $30,000 per year.[91] As this figure shows, the total cost for the Commonwealth is not prohibitive. As such, an increase of 20 students would have a significantly positive effect on health outcomes for WA, but would not represent a major cost imposition for the Federal Government or State Government.

Recommendation 30

The State Government should consider funding extra undergraduate medical positions, which would be in addition to Commonwealth funded positions, and use the commitment of funds to bond students to practicing in areas of un met need.

Professor Lou Landau, Executive Dean, Faculty of Medicine and Dentistry, UWA, gave evidence to the Committee that the University currently has the facilities and resources to accept up to 180 entry level students annually. [92]

In addition to these undergraduate places at UWA, the Committee is aware that Notre Dame University has applied to the Federal Government to establish a 40 place undergraduate medical school.

Recommendation 31

The State Government should negotiate with the Federal Government to increase training places to the University of Western Australia's stated capacity of 180 entry-level medical students.

Recommendation 32

The State Government should support Notre Dame University's application to the Federal Government to establish a medical school for undergraduates, in addition to expanding the number of places at the University of Western Australia.

90 Medical Board of Western Australia, Annual Report, 30 June 2001 and 2002.

91 Professor Lou Landau, Transcript of Evidence, 10/04/02, p.8

92 Transcript of Evidence, 10/04/02, p.6

The Committee is aware that UWA offers scholarships to students from the country, who commit to returning to the country to practice.[93] Further changes in the selection and the educational experience are required to ensure that graduates work in areas of need such as remote and rural areas and outer metropolitan areas. In particular, greater selection of rural students should be ensured by allocating a set number of undergraduate places each year for students from country areas. This may require a different set of entrance standards to be adopted.

The Committee received evidence outlining a number of innovative initiatives undertaken by UWA to attract future medical practitioners to rural areas:

> *We are giving all students a rural experience so that they understand the country, and we hope it will entice them to go to the country….All our medical and dentistry students live in the country for one week in the first year, not concentrating on medicine as such, but experiencing local activities… They get the feel of living in the country right at the beginning of the course before they become fixed in their ideas. We believe it will have a major impact in the next few years.* [94]

Prof. Landau told the Committee:

> *[UWA is to commence] a pilot in June 2002 in which seven students will spend the latter half of the year in rural centres. We will increase that number to 30 by 2004. The experience will be voluntary, but we hope to have excited enough students to want to do it.* [95]

Prof. Landau also told the Committee that a rural clinical school, funded by the Federal Government, is currently under development. The rural clinical school initiative is aimed at establishing centres of excellence in medicine in the country and thereby providing placements for doctors in the country for two years as part of their formal training. By the year 2004, one-quarter of all students will spend a whole year in a rural centre. [96]

There are several benefits identified with the establishment of this program:

- Creation of centre of medical excellence in the country;
- Ability to attract professors of medicine to spend time in the country;
- Provides academic excellence and assistance to other practitioners working in the country;
- Provides an opportunity to train doctors in the country, thereby providing them with the opportunity to experience the benefits of country way of life, to be able to make an informed choice in relation to their choice of location to practice; and
- The creation of the centre and the possibility for training will also assist in attracting and retaining specialists in the country.

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93 Professor Lou Landau, Transcript of Evidence, 10/04/02, p.9
94 Transcript of Evidence, 10/04/02, p.2
95 *Ibid*, p.10-11
96 *Ibid*, p.2

Finding 13

Initiatives such as rural placements for medical students and the Rural Clinical School, are crucial first steps in encouraging doctors to practice in rural areas.

Recommendation 33

The State Government should provide scholarships to eligible medical school entrants on the proviso that, upon graduation, a certain period be served in areas of unmet need, as defined by the State.

Recommendation 34

The State Government should approach private industry and give local government the opportunity to provide scholarships to eligible medical school entrants on the proviso that, upon graduation, a certain period be served in specified locations.

6.2.2 *Postgraduate Training and Accreditation*

As the Committee established in section 6.1.1, Western Australia has a comparatively low ratio of 78 specialists per 100,000 population. This figure can be contrasted with a figure of 99.7 specialists per 100,000 in South Australia. Western Australia would need an immediate increase of approximately 170 specialists to meet the national average.

Whilst the Committee has advocated increased funding to increase the number of places in medical schools, it must also be recognised that this will only be effective if the number of specialist training opportunities in Western Australia also increases. There are not enough specialist training places in Western Australian hospitals. Professor Landau told the Committee that both undergraduate and postgraduate areas needed to be addressed: the increased number of graduates needed for the State; and the integration of the health service so that there are more training positions across the system. [97]

Referring to the number of training posts available in surgery Mr Robert Aitken, Consultant Surgeon told the Committee:

> *I refer you back to the training of surgeons. Evidence has been provided by the Royal Australian College of Surgeons, which revealed that in 1991 there were 163 graduates, and in 2002 there will be 74. There seems to be a fundamental problem. In 2001 there were 135 and in 1998 there were 126. The population is growing, there are greater demands on the system, and yet we are allowing fewer specialists to come out of the system, and that is causing a real problem for salaries and service, and with individuals themselves, because they will have to work longer hours in order to provide the service.* [98]

97 *Ibid*, p.13

98 Transcript of Evidence, 22/05/02, p.4

Mr Aitken, further told the Committee, that in relation to the specialist area of general surgery:

> *I know from evidence previously provided to the Committee that members are aware of the Australian Medical Workforce Advisory Committee. It last met to consider general surgery in 1997 and suggested that the number of general surgical trainees in Western Australia be increased from the then 15 to 21 by 2000. There are only 18 general surgical trainees in Western Australia.*[99]

The Committee is concerned that, despite the Australian Medical Workforce Advisory Committee's recommendation that general surgical places be increased to 21 by year 2000, that in year 2002, only 18 positions are available. The Committee believes that the Department of Health should immediately implement the AMWAC target of 21 places, as a minimum.

Mr Phillip Fisher, Chairman, State Committee of Royal Australasian College of Surgeons, advised the Committee that there are some potential hurdles to increasing the number of specialist training places, particularly the number of hospital beds and nurses. With regard to an increased number of training places, Mr Fisher told the Committee:

> *In light of that number of places, we need to provide that number of patients for them to be taught on, the appropriate nursing staff and everything that goes with it. Many people are trying to get into surgery, so once that is resolved, we can step back and look at the number of people coming through. We would then look at the resident jobs and then the training.*[100]

The Committee acknowledges Mr Fisher's concerns and has established in Chapter 5 that there are only five teaching hospitals in the State. However, if the Committee's recommendations in Chapter Five - to increase the number of training hospitals to include secondary and privately managed public hospitals - is adopted by the Government the number of beds, patients and support staff will be increased, allowing for the potential for an increased number of trainees.

