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Our ref DME:SLD:103815

5 September 2013

Attention: Gina D'Ettorre
Assistant Director, Adjudication Branch
Australian Competition and Consumer Commission
Level 35,360 Elizabeth Street
MELBOURNE VIC 3000

BY EMAIL: Gina.D'Ettorre@accc.gov.au

Dear Ms D'Ettore

Application for Revocation and Substitution of a Non-Merger Authorisation and Substitution of a New Authorisation

We act for the Australian Medical Association (NSW) Limited, and have instructions to file on its behalf an Application for a Revocation of a Non-merger Authorisation and Substitution of a New Authorisation.

We **enclose** Form FC - Application for Revocation of a Non-Merger Authorisation and Substitution of a New Authorisation and Submission in support of the Application, as well as Local Health Districts contact information for your reference.

We note that the current Authorisation expires on December 31, 2013. In the event that the ACCC has been unable to reach a decision regarding the attached application prior to that date, we seek an Interim Authorisation from that date, pending a decision regarding the enclosed application.

Should you have any questions in relation to the Application, or wish to discuss the Application, please contact Dominique Egan or Sarah Dahlenburg.

Yours faithfully
TressCox

Dominique Egan
Email: Dominique.Egan@tresscox.com.au

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Form FC

Commonwealth of Australia

Competition and Consumer Act 2010 — subsection 91C (1)

APPLICATION FOR REVOCATION OF A NON-MERGER AUTHORISATION AND SUBSTITUTION OF A NEW AUTHORISATION

To the Australian Competition and Consumer Commission:

Application is hereby made under subsection 91C (1) of the *Competition and Consumer Act 2010* for the revocation of an authorisation and the substitution of a new authorisation for the one revoked.

PLEASE FOLLOW DIRECTIONS ON BACK OF THIS FORM

1. Applicant

(a) Name of applicant:
(Refer to direction 2)

A91383 The Australian Medical Association (NSW) Limited

(b) Description of business carried on by applicant:
(Refer to direction 3)

AMA(NSW) is an independent association representing the state's medical profession. As an organisation of employers AMA(NSW) is a registered industrial organisation under section 271 of the *Industrial Relations Act* 1996 (NSW). A core component of AMA(NSW)'s role is the provision of industrial representation for all Visiting Medical Officers (hereinafter '*VMOs*') in New South Wales.

(c) Address in Australia for service of documents on the applicant:

Australian Medical Association (NSW) Limited c/o TressCox Lawyers, GPO Box 7085 SYDNEY NSW 2001

2. Revocation of authorisation

(a) Description of the authorisation, for which revocation is sought, including but not limited to the registration number assigned to that authorisation:

Authorisation A91088, made on 22 April 2008.

(b) Provide details of the basis upon which revocation is sought:

The authorisation expires on 31 December, 2013 and a new Authorisation is being sought by AMA (NSW).

3. Substitution of authorisation

(a) Provide a description of the contract, arrangement, understanding or conduct whether proposed or actual, for which substitution of authorisation is sought:
(Refer to direction 4)

AMA(NSW) seeks authorisation to collectively negotiate the terms and conditions of Visiting Medical Officer Contracts in the New South Wales Public Hospital System.

Copies of the current contracts are annexed to the supporting Submission.

(b) Description of the goods or services to which the contract, arrangement, understanding or conduct (whether proposed or actual) relate:

As above

(c) The term for which substitute authorisation of the contract, arrangement or understanding (whether proposed or actual), or conduct, is being sought and grounds supporting this period of authorisation:

As above

4. Parties to the contract, arrangement or understanding (whether proposed or actual), or relevant conduct, for which substitution of authorisation is sought

(a) Names, addresses and description of business carried on by those other parties to the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct:

AMA(NSW) seeks authorisation to collectively negotiate with NSW Health (on behalf of the Minister for Health) and Public Health Organisations (PHOs) in New South Wales.

In relation to negotiations with NSW Health, AMA(NSW) seeks to negotiate the standard terms and conditions, including rates of remuneration, of contracts, for New South Wales Visiting Medical Officers in the Public Hospital System.

In relation to negotiations with PHOs, AMA(NSW) seeks to negotiate on issues relevant to the engagement of Visiting Medical Officers by PHOs, but excluding standard Visiting Medical Officer contract terms and conditions and rates of remuneration.

Visiting Medical Officers in New South Wales who wish to be party to those negotiations and/or contracts which ultimately result from those negotiations would also be parties to the proposed arrangement.

(b) Names, addresses and descriptions of business carried on by parties and other persons on whose behalf this application is made:
(Refer to direction 5)

The Australian Medical Association (NSW) Limited, PO Box 121, St Leonards NSW 1590, on behalf of its members.

Where those parties on whose behalf the application is made are not known - description of the class of business carried on by those possible parties to the contract or proposed contract, arrangement or understanding:

N/a.

5. Public benefit claims

(a) Arguments in support of application for substitution of authorisation:

AMA(NSW) refers to Part 4 of its supporting Submission.

(See Direction 6 of this Form)

(b) Facts and evidence relied upon in support of these claims:

As above.

6. Market definition

Provide a description of the market(s) in which the goods or services described at 3 (b) are supplied or acquired and other affected markets including: significant suppliers and acquirers; substitutes available for the relevant goods or services; any restriction on the supply or acquisition of the relevant goods or services (for example geographic or legal restrictions):

AMA (NSW) refers to Part 5 of its supporting Submission.

(See Direction 7 of this Form)

7. Public detriments

(a) Detriments to the public resulting or likely to result from the substitute authorisation, in particular the likely effect of the conduct on the prices of the goods or services described at 3 (b) above and the prices of goods or services in other affected markets:

AMA (NSW) refers to Part 4 of its supporting Submission.

(See Direction 8 of this Form)

(b) Facts and evidence relevant to these detriments:

As above.

8. Contracts, arrangements or understandings in similar terms

This application for substitute authorisation may also be expressed to be made in relation to other contracts, arrangements or understandings (whether proposed or actual) that are, or will be, in similar terms to the abovementioned contract, arrangement or understanding

(a) Is this application to be so expressed?

Yes

(b) If so, the following information is to be furnished:

(i) description of any variations between the contract, arrangement or understanding for which substitute authorisation has been sought and those contracts, arrangements or understandings that are stated to be in similar terms:

Copies of the contracts are annexed to the Submissions.

(See Direction 9 of this Form)

(ii) Where the parties to the similar term contract, arrangement or understanding(s) are known - names, addresses and description of business carried on by those other parties:

.....

.....

(See Direction 5 of this Form)

(iii) Where the parties to the similar term contract, arrangement or understanding(s) are not known — description of the class of business carried on by those possible parties:

.....

.....

9. Joint Ventures

(a) Does this application deal with a matter relating to a joint venture (See section 4J of the *Competition and Consumer Act 2010*)?

Not applicable.

(b) If so, are any other applications being made simultaneously with this application in relation to that joint venture?

.....

.....

(c) If so, by whom or on whose behalf are those other applications being made?

.....

.....

10. Further information

(a) Name, postal address and telephone contact details of the person authorised by the parties seeking revocation of authorisation and substitution of a replacement authorisation to provide additional information in relation to this application:

.....

.....

Dated: 4 September 2013

Signed by/on behalf of the applicant

(Signature)

FIONA DAVIES
(Full Name)

AUSTRALIAN MEDICAL ASSOCIATION (NSW)
(Organisation)

CHIEF EXECUTIVE OFFICER
(Position in Organisation)

DIRECTIONS

1. Where there is insufficient space on this form to furnish the required information, the information is to be shown on separate sheets, numbered consecutively and signed by or on behalf of the applicant.

2. Where the application is made by or on behalf of a corporation, the name of the corporation is to be inserted in item 1 (a), not the name of the person signing the application and the application is to be signed by a person authorised by the corporation to do so.

3. In item 1 (b), describe that part of the applicant's business relating to the subject matter of the contract, arrangement or understanding, or the relevant conduct, in respect of which substitute authorisation is sought.

4. In completing this form, provide details of the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, in respect of which substitute authorisation is sought.

   (a) to the extent that the contract, arrangement or understanding, or the relevant conduct, has been reduced to writing — provide a true copy of the writing; and

   (b) to the extent that the contract, arrangement or understanding, or the relevant conduct, has not been reduced to writing — provide a full and correct description of the particulars that have not been reduced to writing; and

   (c) If substitute authorisation is sought for a contract, arrangement or understanding (whether proposed or actual) which may contain an exclusionary provision — provide details of that provision.