Finding 14

Use of secondary hospitals and privately managed public hospitals will increase training positions for training purposes.

Mr Fisher, told the Committee that the United Kingdom has implemented a system that requires people to spend two or three years full time in the public hospital system, immediately following the completion of their training.[101]

If implemented in Western Australia, such a system would require the State Government to pay for the specialist training of the doctor. In return the doctor would commit to serve a specific number of years in the public hospital system. The State's public hospital system already bears certain costs to train specialists, such as the provision of training resources and placements. The increased cost of paying for the total training of the specialist would not be prohibitive, if the State decided to pick up this total training cost. Specialists currently are required to pay

99 *Ibid*, p.2
100 Transcript of Evidence, First Session, 15/04/02, p.7
101 *Ibid*, p.16

approximately $40,000 in total towards their specialist training, which will take between four and six years. [102]

Recommendation 35

The State Government should consider providing financial incentives to encourage doctors to train as specialists in exchange for a period of service in the State public health system after qualification.

The adoption of the Committee's recommendations to increase the number of specialist training positions would require some time to take effect. As such, the use of overseas-trained specialists in the Western Australian public health system cannot be ignored as a measure, at least in the short term. The recognition of overseas specialist medical qualifications needs to be reviewed. While the Committee does not wish to see standards in specialist services reduced, the professions need to look at the possibility of facilitating the entry of appropriately qualified overseas specialists.

Mr Kingsley Faulkner, President, RACS, called for the Committee to recommend a national summit of State and Federal Governments to examine the shortage of general practitioners and specialists, and other workforce requirements. Mr Faulkner said:

> *That summit would do a number of things: firstly, it would get the colleges involved and they could decide what they could do; secondly, it would get the state and federal Governments involved and they could decide what funding they could provide; and thirdly, it would get the Australian Medical Workforce Advisory Committee involved presumably with the public having a say.* [103]

Finding 15

The combined problems of training shortages, shortages of GPs and specialists, and areas of unmet need are not being adequately addressed across State and Federal levels.

Recommendation 36

The State Government should immediately call on the Federal Government to hold a national summit on medical training and workforce requirements.

102 Mr Philip Fisher, Transcript of Evidence, 15/04/02, p.2

103 Transcript of Evidence, Third Session, 15/04/02, p.3

6.3 LIFE STYLE, JOB SATISFACTION AND GENDER TRENDS

To this point, the Committee report has highlighted the shortage of doctors as a key environmental factor surrounding WA's use of VMPs. However the Committee's inquiry has revealed that lifestyle, job satisfaction and gender trends are also influencing how, where, and for how many hours per week doctors prefer to practice. These trends are not only influenced by the number of hours per week, but also the dislike for after hour's work. Doctors prefer more family friendly hours. As such, these issues emerged as important in examining the use of VMPs.

6.3.1 Lifestyle and Job Satisfaction

The Committee heard that younger medical practitioners are becoming more lifestyle conscious and are often less willing to work demanding hours. These changes in work place practices have been noted and documented in research surrounding the medical workforce, and are reflected among both metropolitan and regional doctors. [104]

AMWAC have reported that, though the sex related differences in working hours are slowly diminishing, they are still of significance. They say that there is evidence to suggest that male practitioners are choosing to work fewer hours than in the past, and the difference in total hours worked can be attributed to the fact that there are a greater proportion of females clinicians who prefer to work part time.[105] Professor Lou Landau told the Committee he believed female practitioners worked around 20 per cent less hours than their male counterparts.[106]

In keeping with international trends, the AMA recently introduced a campaign to reduce the working hours to safer levels for doctors. A National Code of Practice has been developed in response to long standing concerns regarding the extended hours worked by hospital doctors, particularly junior doctors. This voluntary code provides the employer with a risk assessment checklist in an effort to ensure adequate attention is given to rosters and rest breaks. This assessment categorises a doctor working 50 hours per week over a 7 day period as a lower risk category, with a higher risk being attributed to working 70 hours or more. [107]

The Committee supports safe work practices but acknowledges the need to assess the impact of this campaign on the need to the increased training and employment of doctors. As much as the campaign may result in an improvement to conditions of work and therefore may result in better retention rates, it follows that there will be a greater demand for numbers.[108] However it is not only the total hours worked by doctors, but when doctors prefer to work, that has a direct effect on the cost and ability to supply VMPs.

In relation to the total payments of $770,000 to one VMP in metropolitan Perth, Mr Paul Boyatzis, Executive Director, AMA told the Committee:

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104 University of Western Australia Faculty of Medicine and Dentistry, Background Analysis of Future Directions for Medical Education, August 2001, p.20. Submission, Medical Advisory Committee, Bentley Area Health Service, p.5

105 AMWAC and AIHW, *Female Participation in the Australian Medical Workforce*, 1996, p.9

106 Transcript of Evidence, 10/04/02, p.11

107 Australian Medical Association (WA) web site: 'Docs in Training: Safe Hours.'

108 University of Western Australia Faculty of Medicine and Dentistry, Background Analysis of Future Directions for Medical Education, August 2001, p.20. Submission, The Bentley Advisory Committee Bentley Area Health Service, p.21

> *We see a lack of specialist able to do the work. We have a shortage of doctors. This person has done the work because there are no others to do it. There will be examples in the metropolitan and rural areas. This is caused simply by a shortage of numbers. I am sure that this person would be delighted to have two or three colleagues to share the work.* [109]

According the AMWAC research, there is a high proportion of doctors working 80 hours or more per week, particularly:

- surgeons;
- internal medicine specialists;
- specialists in training; and
- vocationally registered general practitioners.

This highlights the distinct possibility that excessive hours are being worked to cover shortages in these areas. The Committee considers these hours to be excessive and urgent attention is required to provide sufficient training places to overcome these potentially excessive workloads.

The evidence heard by the Committee is consistent with the findings of a recent report commissioned by the AMA examining the availability of general practitioners across Australia. The report further attributed the misdistribution of general practitioners to the fact that in socio-economically disadvantaged areas, bulk billing rates remain high which undermines the practitioners capacity to provide quality care to patients, despite the fact that patient needs tend to complex. Similarly the relative attraction of inner urban areas to general practitioners was attributed to the ready referral of patients to specialists and acute hospitals, less pressure to bulk bill, and the greater ability to provide quality care which was regarded as commensurate with higher job satisfaction.[110]

The Committee also noted that this trend of doctors expecting to work restricted hours will continue to further reduce the total number of hours worked by the medical profession. This needs to be factored into both training and employment of doctors in the public health system.

6.3.2 Gender Trends

A number of studies have found that female medical practitioners display identifiable work practices and preferences, which differ to their male colleagues. The female medical workforce is represented most significantly among the younger age groups and is under represented amongst senior positions. Female medical practitioners prefer to enter specific specialist disciplines. Disciplines favoured by women include:

- paediatrics (63.3% of trainees);
- general practice (60.8%);
- obstetrics and gynaecology (60.0%); and

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109 Transcript of Evidence, First Session, 10/12/01, p.9

110 Access Economics, *A Report to the Australian Medical Association, An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, 2002, p.15-16

- rehabilitation medicine (57.1%)

This comparers with 13.4% of trainee surgeons and 18.3% of trainees in intensive care medicine.[111] Further, it appears that women practitioners currently have a preference for working in the metropolitan regions. [112]

The Committee heard repeatedly that, over a career span, female practitioners generally work fewer hours in comparison to male practitioners.

AMWAC research has reported that female GP reportedly work 66% of the hours of an average male GP and a female specialists, 74.9% of the hours of a male specialist.[113]

The Committee also heard that female medical practitioners have a higher rate of withdrawal from the medical workforce, particularly during the early stages of their careers. This was attributed to the onerous family commitments that many female practitioners undertake.

According to the Medical Advisory Committee of the Bentley Area Health Service:

> *Although the medical profession, like other professions, will always work longer hours than the average, there is a broad social shift towards more family friendly hours, even if the trade off is a lower income.* [114]

The Committee was advised that the expected continued growth of female participation in the medical workforce must be factored into future projections of the workforce because over time, the rising proportion of female doctors may be expected to affect both the supply and distribution of medical services.

MBBS Course Completion - By Gender[115]

Year	Males	% of Males	Females	% of Females	Total
1990	61	59%	42	41%	103
1991	63	61%	40	39%	103
1992	70	65%	38	35%	108
1993	59	57%	44	43%	103
1994	54	50%	53	50%	107
1995	53	55%	44	45%	97
1996	55	49%	58	51%	113
1997	57	54%	49	46%	106
1998	62	51%	60	49%	122
1999	54	51%	52	49%	106
2000	61	48%	66	52%	127
2001	67	53%	60	47%	127
Totals	716		606		1322

111 Medical Training Review Panel; Fifth Report, December 2001, p.3
112 AMWAC, and AIHW, *Female Participation in the Australian Medical Workforce*, 1996
113 *Ibid.*
114 Submission, The Medical Advisory Committee, Bentley Area Health Service, p.5
115 Information supplied by Faculty of Medicine and Dentistry UWA 22/3/02

The above table indicates that in the early 1990's, 60% of medical students were males. The trend indicates that the figure is now more likely to be around 50% or lower. This fact, coupled with the overall preference for more family friendly hours and part time work, has a dramatic effect on the ability to provide adequate health care to the community with the number of current medical student graduates. This becomes even more pronounced considering the lead-time required for doctors to qualify.

There are significant issues for many graduates, both male and female when deciding whether to enter some areas of speciality. It is important to maximise the opportunity for all graduates to specialise.

Finding 16

The onerous hours involved in training for specialties has proved a disincentive for some medical school graduates to further their training.

Recommendation 37

The Department of Health, in conjunction with the colleges, should devise strategies to provide all graduates, regardless of gender, with opportunities to specialise.

Finding 17

Changes in lifestyle preferences and gender mix have resulted in a reduced number of working hours per doctor. The Australian Medical Association (AMA) 'safe hours' campaign is likely to exacerbate this trend.

Recommendation 38

The State Government should encourage the Federal Government to recognise the reduced number of doctors' working hours due to both lifestyle and gender trends, and to factor this into medical student entry-level intake numbers.

6.4 OVERSEAS-TRAINED DOCTORS

Overseas-trained doctors are, as the name suggests, doctors who have obtained either their undergraduate and/or specialist qualifications and/or training in a country other than Australia. Overseas-trained doctors with permanent resident status and who have gained eligibility to practice by meeting the requirements of the Australian Medical Council (AMC) constitute a significant source of permanent additions to the Australian medical workforce.[116]

In 1998 there were 9,873 overseas-trained doctors in the Australian medical workforce, representing 20.4% of employed medical practitioners. In 1998-9, of the 408 medical practitioners who were citizens of foreign countries and who had permanently migrated to Australia, 220 had passed the AMC's clinical examination and were eligible for registration. A further 59 were specialists who had qualified for registration after recognition of their qualifications by the relevant specialty Colleges and the AMC. [117]

In 1999 AMWAC produced a report on the number, distribution and key workforce characteristics of Temporary Resident Doctors (TRDs) including their contribution to the workforce and recent trends in their use. The report defined a TRD as:

> *a medically qualified person holding a temporary resident visa to enter Australian for temporary employment or training purposes, who has been granted conditional registration as a medical practitioner by a State / Territory Medical Board and is a practising doctor in Australia.*[118]

Generally the positions that TRDs fill are positions that the Australian medical workforce has been unable to fill with a resident Australian doctor. Assessing the contribution of TRDs requires appreciation of the broader characteristics of the permanent workforce. TRDs are actively recruited by health authorities and workforce agencies nationwide, to work in hospitals, specialist services, general practice and deputising and locum services as specialists, non-specialist hospital doctors, general practitioners and locums. [119] During the 1990s, State health authorities made increasing use of actively recruiting temporary resident overseas-trained doctors,[120] particularly in areas traditionally filled by junior doctors.

In Western Australia, reliance upon TRDs is 20% higher than the national average. In the Western Australian metropolitan teaching hospitals TRDs work in most areas but are particularly prevalent in newborn services and emergency departments. At Royal Perth Hospital TRDs are used to fill vacant junior medical staff positions at the Resident Medical Officer (RMO) level. TRDs are also strongly represented in the peripheral hospitals. In Western Australia TRDs comprise up to 90% of the deputising workforce and 80% of the locum workforce. In rural areas this figure can be higher.[121]

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116 National Health Labour Force Series, Number 16, *Medical Labour Force*, 1998, p.11

117 *Ibid.*

118 AMWAC, *Temporary Resident Doctors in Australia: Distribution, Characteristics and Role*, 1999, p.1

119 *Ibid*, p.6

120 During the last three years (as at 1999) steady increase in recruitment of TRDs. They were predominantly recruited to work in metro and rural hospitals, and by locum agencies to work as GPs, GP assistants and to provide deputising services.