5. Where substitute authorisation is sought on behalf of other parties provide details of each of those parties including names, addresses, descriptions of the business activities engaged in relating to the subject matter of the authorisation, and evidence of the party's consent to authorisation being sought on their behalf.

6. Provide details of those public benefits claimed to result or to be likely to result from the contract, arrangement or understanding (whether proposed or actual), or the relevant conduct, including quantification of those benefits where possible.

7. Provide details of the market(s) likely to be affected by the contract, arrangement or understanding (whether proposed or actual), in particular having regard to goods or services that may be substitutes for the good or service that is the subject matter of the application for substitute authorisation.

8. Provide details of the detriments to the public, including those resulting from the lessening of competition, which may result from the contract, arrangement or understanding (whether proposed or actual). Provide quantification of those detriments where possible.

9. Where the application is made also in respect of other contracts, arrangements or understandings, which are or will be in similar terms to the contract, arrangement or understanding referred to in item 2, furnish with the application details of the manner in which those contracts, arrangements or understandings vary in their terms from the contract, arrangements or understanding referred to in item 2.

FILE No.
DOC:
MARS/PRISM:

Submission to the Australian Competition and Consumer Commission pursuant to section 91 (1c) of the Competition and Consumer Act 2010 (Cth)

Date: 5 September 2013

TressCox
LAWYERS

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Contents

1. APPLICATION FOR REVOCATION AND SUBSTITUTION OF AN AUTHORISATION TO COLLECTIVELY NEGOTIATE ON BEHALF OF VISITING MEDICAL OFFICERS IN NEW SOUTH WALES

1.1. The Australian Medical Association (NSW) Limited (hereinafter '***AMA(NSW)***') seeks a revocation and substitution of an Authorisation A91088 pursuant to section 91 (1C) of the *Competition and Consumer Act 2010* (Cth).

1.2. On 13 August 2008 the ACCC issued a final Determination granting authorisation (hereinafter '***the Authorisation***") for a period of five years to AMA (NSW) to collectively negotiate with:

- NSW Health the standard terms and conditions, including rates of remuneration, of contracts for Visiting Medical Officers engaged in the New South Wales Public Hospital system; and

- Public Health Organisations (***PHOs***) in New South Wales (as set out in attachment A to the Determination) on issues relevant to the engagement of Vising Medical Officers by PHOs but excluding standard Visiting Medical Officer contract terms and conditions and rates of remuneration.

1.3. AMA (NSW) seeks to have the prior Authorisation substituted with a new authorisation, authorising it to collectively negotiate on behalf of VMOs in New South Wales with the New South Wales Ministry of Health and PHOs regarding the terms and conditions of visiting medical officer contracts in the New South Wales Public Hospital System.

2. BACKGROUND

2.1. AMA(NSW) is an independent association representing the state's medical profession. As an organisation of employers AMA(NSW) is a registered industrial organisation under section 271 of the *Industrial Relations Act* 1996 (NSW).

2.2. A core component of AMA(NSW)'s role is the provision of industrial representation for all Visiting Medical Officers (hereinafter '***VMOs***') in New South Wales. AMA(NSW) makes every effort to ensure the concerns of VMOs are heard and makes representations on their behalf.

2.3. In New South Wales the arrangements for the contracting of doctors in state hospitals and facilities are not unilaterally determined by the State Health Department (hereinafter '***NSW Ministry of Health***').

2.4. AMA(NSW) has a statutory role under the provisions of the *Health Services Act* 1997 (hereinafter '***HSA***') to recommend to the Minister for Health (section 87) and/or seek the

appointment of an arbitrator (section 89) to determine the terms and conditions and rates of remuneration for sessional and fee-for-service VMOs.

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

2.6. In addition to its statutory role, AMA(NSW) has a well-established collaborative working relationship with the NSW Ministry of Health (formerly NSW Health). This relationship is evidenced by the consent position reached regarding the Fee-for-Service and Sessional Determinations in 2007, and subsequent negotiations about the terms and conditions of the Determinations, including remuneration rates. An outline of those negotiations is contained at paragraph 3.15. The consent position reached in 2007 ensured and ensures the ongoing provision of medical services in the New South Wales Public Hospital system across the State, including in rural areas, and avoided the parties needing to expend considerable financial resources (as were expended in the early 1990s) on a contested arbitration process. The recent negotiations at the Ministry level and PHO level ensures on-going service delivery with minimal or no interruptions to service delivery.

3. VISITING MEDICAL OFFICERS IN NEW SOUTH WALES

3.1. Other than the Australian Capital Territory (and limited numbers in Victoria) New South Wales is the only State or Territory in which VMOs are independent contractors.

3.2. The New South Wales Auditor General's Report *Visiting Medical Officers and Staff Specialists* 2012 (hereinafter 'the ***Auditor General's Report***') states that there are 7,012 VMO appointments in the New South Wales Public Hospital System, and a total number of 4,594 individual VMOs in New South Wales Public Hospitals (the difference in the two figures is due to the fact that many VMOs have more than one VMO appointment). Of the 7,012 appointments, 4,645 are appointments under sessional contracts, and 2,367 are appointments under fee-for-service contracts (some of these VMOs are appointed under fee-for-service contracts at facilities covered by the Rural Doctors Settlement Package hereinafter '***RDASP***').

3.3. The table below shows VMO appointments by specialty 2009–10.

Specialty	Sessional	Fee for service	Total
Anaesthetics	1,269	74	1,343
General practice	322	937	1,259
General surgery	242	353	595
General medicine	231	184	415

Specialty	Sessional	Fee for service	Total
Obstetrics/gynae	297	105	402
Psychiatry	358	0	358
Orthopaedics	163	181	344
Ophthalmology	131	103	234
Paediatrics	181	30	211
Emergency medicine	164	18	182
Urology	85	70	155
Ear, nose and throat	99	44	143
Cardiology	99	35	134
Radiology	132	1	133
Others	872	232	1,104
Total	**4,645**	**2,367**	**7,012**

Independent Contractors Act 2006 and VMO Contracts in New South Wales

3.4. Section 7 of the *Independent Contractors Act* 2006, which commenced on 1 March 2007, impliedly repealed State and Territory laws which, inter alia, deem a party to a *services contract* to be an employer or employee, or confer or impose rights, entitlements, obligations or liabilities on a party that, in an employment relationship, would be *workplace relations matters* subject to specified exceptions.

3.5. Section 5 defines a services contract to be a contract to which an independent contractor is a party, that relates to the performance of work by the independent contractor and, relevantly, to which one of the parties is a constitutional corporation.

3.6. The status of VMOs in New South Wales as independent contractors is enshrined in section 76 of the HSA.

3.7. Services contracts between VMOs and PHOs are contracts for the performance of work. Copies of the Fee for Service contract and the Sessional contract are attached and marked Annexure 1 and 2.

3.8. The terms and conditions referred to in sections 87 and 89 of the HSA include workplace relations matters within the meaning of section 8 of the *Independent Contractors Act*.

3.9. Previously, Clause 4 of the *Independent Contractors Regulations* 2007 preserved the provisions of Parts 1, 3 and 4 of Chapter 8 of the HSA. In 2011 the *Independent*

Contractors Amendment Regulations 2011 (No 1) was passed by Parliament, preserving Parts 1 to 4 of Chapter 8 of the HSA.

3.10. In the 2008 AMA (NSW) submission to the ACCC seeking an authorisation (a copy of which is attached and marked Annexure 3) (hereinafter '***the 2008 Submission***'), AMA (NSW) was concerned that as a result of the partial preservation of the provisions of the HSA, a dual system would be in operation.

3.11. Whilst there is not, at the present time, a dual system operating in New South Wales, due to the preservation of Parts 1 to 4 of the HSA, AMA (NSW) nonetheless remains concerned that should the regulation be amended in the future, there would again be uncertainty regarding the contractual arrangements of VMOs in New South Wales. It is submitted that a substitution of an authorisation, as AMA (NSW) is seeking, would provide certainty to both VMOs in New South Wales, the NSW Ministry of Health and public health organisations in New South Wales about the framework within which VMOs provide services.

3.12. The Auditor General's Report states that 35.8% of public hospital doctors in New South Wales are VMOs. Further, the cost of sessional VMOs and fee for service VMOs is significant: $345 million and $200 million respectively in 2009-2010. This reflects an increase in the number of VMOs since 2004. In this regard we refer to paragraph 3.2 of the 2008 Submission.