121 AMWAC, *Temporary Resident Doctors in Australia: Distribution, Characteristics and Role* 1999, p.36-41

Overseas-Trained Conditional Registration[122]

Conditional Registration	30/06/02	30/06/01	30/06/00	30/06/99
Internship	126	122	108	119
Supervised Clinical Practice	27	22	9	9
Postgraduate Training	25	23	47	24
Medical Teaching	-	-	0	1
Medical Research	3	3	2	3
Un-Met Area of Need	364	365	370	254
General Practice in Remote and Rural Western Australia	56	41	30	-
Recognised Specialist Qualifications and Experience	106	79	60	49
Foreign Specialist Qualifications and Experience – Further Training	11	13	15	10
Temporary Registration in the Public Interest	6	6	12	10
Special Continuing	2	2	2	3
Special Auxiliary Service	-	-	2	2
TOTAL	726	676	657	484
Medical Call Services[123]	3	3	3	3

As the table above indicates, the number of temporary registered overseas doctors has increased from 484 in 1999, to 726 in the year 2002. The Committee considers this to be a national disgrace. The fact that this huge increase in TRD's has occurred is because of the doctor shortages, because, despite the increased demand for places in university, there has been no increase in the number of places available. The community should be outraged at this situation. This situation creates unacceptable consequences for the WA health system and for health systems and communities in second and third world countries that are deprived of their own doctors.

Finding 18

There has been an increasing reliance on overseas-trained doctors in the Western Australian health system.

Finding 19

The importation of doctors into Australia is depriving countries like South Africa of much needed medical service and also prevents suitably qualified Australian students from becoming medical doctors.

Recommendation 39

The State Government should urge the Federal Government to increase university places to train Australian medical students in order to reduce the dependence on overseas-trained doctors.

122 Conditional Registration is granted to applicants who do not meet all the requirements of general registration under section 11 of the Medical Act 1894 (As amended). Source: Medical Board of Western Australia Annual Report, 30 June 2001, p.11, and follow up information.

123 A medical call service is a deputising service: practitioners must be registered and meet the normal requirements for registration.

6.4.1 OTD Program : Recruitment and retention of Overseas-Trained Doctors

The OTD Program is a Federal scheme to attract suitably qualified overseas-trained doctors (OTDs) to areas of rural and remote WA which are currently experiencing problems in attracting and retaining doctors. These areas are nominated by the WA Minister for Health and agreed by the Commonwealth Department of Health and Aged Care. The scheme will not apply to any metropolitan areas or regional cities with a population in excess of 50,000. The Commonwealth delegate has authority to grant exemptions for doctors subject to provider number restrictions under the *Health Insurance Act* 1973. These decisions are made on the basis of district workforce shortage. A district of workforce shortage is a geographic area in which the general population need for health care is not met. Population needs are seen to be unmet where a community has significantly less access to medical professional services of the type provided by the OTD than the national average.

In return for agreeing to practice in a district of workforce shortage for 5 years OTDs become eligible for Permeant Residency[124] and a provider number, restricted to the agreed rural or remote location. At the end of five years the Commonwealth will waiver the balance of the ten-year moratorium and allow them to practice anywhere in Australia as a GP and access Medicare. Another important incentive offered by the program is that OTDs do not have to sit the AMC exam if they have equivalent postgraduate qualifications, which allow automatic membership of the RACGP. Relevant experience as a GP will allow OTDs to obtain FRACGP within 2 years.[125]

As the future career plans of large groups of overseas-trained doctors who are registered under the Rural Incentives Program will impact on workforce needs in rural areas, the Committee recommends that the Department of Health undertake a survey to predict how many OTDs plan to move after completing the mandatory period in the country. Further, when considering future supply, the future movements of this part of the workforce must be taken into account.

As a consequence of the OTD Program the Committee suggests that area specific provider numbers be allocated to country towns. Under this program OTDs may wish to shift from one town to another, but may only go to areas that have a particular provider number available. The question of the five-year qualification period for a free transportable provider number may also be considered for Australian graduate doctors. Access to Medicare provider numbers may be a way to alleviate the shortage of doctors in the country.

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124 Once obtained FRACGP they will be supported by the Dept. of Aged Care in their application to the Dept. of Immigration and Multicultural Affairs (DIMR) for PR status. Normal requirements will still apply but upon meeting them DIMA have agreed to expedite granting of PR. Once gained PR doctors are free to leave paid employment and establish their own practice.

125 Doctors without FRACGP will access Medicare rebates at the A2level (non-recognised GP) under the MBS. Once the doctor obtains FRACGP they will be able to access A1 rebates.

CHAPTER 7 THE VMP SYSTEM: COMMONWEALTH STATE RELATIONS IN FUNDING HEALTH

7.1 OVERVIEW OF STRUCTURE OF COMMONWEALTH AND STATE RESPONSIBILITIES FOR HEALTH SERVICES

The use of Visiting Medical Practitioners is significantly effected by the relationship between the State and Commonwealth; in terms of the role each has to play in the provision of health services. While it is the State Government that is responsible for funding public hospitals and critical services within the system, such as emergency departments, it is the Commonwealth that controls other areas of the medical system that are either directly or indirectly effecting the use of VMPs. For example, the Commonwealth controls-

- GP services through the funding of Medicare;
- provider numbers to allow doctors to access Medicare payments;
- the number of positions available in undergraduate medical programs;
- the number of overseas-trained doctors granted temporary, permanent, or migration visa; and
- the accreditation process required to be met for doctors to be able to practice.

The fact that health care in Australia is a joint Commonwealth-State responsibility is widely regarded as a source of administrative difficulties and inefficiencies. Cost-shifting, whether the result of deliberate action or inadvertent consequence, results in funding responsibilities being shifted from one level of government to the other.

The Committee heard repeatedly in formal evidence and in informal briefings that two spheres of funding and administration is an enormous impediment to more efficient provision of quality health care to the Australian community.

As a result of two jurisdictions funding, planning and delivering health services, the Committee is aware that there is considerable time and effort expended by governments on considering ways to shift financial responsibility from one jurisdiction to the other. Moreover, it is also aware, that administrative decisions at one level of government can have immediate resource consequence on the other level of Government.

An unfortunate consequence of this structure of divided government responsibility is that doctors and specialists and other health professionals are at risk of being accused of being involved in illegal activities, such as Medicare fraud, when the Commonwealth is charged for procedures and consultations which, in their opinion, should have been borne by the State. In most cases, the doctors and health professionals' only interest is the patient's wellbeing.

7.2 THE EFFECT OF REDUCTIONS IN BULK BILLING

Bulk billing is the direct billing of medical services and procedures to the Medicare payment system by doctors and health professionals without the patient making any financial contribution. Medicare is the total responsibility of the Federal Government.

Many witnesses reported that as the Commonwealth Medical Benefits Schedule (CMBS-Medicare rebates) rates have not kept pace with inflation, fewer doctors are now bulk billing, resulting in out-of-pocket costs to the patient for a visit to the GP, or patients choosing to go to emergency departments at State hospitals where such services are free.