3.13. New South Wales has a unique and important history of reliance on independent contractor specialists and general practitioners and this reliance provides the State with a flexible, highly qualified and diverse specialist and general practitioner medical service.

3.14. The existing system under the HSA provides an efficient mechanism for managing contract terms for such large numbers of doctors, and is particularly effective in retaining and recruiting specialist medical practitioners to provide services in rural communities.

Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination 2007 (hereinafter 'the 2007 FFS Determination') and the Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007 (hereinafter 'the 2007 Sessional Determination') Negotiations 2008-2013

3.15. In 2007, the first major renegotiation of the terms and conditions of the appointment of VMOs for some time occurred. Those negotiations and the public benefit derived from the ensuing arrangements were outlined in detail in the 2008 Submission.

3.16. During the five years that the Authorisation has been in place, a number of negotiations have occurred between AMA (NSW) and NSW Ministry of Health (formerly NSW Health) regarding the terms and conditions of the appointment of VMOs in New South Wales.

(a) In 2009, AMA (NSW) reached agreement with NSW Health to increase the remuneration rates for sessional VMOs effective from 1 January 2010.

(b) In 2009 AMA (NSW) reached agreement with NSW Health to maintain the fees paid to fee-for-service VMOs for cataract operations, following a reduction in the Medicare Benefit Schedule fee by the Federal Government.

(c) In 2010, AMA (NSW) reached agreement with NSW Health to increase the remuneration rates for sessional VMOs effective from 1 January 2011.

(d) In 2011 AMA (NSW) was consulted by NSW Health in relation to proposed amended Performance Review arrangements for VMOs in New South Wales.

(e) In 2012, AMA (NSW) reached agreement with NSW Ministry of Health to increase the remuneration rates for sessional VMOs effective from 1 November 2012.

(f) In 2013, negotiations commenced regarding changes to the Determinations, proposed by NSW Ministry of Health following recommendations by the Auditor General (NSW). Negotiations are ongoing.

Negotiations with Public Health Organisations 2008-2013

3.17. During the five years since the Authorisation was granted, AMA (NSW) has negotiated directly with several PHOs in relation to the terms and conditions of VMO arrangements at the Local level:

(a) In 2008 and 2009, AMA (NSW) assisted VMOs in Dubbo in their negotiations with the hospital regarding hospital specific emergency surgery arrangements.

(b) In 2008, AMA (NSW) assisted and negotiated on behalf of VMOs at Bankstown Hospital regarding the proposal to alter the VMOs arrangements from fee for service contracts to either sessional contracts or licence arrangements. The involvement of AMA (NSW) ensured that all specialist craft groups at the hospital continued to provide specialist services at the hospital during the negotiation period and following the conclusion of negotiations.

In 2008, AMA (NSW) assisted and negotiated on behalf of VMOs at Port Macquarie Hospital regarding the preservation of their previous contractual arrangements which were established when the hospital was operated by a private organisation. Agreement was reached which ensured that VMOs continued to provide specialist services at the hospital. In 2013, negotiations regarding the renewal of the contracts commenced and remain ongoing.

(c) In 2009, AMA (NSW) assisted VMOs at Campbelltown Hospital regarding the proposal to alter the VMOs fee for service contracts to licence arrangements.

(d) In 2011 AMA (NSW) assisted and negotiated on behalf of VMOs at Wagga Wagga Hospital regarding the emergency surgery roster arrangements, theatre allocation and remuneration arrangements.

(e) In 2012 and 2013, AMA (NSW) assisted and negotiated on behalf of VMO paediatric surgeons regarding remuneration arrangements, workload and rostering arrangements, training of junior medical staff, and attraction and retention of senior medical staff. These negotiations occurred at both a local health district level and with NSW Health. The negotiations are ongoing.

(f) During the period 2008 and 2013, AMA (NSW) has assisted with negotiations on behalf of VMOs specialising in anaesthetics in many regional hospitals, including Coffs Harbour, Lismore, and Bathurst.

(g) In 2012, AMA (NSW) assisted VMOs at Orange Base Hospital regarding the reduction of sessional hours contained in the contracts of several rehabilitation physicians, and the arrangements for the physicians to provide services at outpatient clinics in regional NSW towns including Cowra and Blayney.

(h) In 2013, AMA (NSW) assisted VMO psychiatrists who provide services to Broken Hill, with their concerns surrounding alleged unilateral changes to their contracts concerning late payment and changes to rostering. The negotiations are ongoing.

(i) In 2013, AMA (NSW) assisted VMOs at Westmead Hospital regarding the provision of parking for VMOs who are called into the hospital for the provision of urgent, emergency medical care to patients.

(j) In 2013, AMA (NSW) assisted VMOs in the Ear, Nose and Throat surgery department at Manly Hospital, who raised issues concerning equipment and staffing, and concerns as a consequence the safety of patients being compromised. Negotiations are ongoing.

(k) In 2013, AMA (NSW) assisted VMOs at Coffs Harbour Hospital regarding issues relating to the on-call roster and the provision of emergency after-hours care for paediatric patients.

(l) In 2013, several VMOs who work in the Emergency Department at Lithgow hospital approached AMA (NSW) for assistance in their negotiations with the Hospital regarding patient transfer protocols for patients who were critically ill. AMA (NSW) assisted the VMOs to negotiate an alternative patient transfer

protocol which was accepted by the hospital, ensuring the VMOs continue to provide emergency care at Lithgow Hospital.

4. PUBLIC BENEFIT AND PUBLIC DETRIMENT ARGUMENTS

4.1. AMA (NSW) is seeking the substitution of the Authorisation to preserve the current status quo. The experiences of the past five years whilst the Authorisation has been in place have demonstrated that there is public benefit to the further granting of a substituted authorisation, and no demonstrated public detriment.

4.2. In the 2008 submission, AMA (NSW) submitted that while there is nothing to prevent an individual or a particular craft group attempting to negotiate an arrangement outside the HSA framework, the majority of VMOs providing services in New South Wales elect to provide services as provided for under the HSA. This has continued to be the case over the last five years. Despite significant local challenges, VMOs have continued to provide services as provided for under the framework of the HSA, and have continued to seek assistance of AMA (NSW) when local issues arose (for examples see paragraph 3.17).

4.3. In the 2008 submission, reference was made to the existence of significant discontent amongst VMOs in New South Wales, and the unique ability of AMA (NSW) to negotiate the terms and conditions of engagement, as well as other issues pertaining to the work of VMOs in the Public Health System.

4.4. In 2013, similar levels of discontent exist amongst VMOs in relation to their work within the Public Health System. In 2013, AMA (NSW) conducted a survey of Public Hospital doctors regarding their experience of working in the public health system. The results reflect the views of VMOs, staff specialists and junior doctors, but nonetheless reflect the difficulties VMOs continue to face in the public hospital system, for example:

(a) 22% of doctors intend to resign or retire from the public sector in the next five years;

(b) 56% of doctors did not believe that the New South Wales Public Hospital System had become a better place to work in during the last 12 months;

(c) 32% of doctors had high levels of stress working in the New South Wales Public Hospital System; and

(d) 60% of doctors believed the provisions for doctors to be involved in decision making in their hospital/health service were poor or inadequate.

4.5. The 2008 decision made by the ACCC to grant the Authorisation acknowledged that "*the proposed collective bargaining arrangement may, to some extent, enhance the effective representation of VMOs in dealings with NSW Health in the future. This outcome in itself*

may provide VMOs with greater confidence with respect to the stability and development of medical services in NSW which may have a positive influence on the retention of VMOs" (see page 19 of the decision of the ACCC in 2008).

4.6. As the above survey results indicate, significant discontent remains amongst VMOs which provides a challenge to the Public Health System in relation to the retention of VMOs in New South Wales. A number of the examples provided above at paragraph 3.17 demonstrate the ability of AMA (NSW) to negotiate successfully with NSW Health and public health organisations in circumstances where in a number of those examples, VMOs considered resigning from the Public Hospital Systems. AMA (NSW) is able to provide support to individual VMOs, as well as groups of VMOs, negotiating with management. This support helps to ensure that many VMOs facing issues with Local Health Districts remain in the New South Wales Public Health System as opposed to allowing feelings of disenchantment and the like to result in resignations and disruption to the provision of services, particularly in regional and rural areas and critical service delivery areas of practice such as paediatrics.