Patients who choose to use the emergency departments cause cost shifting to the State, but, more importantly, a requirement for increased resources such as more VMP services. This is particularly significant where emergency departments are exclusively staffed by VMPs. This direct relationship between bulk billing and increases in emergency department attendances can be clearly seen in the following tables and charts. The combined effect of the tables and charts is to demonstrate a correlation between declining Medicare funding and availability and increasing use of emergency departments.

Percentage increase in CPI and Medicare benefits schedule rates 1991-2001[126]

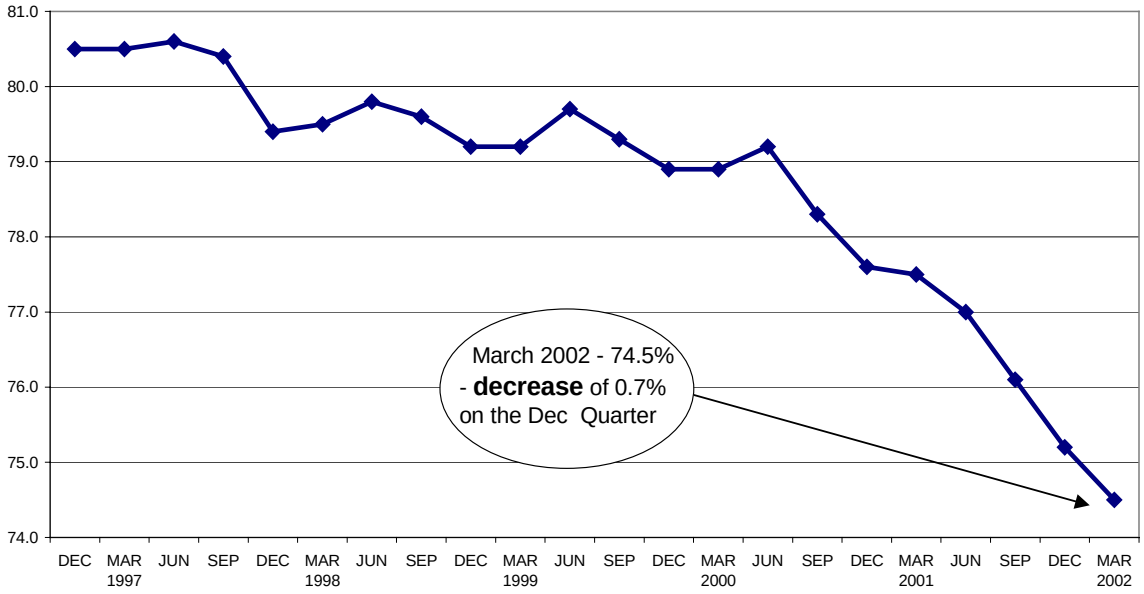
June – June	CPI	Fee Increase
1991-92	1.9%	2.31%
1992-93	1.03%	1.09%
1993-94	1.85%	1.27%
1994-95	3.17%	1.8%
1995-96	4.21%	None
1996-97	1.35%	1.7%
1997-98	0.7%	1.7%
1998-99	1.1%	1.5%
1999-00	3.2%	1.2%
2000-01	6.0%	1.6%

The rate of bulk billing in Australia has continued to fall since 1996 and has now fallen to alarming levels. In the March quarter of 2002, the reported fall of 0.7% in bulk billing, calculated on an annual basis, represents around 2.5 million fewer GP consultations being bulk billed. [127] To the extent that these consultations are being taken to emergency departments, rather than a GP, significant resourcing issues arise for the State's hospitals, including an increasing reliance on VMPs.

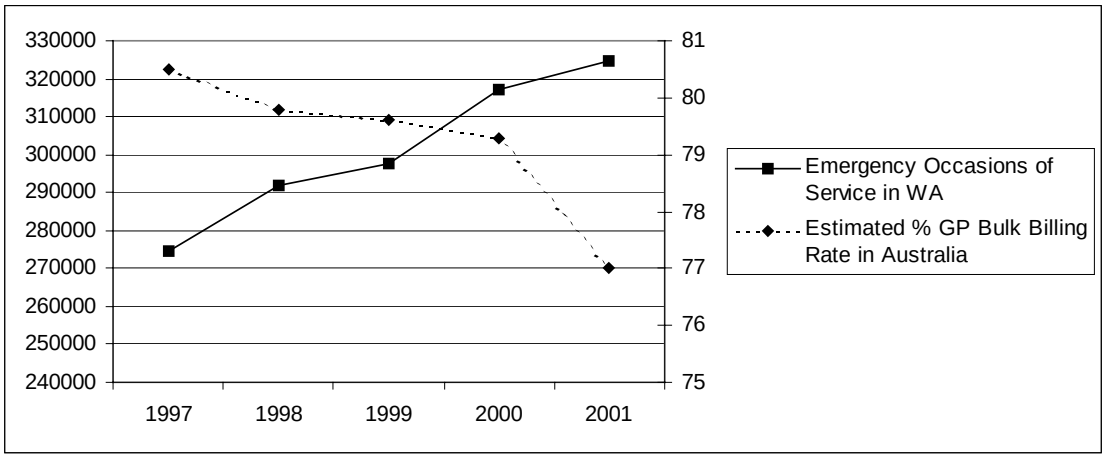
126 Medicare Benefits Schedule Rates fee increase information supplied by letter, Commonwealth Department of Health and Ageing, Health Access and Finance Division, 2 July, 2002

127 Australian Medical Association website: Media Releases 20 May 2002

GP bulk billing rate (December 1996 - March 2002



Emergency department attendances and estimated bulk billing rates



In 1996/97 the number of patients seeking assistance in emergency departments in public hospitals in Western Australia was approximately 275,000. This figure has increased substantially, and last year (2000/2001) was estimated to be 324,500 patients. Although there are other factors to consider, the fall in the availability of bulk billing has not discouraged patients from seeking help from emergency departments, where treatment is free, instead of at general practitioners where it may, at times, have been more appropriate for their health needs.

The Committee acknowledges the State's obligations under the Australian Health Care Agreement to provide eligible persons the choice to receive public hospital services free of charge as public patients. And, while the Committee acknowledges that there will be a variety of factors influencing the increase in emergency department presentations, repeated anecdotal

evidence suggests that there are a number of attendances that would be better treated by a general practitioner. The lack of bulk billing practitioners, combined with the financial reality that emergency department services are provided free of charge, results in an obvious incentive for patients to choose to attend an emergency department instead of visiting a general practitioner. This results not just in the general practitioner's costs being charged to the State, but also the ancillary costs such as pharmaceuticals, x-rays and other tests which may be required.