4.7. AMA (NSW), by assisting in negotiations at the local level, and with the Ministry, allows VMOs to continue to provide services while negotiations about issues that may otherwise compromise service delivery are undertaken. This is not a suggestion that boycotts are contemplated, but the time associated with negotiations about terms and conditions are necessarily time consuming and can take the VMOs away from clinical responsibilities.

4.8. In order to retain VMOs within the Public Hospital System, the framework under the HSA has the requisite degree of flexibility to accommodate variations in the terms and conditions under which VMOs provide services. The local negotiations carried out by AMA (NSW) on behalf of VMOs demonstrate the capacity of the framework under the HSA to accommodate variations in local circumstances.

4.9. In the 2008 submission, AMA (NSW) argued that the role of AMA(NSW) as the collective negotiator of rates of remuneration for sessional and fee-for-service VMOs, ensures that, while endeavouring to act in the best interest of its members, and VMOs more generally, it can objectively balance the needs (and wants) of VMOs against the collective public interest in:

(a) The continuing provision of medical services of the highest quality in the New South Wales Public Health System; and

(b) The provision of those services on a cost effective basis.

4.10. This has been achieved over the past five years. AMA (NSW)'s previous submission argued that whilst individually negotiated contracts may be consistent with the philosophy behind independent contacting arrangements, such negotiations in the public health system will, without doubt, add to increases in the cost of public health care, both in

terms of the time and cost of administrators having to negotiate with individuals, and the potential for inflated remuneration rates. This remains true today.

4.11. The public policy benefit arguments above support the granting of a substituted Authorisation. In 2011, when the NSW State Government implemented a cap on wages paid to all public service 'employees', AMA (NSW) balanced the interests of VMOs and the continuing provision of high quality healthcare in the public system, and presented both sides of the argument to VMOs and invited them to make an informed decision about whether to accept or reject the proposal.

4.12. In 2011, the State Government introduced amendments to the *Industrial Relations Act* 1996 (NSW) to require the New South Wales Industrial Relations Commission to give effect to aspects of the abovementioned government policy relating to New South Wales public sector terms and conditions of employment. The Second Reading Speech indicated that the Government's policy and legislative response for fiscal restraint was to limit wages increases to public sector employees to 2.5%.

4.13. In June 2011, the State Government introduced into Parliament the *Parliamentary, Local Council and Public Sector Executives Remuneration Legislation Amendment Act* 2011, which amongst other amendments, amended Section 92 of the HSA, to require the arbitrator exercising arbitration powers in relation to the VMO Determinations, to give effect to the same policies on increases in remuneration as those the Industrial Relations Commission is required to give effect to (ie the wages cap of 2.5%).

4.14. The disadvantage suffered by Australians living in regional and remote New South Wales in relation to access to quality health care is well demonstrated. The Australian Institute of Health and Welfare states:

> *Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment.*
>
> *Clear differences exist in health service usage between areas. There are, for example, lower rates of some hospital surgical procedures, lower rates of GP consultation and generally higher rates of hospital admission in regional and remote areas than in major cities.*[1]

[1] Australian Institute of Health and Welfare, Rural Health- Impact of Rurality, Australian Institute of Health and Welfare, 2013, online , http://www.aihw.gov.au/rural-health-impact-of-rurality/, 3 July 2013

4.15. The ability of AMA (NSW) to negotiate directly with regional and rural hospitals in relation to VMO terms and conditions is of benefit to the public, particularly where VMOs continue providing services in regional areas while their local arrangements are the subject of negotiation. The number of negotiations which resulted in agreed beneficial outcomes in the last five years demonstrates the importance of the role of AMA (NSW) in resolving issues in regional New South Wales Public Hospitals, increasing the likelihood of regional VMOs continuing to provide services in regional New South Wales.

4.16. It is AMA (NSW)'s submission that there is no readily identifiable public detriment should a further Authorisation be granted. After the current Authorisation was granted, there was no "pressure" to increase fees. In relation to increases in the future, AMA (NSW) will continue to negotiate in good faith with NSW Ministry of Health to ensure the ongoing provision of public health services to public patients in New South Wales. This has been demonstrated over the last five years, where AMA (NSW) continued to negotiate with the interests of both VMOs and the patients in mind. In the 2008 decision granting Authorisation, the ACCC noted that certain features of the New South Wales Public Health System (that is, the VMO Determinations and the provisions of the HSA regarding the framework for negotiations) limit any associated detriment. This remains the case.

4.17. When assessing the public benefit and public detriment generated by conduct, the ACCC applies the future with-and-without test (the "counterfactual" test). With the benefit of the experience of the last five years, it has been demonstrated that the existence of the Authorisation has ensured that VMO terms and conditions have remained centrally negotiated with the involvement of AMA (NSW), providing significant benefit to the New South Wales Public Health System in terms of continuity of medical services and fiscal stability. No readily identifiable public detriment can be shown from the past five years during which the authorisation has been in place.

5. THE MARKET

5.1. There has been little change to the market in the five years since the current Authorisation was granted.

5.2. In 2011, PHOs became known as 'Local Health Districts'. Local Health Districts replaced the larger area health service model that previously existed in New South Wales to administer public health services in New South Wales. The AMA (NSW) 2013 Hospital Doctors' Survey indicates that doctors' perceptions of the state hospital system have improved marginally since the introduction of the smaller less centralised local health districts (their perception changed from very poor to poor).

5.3. In 2012, the Federal government changed the way it provided hospital funding to the states, to a model of activity based funding (with some block funding remaining in place for certain sectors of the state public health system). To date there has been little effect

on the New South Wales Public Hospital System, and the model for engagement of VMOs.

5.4. The number of medical graduates has increased markedly from 1999, when there were under 1500 medical graduates in Australia. In 2015, on current projections, there will be almost 3800 medical graduates in Australia for that year. Whilst not all medical graduates will work in Australia (some are international students, for example), there is likely to be a change in the market and in particular changes to the available medical workforce in New South Wales over the next ten years, as the increase in medical students leads to an increase in the number of fully qualified doctors.[2]

6. DOCTRINE OF DERIVATIVE CROWN IMMUNITY

6.1. In the 2008 submission, AMA (NSW) raised its concerns regarding the doctrine of derivative crown immunity. Those concerns remain, as there has been no further clarity provided by case law or statute since 2008.

6.2. The High Court, in the decision of *Australian Competition and Consumer Commission v Baxter Healthcare Pty Limited & Others* [2007] HCA 38 (hereinafter '***Baxter Healthcare***'), found that the former *Trade Practices Act* may be enforceable against parties dealing with a non-business crown entity while exempting that Crown entity.

6.3. The question of whether PHOs are to be regarded as are carrying on a business in so far as entering into agreements with VMOs, AMA(NSW) and others, has not yet been tested.

6.4. Regardless of whether PHOs are carrying on a business or not, the decision in *Baxter Healthcare* does not allay the concerns of AMA(NSW) when negotiating with PHOs and NSW Health on behalf of VMOs.

6.5. The High Court, in *Baxter*, confined the doctrine of derivative Crown immunity to legal, equitable or statutory rights. In the context of negotiations between AMA (NSW) and a PHO or NSW Health regarding a contract, or a future, contract, there are no concluded legal rights and as such, on the basis of the decision in *Baxter Healthcare*, the protections of derivative Crown Immunity may not extend to those negotiations.

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[2] Medical Training Review Panel, Fourteenth Report, Medical Training Review Panel, March 2011, online, http://www.health.gov.au/internet/main/publishing.nsf/Content/DF4270A0C4E8B812CA257864008017B5/$File/mtrp14.pdf, 30 July 2012.

7. CONCLUSION

7.1. AMA(NSW) seeks a substituted authorisation to collectively negotiate with NSW Ministry of Health and PHOs on behalf of VMOs in the New South Wales Public Hospital System.

7.2. During the past five years the previous Authorisation has been in place, the New South Wales Public Health System has continued to benefit from the stability the regime established under the HSA provides. The examples provided of the negotiations conducted over the past five years provide strong evidence of the public benefit obtained from the role of AMA (NSW) being continued and strengthened by a further Authorisation being granted.

Dated: 5 September 2013

.....

TressCox Lawyers
Per: Dominique Egan

ANNEXURE 1

Model Fee-For-Service Service Contract

MODEL FEE-FOR-SERVICE SERVICE CONTRACT

This contract is made on the *[insert day of the month]* day of *[insert month]* 20__
BETWEEN *[insert the name of the relevant public health organisation],* ('the public health organisation'),

AND *[insert name of the medical practitioner]* whose MPO number is *[insert MPO number]* ('the Visiting Medical Officer').

PREAMBLE

Whereas:

A. The public health organisation has determined to appoint the Visiting Medical Officer to provide services at certain facilities of the public health organisation, and the Visiting Medical Officer has agreed to accept such an appointment;

B. The Visiting Medical Officer is to provide such services as an independent contractor and is to be remunerated under this contract on the basis of services performed over the period of this contract on a fee-for-service basis as specified in the Determination and this Contract.

TERM OF THE CONTRACT

1. The term of this contract is to be for the period from *[insert date of commencement]* to *[insert date of expiration]* (being a period not exceeding five (5) years), unless:
   (i) the contract is terminated earlier in accordance with clause 10 of the Determination;
   (ii) a longer term (not exceeding ten years) has been approved by the Director General in accordance with clause 7(4) of the Regulation.

DEFINITIONS

2. (i) 'Act' means the *Health Services Act 1997*

(ii) 'Determination' means the *Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination 2007*.

(iii) 'Regulation' means the *Health Services Regulation 2008*.

(iv) The definitions set out in the Act, the Regulation and the Determination apply to the terms used in this contract.

THE DETERMINATION

3. This contract is made subject to, and incorporates the terms of, the Determination. The Determination is available on the NSW Department of Health's internet site at: http://www.health.nsw.gov.au/resources/jobs/conditions/awards/FeeforServiceDetermination_pdf.asp

SERVICE CONTRACT

4. This contract constitutes a service contract as referred to in s. 80(1)(a) of the Act between a public health organisation and a medical practitioner.

FEE-FOR-SERVICE CONTRACT

5. This contract is a fee-for-service contract as referred to in s. 82 of the Act.

CLINICAL PRIVILEGES

6. The Visiting Medical Officer's clinical privileges are as specified in **Schedule 1** to this contract.

7. (i) The public health organisation may review and vary the clinical privileges of the Visiting Medical Officer at any time, after advice from the relevant Credentials (Clinical Privileges) Subcommittee, and the Medical and Dental Appointments Advisory Committee.

(ii) Schedule 1 is to be amended to reflect any variation made to clinical privileges in accordance with clause 7(i), with such amendments to take effect from the date of approval of the variations by the Chief Executive or

delegate.

8. The services provided under this contract shall be consistent with the clinical privileges as so specified.

SERVICES

9. (i) The Visiting Medical Officer shall provide the services (other than emergency after-hours services) specified in **Schedule 2** to this contract consistent with clause 5(1) of the Determination, at the hospitals therein described.

(ii) Schedule 2 is to include a budget for the provision of such services.

(iii) Schedule 2:

(a) is to be amended to reflect amendments to the services plan made in accordance with clause 5 of the Determination, with such amendments to take effect from the applicable date of effect under that clause;

(b) may be amended at any time by written agreement between the Visiting Medical Officer and the public health organisation, with such amendments to take effect from the date specified in the agreement.

REMUNERATION

10. (i) The Visiting Medical Officer shall be remunerated for services actually provided to public patients in accordance with the applicable rates set out at Annexure A to the Determination.

(ii) In relation to services other than emergency after-hours services, the remuneration shall be limited to the budget set out at Schedule 2.

11. The Visiting Medical Officer shall be remunerated for services covered by clause 5(5) and 5(14) of the Determination in accordance with the relevant hourly rates applying at that time under sessional Visiting Medical Officer contracts.

COMPLIANCE WITH NSW HEALTH POLICIES

12. The Visiting Medical Officer shall comply with
    (i) the NSW Health Code of Conduct, currently being Policy Directive PD2012_018, as amended or reissued from time to time;
    (ii) such other NSW Health Policy Directives, and public health organisation policies, that are expressed to apply to Visiting Medical Officers (or Visiting Practitioners), as issued and/or amended from time to time.

EMERGENCY AFTER-HOURS ROSTER

13. The requirements of the public health organisation for the participation of the Visiting Medical Officer on an emergency after-hours medical services roster, consistent with clause 4 of the Determination, may be set down as **Schedule 3** to this contract, or are as otherwise specified by the public health organisation.

OTHER CONDITIONS OF APPOINTMENT

14. (i) Other conditions of the Visiting Medical Officer's appointment to the public health organisation may be set out in, or as an attachment to, the letter of offer of appointment as a Visiting Medical Officer, provided that those conditions are not inconsistent with the provisions of:
    (a) clauses 1 –13 of this contract;
    (b) the Determination;
    (c) applicable legislation including the Act and the Regulation; or
    (d) the by-laws of the public health organisation;
    and to the extent of any inconsistency arising, such inconsistent conditions of appointment will not apply.

(ii) The signing of this contract constitutes acceptance of the conditions of appointment by the Visiting Medical Officer.

SIGNATURES

Signed on behalf of the public health organisation by:

Signature: .....

Name: .....

Position: .....

Date: .....

In the presence of:
Signature of witness: .....

Name of witness: .....

Signed by the Visiting Medical Officer:

Signature: .....

Full Name: .....

Date: .....

In the presence of:
Signature of witness: .....

Name of witness: .....

Schedule 1

Clinical Privileges

Hospital(s)	Clinical privileges granted to the Visiting Medical Officer in respect of the hospital(s)

Schedule 2

Services at [*insert name(s)*] Hospital(s)

(as per clause 5(1) of the Determination)

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(1) Services to be provided

(2) Services Plan

(3) Budget

Schedule 3

Emergency After Hours Roster

(This Schedule may be utilised as per clause 4(8) of the Determination)

ANNEXURE 2

Model Sessional Service Contract

MODEL SESSIONAL SERVICE CONTRACT

This contract is made on the *[insert day of the month]* day of *[insert month]* 20__
BETWEEN *[insert the name of the relevant public health organisation]*, ('the public health organisation');

AND *[insert name of the medical practitioner]* whose MPO number is *[insert MPO number]* ('the Visiting Medical Officer').

PREAMBLE

Whereas:

A. The public health organisation has determined to appoint the Visiting Medical Officer to provide services at certain facilities or services of the public health organisation, and the Visiting Medical Officer has agreed to accept such an appointment.

B. The Visiting Medical Officer is to provide such services as an independent contractor and is to be remunerated under this contract on the basis of services performed over the period of this contract at those hourly rates that are relevant to the Visiting Medical Officer's classification as specified in the Determination and this Contract.

TERM OF THE CONTRACT

1. The term of this contract is to be for the period from *[insert date of commencement]* to *[insert date of expiration]* (being a period not exceeding five (5) years), unless:
   (i) the contract is terminated earlier in accordance with clause 16 of the Determination;
   (ii) a longer term (not exceeding ten years) has been approved by the Director General in accordance with clause 7(4) of the Regulation.

DEFINITIONS

2. (i) 'Act' means the *Health Services Act 1997*.

(ii) 'Determination' means the *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007*.

(iii) 'Regulation' means the *Health Services Regulation 2008*.

(iv) The definitions set out in the Act, the Regulation and the Determination apply to the terms used in this contract.

THE DETERMINATION

3. This contract is made subject to, and incorporates the terms of, the Determination. The Determination is available on the NSW Department of Health's internet site at: http://www.health.nsw.gov.au/resources/jobs/conditions/awards/SessionalDetermination_pdf.asp

SERVICE CONTRACT

4. This contract constitutes a service contract as referred to in s. 80(1)(a) of the Act between a public health organisation and a medical practitioner.

SESSIONAL CONTRACT

5. This contract is a sessional contract as referred to in s. 83 of the Act.

CLINICAL PRIVILEGES

6. The Visiting Medical Officer's clinical privileges are as specified in **Schedule 1** to this contract.

7. (i) The public health organisation may review and vary the clinical privileges of the Visiting Medical Officer at any time, after advice from the relevant Credentials (Clinical Privileges) Subcommittee, and the Medical and

Dental Appointments Advisory Committee.

(ii) Schedule 1 is to be amended to reflect any variation made to clinical privileges in accordance with clause 7(i) above, with such amendments to take effect from the date of approval of the variations by the Chief Executive or delegate.

8. The services provided under this contract shall be consistent with the clinical privileges as so specified.

SERVICES

9. The Visiting Medical Officer shall provide the services specified in **Schedule 2** to this contract, at the hospitals therein described.