Finding 20

Medicare rebates have failed to increase in line with the Consumer Price Index (CPI).

There has been a corresponding increase in the number of attendances at emergency departments.

Recommendation 40

The State Government should negotiate with the Federal Government to increase the Medicare rebates to a level that will encourage doctors to return to bulk billing.

7.3 OTHER COMMONWEALTH/STATE FUNDING ISSUES

7.3.1 More Effective Use of Out Patient Services by the Health System

A patient who visits a GP with a complaint may, upon being asked by the GP, elect to utilise the public health system rather than the private health system for further treatment. In many such cases the patient will attend a public hospital but be referred to or treated by a private doctor, working at the hospital as a VMP. The effect of this arrangement is that the State hospital incurs the cost of the patient, whereas if the patient had visited the same doctor in their outpatient clinic, Medicare and the patient would fund this consultation.

As outlined in section 5.3.2 of this report, a quality of care initiative has been in operation in New South Wales, whereby private outpatient clinics are permitted to operate from the public hospital premises. The effect of this arrangement is that the cost of a patient's initial consultation, before a decision is made as to whether the patient should be admitted as a hospital in-patient is not borne by the State.

Whilst the Committee acknowledges that the Commonwealth Health Insurance Commission will have an interest in ensuring that Medicare funds are properly incurred, the State Government is within its rights to seek the correct funding outcome for patients, who are properly classed as out-patients.

7.3.2 Co-located GP Practices

Co-located GP services can have a dramatic impact on the operations of emergency departments at State hospitals. Not only are there direct cost savings to the States, it can provide a far better screening service for emergency department admissions. The Committee has addressed this issue in Chapter 5 as part of its restructure proposal and advocates that this issue is of paramount importance in the next round of State-Federal negotiations on health care. It also needs to be resolved in the interests of those health professionals working in these areas.

Recommendation 41

The State Government should investigate the establishment of co-located GP clinics at appropriate public hospital sites, including the teaching hospitals.

7.3.3 Pharmaceutical Benefits Access to Outpatients

During the Committee's visit to Victoria, it was indicated that agreement had been reached with the Federal Government that doctors working in the State Government hospitals were able to give patients prescriptions redeemable under the Pharmaceutical Benefit Scheme (PBS). This is a huge cost saving to the Victorian health system. This pilot scheme has been implemented in order to give a better health outcome to patients, especially after patients leave hospital and return into the community. The Committee urges the Department of Health to investigate the possibility of implementing this program immediately.

Recommendation 42

The State Government should investigate the Victorian pilot program with a view to implementing 'pharmaceutical benefits scheme' prescribing by doctors working in Western Australian public hospitals.

7.3.4 Aged Care Patients Occupying State Hospital Beds instead of Federally Funded Beds

There are more than 300 patients awaiting aged care residential placement currently occupying State hospital beds. This is an enormous cost burden on the State, and in the case of many regional hospitals, requires VMPs to care for these patients. In Victoria, Sunshine hospital has now implemented a scheme in which the hospital supplements private providers to help shift these patients out of the State hospital beds and into private arrangements. This includes providing support nursing services as well as other health service required. The Committee recommends that this issue be recognised in any future State Government-Federal Government negotiations.

Recommendation 43

The State Government should negotiate with the Federal Government to provide sufficient aged care beds to overcome the current shortage.

Recommendation 44

The State Government should make provision for alternative services to aged care patients who are currently occupying public hospital beds.

CHAPTER 8 THE VMP SYSTEM: FEE SCHEDULES

8.1 OVERVIEW OF FEE SCHEDULES

The WA State Government spends over $63 million on payments to Visiting Medical Practitioners. VMPs are remunerated on the basis of a schedule of fees, which is largely based on the Commonwealth Medical Benefits Scheme (CMBS). The WA Government Medical Services Schedule (WAGMSS) have historically been set at a premium above the CMBS. In the 1995 Agreement that premium meant that visiting medical practitioners were being paid at up to 20% above the CMBS.

From 1 December 2000 VMPs were to be paid fees at a premium of 9% above CMBS for all CMBS items, with the following exceptions: diagnostic imagining which is set at the CMBS fee; anaesthetics which was set at a premium of 25% above the CMBS; and obstetrics which was set at a premium of 50% above the CMBS, subject to medical practitioners signing the proposed Medical Services Agreement.[128]

In evidence to the Committee, Prof. Bryant Stokes, former Acting Commissioner for Health, explained the reason for the VMP fee scale in Western Australia:

> *Our fee schedule which we pay them is slightly higher than the fee schedule that there is for the Commonwealth Medical Benefits Scheme. That is because we needed to have – this was some 10-12 years ago – something to attract them to work in our system. We have been able to negotiate some downward turn in fees.*[129]

The Committee looked at the question of fee levels in comparative perspective.

- fee-for-service arrangements do not exist in the Northern Territory, Queensland or Tasmania;
- South Australia only uses the fee-for-service model in rural areas (with one exception) and the rate is the a 5.7% premium above the CMBS;
- Victoria took a policy decision in the mid-1990s of moving away from fee-for-service arrangements. While they still exist, predominantly in rural areas, fees are negotiated on a health-service-by-health service basis and are not publicly available. Where fee-for-service arrangements are in place, in large regional centres they are at CMBS rates or discounted. This is however not the case in remote rural locations. One arrangement indicated to the Committee was 75% of the CMBS rates; and
- New South Wales has a sliding scale of fees, with the 110% of the CMBS rate being the highest rate paid under the fee-for-service model, where there is no Resident Medical Officer or Chief Medical Officer available 24 hours a day. There is also a Rural Doctors' Settlement Package, which provides an

128 Department of Health, Submission, p.7

129 Prof. Bryant Stokes, former Acting Commissioner for Health, Transcript of Evidence, 29/08/01, p.4

altogether different scale of fees for doctors working identified rural hospitals. However in most cases presented to the Committee the CMBS rate or a discounted rate was adopted. In cases where using fee-for-service resulted in huge payments to VMPs, the health system changed the hospital where these procedures were undertaken where salaried staff would perform those procedures e.g. cataract surgery.

The Western Australia Medical Services Agreement 2002 remunerates fee-for-service activity at a rate of 9% above the CMBS rate for most items. There is also a rural loading of between 4-20% depending on the level of rurality that is paid to rural medical practitioners. The rural loading is offered both as an incentive to attract and retain doctors to the country and as a recognition of the different circumstances and additional burdens placed on rural practitioners including professional isolation, lack of specialist facilities and medical back up.

The Committee recognises that, while the CMBS rate is a rebate, and is not the rate that medical practitioners can attract in the private sector or the AMA recommended rate, it is nonetheless the standard rate against which State Governments gauge their payments for fee-for-service service delivery. In that climate, it is clear that Western Australia is continuing to pay a rate that is higher than the rate that is paid in almost any other State in Australia.