ORDINARY HOURS

10. (i) The ordinary hours during which the Visiting Medical Officer is to provide services (other than call-back or on-call services) are as specified at **Schedule 3** to this contract, consistent with clause 5(1) of the Determination.

(ii) Schedule 3:

(a) is to be amended to reflect amendments to the number of ordinary hours made in accordance with clause 5 of the Determination, with such amendments to take effect from the applicable date of effect under that clause;

(b) may be amended at any time by written agreement between the Visiting Medical Officer and the public health organisation (consistent with clause 5(4) of the Determination), with such amendments to take effect from the date specified in the agreement.

REMUNERATION AND CLASSIFICATION

11. In relation to ordinary hours of services, the Visiting Medical Officer shall be remunerated on the basis specified in **Schedule 4** to this contract.

12. (i) The classification of the Visiting Medical Officer for the purpose of remuneration under this contract is as specified in **Schedule 5** to this contract.

    (ii) Where the classification of the Visiting Medical Officer is varied in accordance with the process set out in clause 6 of the Determination, Schedule 5 will be amended to give effect to that variation with such amendments to take effect from the date of approval of the variations by the Chief Executive or delegate.

13. The applicable rate for background practice costs will be as advised by the New South Wales Department of Health from time to time consistent with the terms of Annexure B to the Determination.

COMPLIANCE WITH NSW HEALTH POLICIES

14. The Visiting Medical Officer shall comply with

    (i) the NSW Health Code of Conduct, currently being Policy Directive PD2012_018, as amended or reissued from time to time;

    (ii) such other NSW Health Policy Directives, and public health organisation policies, that are expressed to apply to Visiting Medical Officers (or Visiting Practitioners), as issued and/or amended from time to time.

ON-CALL

15. The requirements of the public health organisation for the on call availability of the Visiting Medical Officer, consistent with clause 4 of the Determination, may be set down as **Schedule 6** to this contract, or are as otherwise specified by

the public health organisation.

OTHER CONDITIONS OF APPOINTMENT

16. (i) Other conditions of the Visiting Medical Officer's appointment to the public health organisation may be set out in, or as an attachment to, the letter of offer of appointment as a Visiting Medical Officer, provided that those conditions are not inconsistent with the provisions of:

(a) clauses 1 –15 of this contract;

(b) the Determination;

(c) applicable legislation including the Act and the Regulation; or

(d) the by-laws of the public health organisation;

and to the extent of any inconsistency arising, such inconsistent conditions of appointment will not apply.

(ii) The signing of this contract constitutes acceptance of the conditions of appointment by the Visiting Medical Officer.

SIGNATURES

Signed on behalf of the public health organisation by:

Signature: .....

Name: .....

Position: .....

Date: .....

In the presence of:
Signature of witness: .....

Name of witness: .....

Signed by the Visiting Medical Officer:

Signature: .....

Full Name: .....

Date: .....

In the presence of:
Signature of witness: .....

Name of witness: .....

Schedule 1
Clinical Privileges

Hospital(s)	Clinical privileges granted to the Visiting Medical Officer in respect of the hospital(s)

Schedule 2
Services

Hospital(s)	Services to be provided at the hospital(s)

Schedule 3

Ordinary Hours for the provision of Services

(Here specify the ordinary hours during which services are to be provided as per clause 5(1) of the Determination)

Schedule 4

Remuneration for Ordinary Hours

(Here specify the remuneration option for ordinary hours to apply as per clause 5(3) of the Determination)

Schedule 5

Classification of the Visiting Medical Officer

(Here specify the classification of the Visiting Medical as per clause 6 of the Determination)

Schedule 6

On-Call Roster

(This Schedule may be utilised as per clause 4(8) of the Determination)

ANNEXURE 3

2008 AMA (NSW) Submission to the ACCC

Submission to the Australian Competition and Consumer Commission pursuant to section 88(1) of the *Trade Practices Act* 1974 (Cth)

Date:

TressCox
LAWYERS

Level 20, 135 King St Sydney NSW 2000
Tel: (61 2) 9228 9200 Fax: (61 2) 9228 9299 DX 123 Sydney

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Contents

1. APPLICATION FOR AUTHORISATION TO COLLECTIVELY NEGOTIATE ON BEHALF OF VISITING MEDICAL OFFICERS IN NEW SOUTH WALES

1.1. The Australian Medical Association (NSW) Limited (hereinafter '***AMA(NSW)***') seeks authorisation pursuant to section 88(1) of the *Trade Practices Act* 1974 (Cth) to collectively negotiate on behalf of visiting medical officers in New South Wales with the New South Wales Health Department and public health organisations regarding the terms and conditions of visiting medical officer contracts in the New South Wales Public Hospital System.

2. BACKGROUND

2.1. AMA(NSW) is an independent association representing the state's medical profession. As an organisation of employers AMA(NSW) is a registered industrial organisation under section 271 of the *Industrial Relations Act* 1996 (NSW).

2.2. A core component of AMA(NSW)'s role is the provision of industrial representation for all Visiting Medical Officers (hereinafter '***VMOs***') in New South Wales. AMA(NSW) makes every effort to ensure the concerns of VMOs are heard and makes representations on their behalf. In the negotiation of the 2007 Visiting Medical Officer Determinations (see below) AMA(NSW) established regional and metropolitan networks to ensure that the interests and concerns of both regional/rural VMOs and those of metropolitan VMOs were voiced and heard.

2.3. In New South Wales the arrangements for the contracting of doctors in state hospitals and facilities are not unilaterally determined by the State Health Department (hereinafter '***NSW Health***').

2.4. AMA(NSW) has a statutory role under the provisions of the *Health Services Act* 1997 (hereinafter '***HSA***') to recommend to the Minister for Health (section 87) and/or seek the appointment of an arbitrator (section 89) to determine the terms and conditions and rates of remuneration for sessional and fee-for-service VMOs.

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

2.6. In addition to its statutory role, AMA(NSW) has a well-established collaborative working relationship with NSW Health. This relationship is evidenced by the consent position reached regarding the new Fee-for-Service and Sessional Determinations in 2007. The consent position ensured and ensures the ongoing provision of medical services in the New South Wales Public Hospital system across the State, including in rural areas, and

avoided the parties needing to expend considerable financial resources (as were expended in the early 1990s) on a contested arbitration process.

3. VISITING MEDICAL OFFICERS IN NEW SOUTH WALES

3.1. Other than the Australian Capital Territory, (and limited numbers in Victoria) New South Wales is the only State or Territory in which VMOs are independent contractors.

3.2. There are approximately 6,000 VMO appointments in the NSW Public Hospital System. Approximately 4,800 of VMOs are appointed under sessional contracts, 1,400 are appointed under fee-for-service contracts and 1,000 are appointed under fee-for-service contracts at facilities covered by the Rural Doctors Settlement Package (hereinafter '***RDASP***') (see below). Some VMOs hold multiple appointments.

The Health Services Act 1997 (NSW)

3.3. Chapter 8 of the HSA governs the appointment of VMOs and the services contracts under which VMOs provide services in NSW public hospitals.

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

3.5. A VMO is a medical practitioner appointed under a service contract to provide medical services for monetary remuneration for or on behalf of a PHO (section 78).

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

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

3.8. The Minister for Health may approve sets of conditions recommended by the Australian Medical Association (NSW) Limited for inclusion in service contracts (section 87).

3.9. The Minister or the Australian Medical Association (NSW) Limited may (jointly or individually) apply to the Minister for Industrial Relations for the appointment of an arbitrator to determine the terms and conditions of work, the amounts or rates of remuneration and the bases upon which those amounts or rates are applicable for VMOs appointed under sessional or fee-for-service contracts (or both) (section 89).

3.10. An arbitrator is bound to have regard to the economic consequences of a proposed Determination (section 92(2)).

3.11. Part 2 goes on to stipulate the functions and duties of the arbitrator. One of those duties is to bring the parties to agreement (section 91(2)).

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

3.13. Variations to standard service contracts are not uncommon and accommodate the particular circumstances and needs of individual VMOs (or small groups of VMOs) and individual PHOs.

3.14. A VMO may appeal against a decision of a PHO to:

(a) reduce his or her clinical privileges;

(b) not re-appoint him or her; or

(c) the suspension or termination of his or her services (section 105).