8.1.1 VMP Fees in Comparative Perspective

CMBS Item Number	Item Description	CMBS	WAGMSS	% Above CMBS
16520	Caesarean section and post operative care for 7 days	$493.40	$537.80	9%
17603	Pre-Anaesthesia Consultation	$33.95	$42.90	26%
20830	Anaesthesia for all hernia repairs in lower abdomen	$68.60	$85.80	25%
30330	Lymph glands of groin - radical excision of	$568.55	$619.75	9%
30351	Breast - female - total mastectomy	$582.40	$634.85	9%
30425	Liver - repair of deep multiple lacerations of - or requiring debridement - for trauma	$1,033.75	$1,126.80	9%
30511	Morbid obesity - gastric reduction or gastroplasty for - by any method	$672.00	$732.50	9%
35670	Hysterectomy - abdominal - with radical excision of pelvic lymph glands - with or without removal of uterine adnexae	$803.90	$876.25	9%

The above chart is only an indication of some of the current fees negotiated by the Department of Health and the AMA.

Finding 21

With the exception of New South Wales, other States predominantly employ salaried doctors in the metropolitan region and restrict their reliance on VMPs to the rural areas. Even in New South Wales the reliance on VMPs in the metropolitan area is minimal.

Finding 22

The Schedule of Fees contained in the July 2002 Medical Services Agreement provides for payments for most items at 9% premium above the Commonwealth Medicare Benefits Schedule. At 9% above the CMBS, this premium is higher than what is being paid for VMPs in other States.

Recommendation 45

The 109% fee should be further negotiated in the next round of negotiations with the Australian Medical Association.

APPENDIX ONE

BRIEFINGS HELD

Date	Name	Organisation	Location of Briefing
29/04/02	Mr Bruce Marshall Chief Executive Officer	Djerriwarrh Health Service	Victoria
	Mr David Grace Director	Acute & Residential Care Djerriwarrh Health Service	Victoria
	Dr John Ferguson Executive Director	Acute Services Bendigo Health Care Group	Victoria
	Mr James Digby General Manager	Corporate Services Bendigo Health Care Group	Victoria
30/04/02	Prof. John Balla Chief Medical Officer	Sunshine Hospital Western Health	Victoria
	Mr Jon Evans Chief of Operations	Sunshine Hospital Western Health	Victoria
	Mr George Shaw Chief Executive	Sunshine Hospital Western Health	Victoria
	Prof. Brendan Murphy Chief Medical Officer	St Vincent's Hospital	Victoria
	Dr Clive Wellington Executive Officer	St Vincent's Hospital	Victoria
	Mr Simon Chant Industrial Relations Consultant	Department of Human Services	Victoria
	Mr Lance Wallace Executive Director	Financial and Corporate Services Department of Human Services	Victoria
	Dr Chris Brook	Rural and Regional Health and Aged Care Department of Human Services	Victoria
02/05/02	Ms Karen Crawshaw	NSW Health Department	NSW
	Mr Robert McGregor Acting Director General	NSW Health Department	NSW
	Mr Ken Barker Chief Financial Officer	NSW Health Department	NSW
	Mr Tony Farley Assistant Director	Employee Relations NSW Health Department	NSW
	Mr Paul Gavel Executive Officer	Australian Medical Workforce Advisory Committee	NSW
	Ms Justine Kernow Senior Policy Analyst	Australian Medical Workforce Advisory Committee	NSW
	Assoc. Prof. Steve Boyages Chief Executive Officer	Western Sydney Area Health Service	NSW
	Mr Bernard Deady Director	Finance & Corporate Services Western Sydney Area Health Service	NSW
	Dr Siun Gallagher Director	Sere Development & Population Health Western Sydney Area Health Service	NSW
	Ms Jenny Coutts Director of Nursing	Western Sydney Area Health Service	NSW
	Dr Claire Blizard Director	Clinical Management Unit Western Sydney Area Health Service	NSW
02/05/02	Ms Roy Cordell Director	Clinical Management Unit Western Sydney Area Health Service	NSW

Date	Name	Organisation	Location of Briefing
02/05/02	Mr Russell Mills Director	Clinical Management Unit Western Sydney Area Health Service	NSW
	Mr Nick Gerrand Director	Human Resources Western Sydney Area Health Service	NSW
	Ms Miriam McCartney Acting Director	Corporate Affairs Western Sydney Area Health Service	NSW
03/05/02	Dr Ian Rewell Director	Clinical Services South Eastern Sydney Health Service	NSW
	Mr Ken English	Human Resources South Eastern Sydney Health Service	NSW
08/07/02	Dr Brian Lloyd Assistant Director General	Department of Health of Western Australia	Minister for Health's Office
	Mr Philip Aylward A/ General Manager Health Workforce & Reform	Department of Health of Health of Western Australia	Minister for Health's Office

APPENDIX TWO

WITNESSES TO HEARINGS

Date	Witness	Position	Organisation
29/08/01	Professor Bryant Stokes	Acting Commissioner of Health	Department of Health
	Mr Michael Harris Moodie	Executive General Manager, Finance & Infrastructure	Department of Health
	Mr Julian Henderson	General Manager, Executive Services Division	Department of Health
05/11/01	Professor Bryant Stokes	Acting Commissioner of Health	Department of Health
	Mr Colin Peter Xanthis	Acting General Manager, Officer of Aboriginal Health	Department of Health
	Mr Brian James Troy	General Manager, Health Workforce	Department of Health
	Mr Peter Richard Bartlett	Project Manager	Department of Health
	Mr Phillip Aylward	General Manager	Swan & Kalamunda Health Services
	Mrs Helen Margaret Morton	General Manager	Armadale Health Service
	Mr John Herbert Dowling	Manger, Business Services	Armadale Health Service
	Mr Steven Roy Marshall	Acting General Manager	North Metropolitan Health Service, Osborne Park Hospital
	Mr Ronald Shand	Manager, Financial Services	North Metropolitan Health Service, Osborne Park Hospital
19/11/01	Dr David Jonathon Russell-Weisz	Director of Medical Services	North West Health Services
	Mr Ian Trevor Smith	General Manager	Kimberley Health Service
	Dr Lindsay David Adams	Paediatrician	Kimberley Health Service
	Mr Andrew John Waters	Executive Officer	Kimberley Division of General Practice
20/11/01	Ms Bronwen Claire Scott	General Manager	Midwest Health Service
	Mr Allan Gordon Putland	Deputy Chair	Midwest Health Service District Clinic Council
	Mr Brian Christopher Chinnery	Operational Support Manager	Midwest Health Service
	Ms Jayne Sarah Reid	Union Official	Australian Liquor, Hospitality and Miscellaneous Workers Union
	Mr Dermot Buckley	Project Officer	Men's Health Inc
	Mr Terence Gerard Brennan	Operations Manager	Geraldton Regional Aboriginal Medical Service
	Mr Kim Snowball	General Manager	Geraldton Health Service
	Mr Alan Morton Glover	Manager, Finance & Support Services	Geraldton Health Service
	Mrs Elizabeth Annette Anderson	Director of Nursing	Geraldton Health Service
	Mr Paul Flanagan	Visiting Medical Officer & Surgeon	
	Dr John Geoffrey Pollard	General Practitioner	University Medical Practice