3.15. The Minister for Health must appoint a Committee of Review to determine an appeal (section 108).

Existing Arrangements

3.16. The arbitration provisions in Part 2 of Chapter 8 (and before that, the relevant provisions under the *Public Hospitals Act* 1929), provide an effective means for VMOs and NSW Health to attempt to negotiate agreed terms for the ongoing provision of services to public patients in public hospitals in New South Wales.

3.17. The provisions of Part 2 of Chapter 8 do not compel the parties to arbitrate but provide a framework within which VMOs and NSW Health are encouraged to reach agreement regarding rates secure in the knowledge that if agreement cannot be reached the assistance of an independent arbitrator is available. Section 91(2) requires the arbitrator

to attempt to bring the parties to agreement regarding the matters in respect of which the arbitrator is required to make a determination.

3.18. The framework under Part 2 of Chapter 8 of the HSA and its predecessor, the *Public Hospitals Act* 1929, has provided a level playing field within which VMOs and the NSW Health have successfully negotiated and agreed upon the rates and terms and conditions under which VMOs have provided services. The effectiveness of this safety-net as a means of ensuring the ongoing provision of services in New South Wales is evidenced by the fact that, until an application made by AMA(NSW) in 2006 for the appointment of an Arbitrator for sessional and fee-for-service contract determinations, there had not been, under the *Public Hospitals Act* 1929 or the HSA, an arbitration in relation to fee-for-service contracts.

3.19. In 1976 following dispute arising between medical practitioners and the then NSW Department of Health, regarding the payments to be made to VMOs working under sessional contracts, Mr Rogers QC was appointed as an independent arbitrator to determine the rates to be paid to sessional VMOs.

3.20. In 1978 the *Public Hospitals Act* 1929 was amended to provide for the arbitration of sessional rates and terms of conditions of work under sessional contracts. Arbitrations of sessional rates were conducted in 1978, 1980, 1981, 1982, 1983, 1985, and 1991 - 1994.

3.21. In 1980 the *Public Hospitals Act* 1929 was amended to provide for the arbitration of fee-for-service rates.

3.22. In 1997 the *Public Hospitals Act* 1929 was repealed by the *Health Services Act* 1997.

3.23. Prior to 2007, the arrangements for Fee-for-Service VMOs were determined by agreement between NSW Health and AMA(NSW). The terms of that agreement were reduced to writing in 1995 in the *Joint Agreement* between the (then) NSW Branch of the Australian Medical Association and the NSW Department of Health. That agreement was varied from time to time as agreed between the parties.

3.24. In 2006, AMA(NSW) applied for the appointment of an Arbitrator for Sessional and Fee-for-Service Contract Determinations. That appointment was made in January 2007. Whilst there were a number of reasons for seeking the appointment, a primary reason was concern surrounding the recruitment and retention of VMOs in rural and regional hospitals, coupled with the desire of AMA(NSW), NSW Health and rural VMOs to secure an arrangement whereby people living in rural and remote communities would continue to have access to the highest quality health care.

3.25. Rather than limiting the ability for VMOs as independent contractors to enter into commercial arrangements, the framework under the HSA ensures a stable environment in which VMOs:

(a) Competitively compete for appointments at PHOs; and

(b) Annually negotiate with each PHO at which he or she is appointed the number of routine hours that the VMO will be offered to provide services to public patients. Commercial considerations on the part of both the PHO and the VMO are the primary driving factors in these negotiations.

Independent Contractors Act 2006 and VMO Contracts in New South Wales

3.26. Section 7 of the *Independent Contractors Act* 2006, which commenced on 1 March 2007, impliedly repeals State and Territory laws which, inter alia, deem a party to a *services contract* to be an employer or employee, or confer or impose rights, entitlements, obligations or liabilities on a party that, in an employment relationship, would be *workplace relations matters* subject to specified exceptions.

3.27. Section 5 defines a services contract to be a contract to which an independent contractor is a party, that relates to the performance of work by the independent contractor and, relevantly, to which one of the parties is a constitutional corporation.

3.28. The status of VMOs in New South Wales as independent contractors is enshrined in section 76 of the HSA.

3.29. Services contracts between VMOs and PHOs are contracts for the performance of work.

3.30. The terms and conditions referred to in sections 87 and 89 of the HSA include workplace relations matter within the meaning of section 8 of the *Independent Contractors Act*.

3.31. Clause 4 of the *Independent Contractors Regulations* 2007 preserves the provisions of Parts 1, 3 and 4 of Chapter 8 of the HSA.

3.32. Part 2 of Chapter 8 of the HSA is preserved for a period of 3 years in relation to pre-reform commencement VMO contracts and related continuation VMO contracts (Part 5 of the Act).

3.33. Part 2 of Chapter 8 of the HSA has no application to new VMO service contracts entered into on or after 1 March 2007, and will have no application to current and continuing VMO service contracts after 28 February 2010.

3.34. In AMA(NSW)'s submission, the preservation of Parts 1, 3, and 4 of Chapter 8 and the exclusion of Part 2 is anomalous. Parts 1, 2 and 4 of Chapter 8 are inextricably linked to give effect and meaning to the Chapter as a whole and the regulation of VMOs in NSW.

Dual Systems

3.35. As a consequence, there is now a dual system in operation for the regulation of VMO service contracts (and appointments) in New South Wales. This dual system will continue for a period of 3 years.

3.36. Whilst those VMOs currently in the system will (subject to the continuation of their pre-reform commencement contracts) continue to be regulated under the HSA, VMOs new to the system, or returning to the system after a period of absence will not be so regulated. Furthermore, the option available to VMOs to opt in to the Federal system is likely to create uncertainty for both VMOs and the public health organisations at which those VMOs are providing, or wish to provide, services.

3.37. Following the expiry of the three year period during which the transitional provisions apply, there will be no regulation of VMO service contracts in the New South Wales public hospital system.

3.38. The most recent AMWAC report (The Public Hospital Medical Workforce Report) published in 2004 indicates that 30.8% of public hospital doctors in NSW are VMOs.

3.39. New South Wales has a unique and important history of reliance on independent contractor specialists and general practitioners and this reliance provides the State with a flexible, highly qualified and diverse specialist and general practitioner medical service.

3.40. The existing system under the HSA provides an efficient mechanism for managing contract terms for such large numbers of doctors, and is particularly effective in retaining and recruiting specialist medical practitioners to provide services in rural communities.

Public Hospitals (Visiting Medical Officers Fee-for-Service Contracts) Determination 2007 (hereinafter 'the 2007 FFS Determination') and the Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007 (hereinafter 'the 2007 Sessional Determination')

3.41. As noted above, prior to and during the negotiation of the 2007 Determinations AMA(NSW) consulted with rural/regional VMOs and metropolitan VMOs. A survey of all VMOs across the State in 2004 demonstrated, inter alia, that the on-call commitments of the majority of respondents had increased in the previous 12 month period, over 50% of regional and rural respondents indicated an intention to retire in the next 5 years and of those not intending to retire, one-third said they were considering leaving rural practice.

3.42. Given the serious issues confronting rural and regional health, the Regional Network was formed and was comprised of representatives from through out rural and regional New South Wales. The members of the Regional Network consulted with their colleagues and communicated their views and concerns to AMA(NSW). AMA(NSW) conducted four teleconferences with the Regional Network over a six month period, as well as seeking additional feedback through surveys.

3.43. AMA(NSW) took those views and concerns to NSW Health.

3.44. The features of the regional VMO arrangements in the 2007 Determinations are as follows:

(a) an additional loading for providing emergency after hours or on-call services; and

(b) professional support payments for expenses including those incurred in association with continuing medical education requirements, locum expenses and other items associated with ongoing professional support as approved on an individual case basis.

3.45. In addition, provisions agreed between AMA(NSW) and NSW Health included the following:

(a) FFS and Sessional VMOs to be remunerated for cancelled theatre lists in certain circumstances;

(b) FFS VMOs to be remunerated for time spent teaching and training;

(c) Sessional VMOs to receive the on-call allowance while providing services pursuant to a call back.

(d) Amendment of the dispute resolution procedure for both FFS and Sessional VMOs with the aim of ensuring disputes are dealt with expediently, efficiently and cost effectively.