Date	Witness	Position	Organisation
21/11/01	Mr Trevor Canning	General Manager	Northern Goldfields Health Service
	Dr Keith Arnold McCallum	Obstetrician & Gynaecologist	
	Dr Charles Nadin	Medical Practitioner	
21/11/01	Dr Ian Skinner	Orthopaedic Srugeon	
	Ms Christine Bolvig	Executive Support & Compliance Officer	City of Kalgoorlie-Boulder
	Dr Christine Jeffries-Stokes	Paediatrician	
	Dr Michael McGushin	Medical Practitioner	
22/11/01	Mr Alistair Holmes		
	Dr Mark Zafir	General Practitioner	
	Mr Stan Wisniewski	Urologist	College of Surgeons
	Dr Ian Leggett	General Practitioner	Southern Regional Medical Group
	Dr Leanne Abas	General Practitioner	Albany Clinical Society
	Dr John Treanor	Surgeon	
	Dr David Tadj	General Practitioner	North Road Family Practice
	Dr Lorraine Rae Spurgeon	General Practitioner, Visiting Medical Officer	
	Dr Darcy Peter Smith	General Practitioner	Albany Clinical Society
	Dr John Lindsey	Physician	
	Miss Katherine Ivey	Health Information Manager	Lower Great Southern Health Service
	Mr Douglas Alistair Gilchrist	Director of Nursing	Lower Great Southern Health Service
	Mr Keith John Symes	General Manager	Lower Great Southern Health Service
	Mr Paul Williams	Finance Officer	Lower Great Southern Health Service
	Mr Ian Wesley Wilson	Councillor	City of Albany
	Mr Andrew Hammond	Chief Executive Officer	City of Albany
	Professor John Maloney	Executive Chairman	Consulting International Partnerships
	Mr Dennis William Wellington	Business Proprietor/Albany City Councillor	Albany Health Action Group
	Dr Joe Maurice Lubich	Doctor	Southern Regional Medical Group, Member of Medical Board of Western Australia
23/11/01	Dr Ronald Charles Jewell	Specialist Obstetrician /Gynaecologist, Visiting Medical Practitioner	
	Ms Linley Anne Donaldson	General Manager	Bunbury Health Service
	Dr Jonathon Bruce Mulligan	Director, Medical Services	South West Health Services
	Mr Noel Stephen Carlin		
	Mr Luigi Angelo Tuia	Chairman	Bunbury Health Service Board
	Dr Robert Baden Jarvis	Treasurer	Rural Doctors' Association of Western Australia
28/11/01	Mr Alan Bansemer		

Date	Witness	Position	Organisation
10/12/01	Dr Edward Pedlow	President	Rural Doctors' Association of Western Australia
10/12/01	Dr Andries van Ballegooyen	Rural General Practitioner	
	Mr Peter Jennings	Deputy Executive Director	AMAWA
	Mr Paul Boyatzis	Executive Director	AMA
	Dr Simon Towler	Medical Practitioner	
	Dr Warwick Ruse	Chairman	Medical Advisory Committee, Bentley Area Health Service
20/02/02	Dr Gary Hastwell	Obstetrician / Gynaecologist	
13/03/02	Mr Graeme Clarke	General Surgeon	
10/04/02	Professor Louis Landau		
15/04/02	Mr Kingsley Faulkner	President	Royal Australasian College of Surgeons (WA)
	Mr Phillip Fisher	Chairman	Royal Australasian College of Surgeons (WA)
22/05/02	Mr R J Aitken		
10/06/02	Mr Craig Bennett	Chief Executive	Sir Charles Gairdner Hospital
	Dr Mark Platell	Acting Executive Director, Medical Services	Sir Charles Gairdner Hospital
	Dr Philip Montgomery	Acting Director, Clinical Services	Royal Perth Hospital
	Mr John Burns	Chief Executive	Fremantle Hospital and Health Service
	Dr Shane Kelly	Executive Director, Medical Services	Fremantle Hospital and Health Service

APPENDIX THREE

WRITTEN SUBMISSIONS RECEIVED

Date	Name	Position	Organisation
19/10/01	Dr Michael O'Halloran		
22/10/01	Mr Robert Goldman		
26/10/01	Mr Warwick Ruse	Chairman	The Medical Advisory Committee, Bentley Health Service
01/02/02	Mr Warwick Ruse	Chairman	The Medical Advisory Committee, Bentley Health Service
29/10/01	Dr Christine Jeffries-Stokes		
29/10/01	Dr Roly Bott	Chairman	Canning Division of General Practice
02/11/01	Mr Graeme Clarke		
02/11/01	Mr Ian Skinner		
07/11/01	Mr Ian Fletcher	Chief Executive Officer	City of Kalgoorlie-Boulder
07/11/01	Dr J Lubich		Southern Regional Medical Group
07/11/01	Dr Bernard Pearn-Rowe	President	Australian Medical Association (WA)
12/11/01	Dr R B Jarvis		
13/11/01	Mr Andrew Waters	Executive Officer	Kimberley Division of General Practice (Inc)
05/12/01	Mr Andrew Waters	Executive Officer	Kimberley Division of General Practice (Inc)
14/11/01	Dr Kim Pedlow	President	Rural Doctors Association of Western Australia Inc.
15/11/01	Mr G A Holmes		
16/11/01	Mr Joe Ripepi	Principal	Acumen Enterprises
16/11/01	Mr Cobie Rudd	Chief Executive	General Practice Divisions of Western Australia Ltd
17/11/01	Mr Mike Daube	Director General	Department of Health
27/11/01	Ms Michele Kosky	Executive Director	Health Consumers' Council WA (Inc)
03/12/01	Mr Nick Newman		
04/12/01	Mr Stephen Cohen		
04/12/01	Dr Keith McCallum		
20/02/02	Dr Gary Hastwell		
14/12/01	Mr Vernon Brabazon		
22/03/02	Mr Stephen Lawrie	Admissions Officer	Faculty of Medicine & Dentistry, University of Western Australia