3.46. Copies of the following documents are annexed to this Submission which reflect the current terms and conditions under which VMOs are contracted to provide services in the New South Wales Public Hospital System:

(a) NSW Health Policy Directive PD 2007_032: Visiting Medical Officers – Remuneration (**Annexure A**);

(b) NSW Health Information Bulletin IB 2007_044: Visiting Medical Officers – New Determinations (**Annexure B**);

(c) NSW Health Information Bulletin IB2008_007: Visiting Medical Officers – Remuneration (**Annexure C**);

(d) NSW Health Policy Directive PD2008_002: VMOs in Rural Doctors' Settlement Package Hospitals Indexation of Fees from 1 August 2007 (**Annexure D**).

4. DOCTRINE OF DERIVATIVE CROWN IMMUNITY

4.1. The principle of Crown Immunity creates a presumption that the Crown is immune from the operation of the general words of a statutory provision in relation to the activities of governmental instrumentalities or agents acting in the course of their functions of duties.

4.2. In 1996 Part IV of the *Trade Practices Act* was amended reversing this presumption so that in so far as the Crown carries on a business, it is bound by the provisions of the *Trade Practices Act*.

4.3. The doctrine of derivative Crown Immunity provides that the provisions of a statute, in this case this *Trade Practices Act*, will not be applied to parties to a transaction with the Crown if its application would prejudice the legal, equitable or statutory rights of the Crown.

4.4. The High Court, in the decision of *Australian Competition and Consumer Commission v Baxter Healthcare Pty Limited & Others* [2007] HCA 38 (hereinafter '***Baxter Healthcare***'), found that the *Trade Practices Act* may be enforceable against parties dealing with a non-business crown entity while exempting that Crown entity.

4.5. The question of whether PHOs are to be regarded as are carrying on a business in so far entering into agreements with VMOs, AMA(NSW) and others, has not yet been tested.

4.6. Regardless of whether PHOs are carrying on a business or not, the decision in *Baxter Healthcare* does not allay the concerns of AMA(NSW) when negotiating with PHOs and NSW Health on behalf of VMOs.

4.7. The High Court, in *Baxter*, confined the doctrine of derivative Crown immunity to legal, equitable or statutory rights. In the context of negotiations between AMA(NSW) and a PHO or NSW Health regarding a contract, or a future, contract, there are no concluded legal rights and as such, on the basis of the decision in *Baxter Healthcare*, the protections of derivative Crown Immunity may not extend to those negotiations.

5. PUBLIC BENEFIT AND PUBLIC DETRIMENT ARGUMENTS

5.1. In practical terms, AMA(NSW) is seeking authorisation to preserve the current status quo.

5.2. The existing framework under the HSA provides an effective and cost effective means of ensuring the continuing provision of medical services in the public hospital system in NSW. AMA(NSW) is aware from discussions with various PHOs in New South Wales that the continuation of the existing framework is supported by them.

5.3. While there is nothing to prevent an individual or a particular craft group attempting to negotiate an arrangement outside the HSA framework (subject to the comments below regarding medical indemnity arrangements), the vast majority of VMOs providing services in NSW elect to provide services as provided for under the HSA.

5.4. To the extent required to retain VMOs within the public hospital system, the framework under the HSA has the requisite degree of flexibility to accommodate variations in the terms and conditions under which VMOs provide services.

5.5. The current system is a sophisticated system which accommodates variances between craft groups and recognises that the value to be attributed certain services is greater than that which may be attributed to others. For example, FFS VMOs are remunerated by reference to the Commonwealth Medicare Benefits Schedule which recognises that medical practitioners providing specialist services should be remunerated at higher rates than those providing general medical services. This is not a fee system AMA(NSW) would be seeking to replace or modify.

5.6. Similarly, sessional VMOs are classified according to their training and experience: VMOs are classified under the 2007 Determination on the basis of whether they are a general practitioner with less or more than 5 years experience, or whether they are a specialist or senior specialist and remunerated accordingly. Even within those classifications recognition is made of the variances between craft groups. For example, the background practice costs paid to anaesthetists, physicians and general practitioners are less than those paid to surgeons to reflect the differences between the overheads borne by different craft groups.

5.7. In addition to its well-established relationships with NSW Health and PHOs, AMA(NSW) has also developed relationships with other craft groups. AMA(NSW) regularly meets with those groups and consults with them regarding issues confronting VMOs, and in particular VMO contracts. For example, during the negotiation of the 2007 Determinations, in addition to directly seeking feedback from VMOs themselves, AMA(NSW) also met with craft groups including the Rural Doctors Association NSW Branch and the Australian Society of Anaesthetists.

5.8. The role of AMA(NSW) as the collective negotiator of rates of remuneration for sessional and fee-for-service VMOs, ensures that, while endeavouring to act in the best interest of its members, and VMOs more generally, it can objectively balance the needs (and wants) of VMOs against the collective public interest in:

(a) The continuing provision of medical services of the highest quality in the NSW public health system; and

(b) The provision of those services on a cost effective basis.

5.9. Whilst individually negotiated contracts may be consistent with the philosophy behind independent contacting arrangements, such negotiations in the public health system will, without doubt, add to increases in the cost of public health care, both in terms of the time and cost of administrators having to negotiate with individuals, and the potential for inflated remuneration rates.

5.10. At the same time it is also foreseeable that without a level playing field many VMOs may well withdraw from the public hospital system, particularly in rural and remote areas where VMOs currently struggle to cope with lack of professional support and limited resources.

5.11. Should the ACCC decide not to grant authorisation to AMA(NSW) to collectively negotiate the terms and conditions of VMO contracts in New South Wales this most likely will result in:

(a) Increased costs for the State Government as individuals and/or groups of medical practitioners attempt to negotiate their fees with the State Government.

(b) Increased competition between craft groups may result in certain specialties withdrawing their services from some hospitals and only offering their services at other hospitals.

(c) VMOs leaving the Public Hospital System which will result in a further strain on the those staff specialists, Career Medical Officers, junior doctors and other doctors remaining in the Public Hospital System.

5.12. There is a demonstrated level of discontent amongst medical practitioners, including VMOs, working in the Public Hospital System in New South Wales, regarding not only remuneration but other terms and conditions of their engagement. For example:

(a) In 2004 AMA(NSW) conducted a VMO Hospital Survey[1] the key findings of which were:

(i) On-call commitments for the majority of respondents had increased in the previous 12 month period;

[1] AMA(NSW) VMO Hospital Survey

(ii) One-third of respondents had had elective surgery lists frequently reduced, and a further one-third indicated that elective lists had either been reduced or cancelled;

(iii) Approximately half of the respondents indicated that they had considered leaving the New South Wales Public Hospital System because of a lack of resources and poor management; and

(iv) Over 50% of regional and rural respondents indicated an intention to retire in the next 5 years. Of those who did not express such an intention, one-third said they were considering leaving rural practice. (VMOs were asked to nominate whether they regarded themselves to be regional/rural for the purposes of the survey).

(b) A 2008 survey of those working in the New South Wales Public Hospital System[2] provides that approximately 70% of VMOs working in the Public Hospital System have considered leaving in the last 12 months.

5.13. AMA(NSW), as the peak industrial organisation representing medical practitioners in New South Wales, has a unique understanding of the Public Hospital System and the issues confronting VMOs working within the system. AMA(NSW) not only negotiates rate increases for VMOs but also engages NSW Health regarding other terms and conditions of VMO contracts. For example, the 2007 Determinations included terms regarding:

(a) Consultation regarding an increase in a VMO's on-call hours and available resources as a part of the annual review of services conducted between individual VMOs and PHOs;

(b) Provisions regarding the cancellation of elective surgery lists;

(c) A regional package to improve retention and recruitment of VMOs in regional hospitals.

5.14. In a climate where VMOs consider that their contributions to the Public Health System are not recognised by management, ensuring terms and conditions are maintained and improved is fundamental to retaining (and recruiting) VMOs. While VMOs can and do negotiate individual variations with PHOs, any erosion in AMA(NSW)'s current role within the New South Wales Public Hospital System is likely to result in a lessening of VMOs working conditions.

[2] Working Conditions for Doctors and Nurses in NSW Public Hospitals

5.15. Craft groups may negotiate in the interests of their members. That said, it is in the interests of the New South Wales public that the Public Hospital System provides a full range of services in all areas in a cost effective manner.

5.16. It is AMA(NSW)'s submission that there is no readily identifiable public detriment should authorisation be granted. There will not be an associated push to increase fees. In relation to increases in the future, AMA(NSW) will continue to negotiate in good faith with NSW Health to ensure the ongoing provision of public health services to the public of New South Wales.

5.17. An example of the role of AMA(NSW) to ensure the ongoing provision of services yet at the same time representing the interests of VMOs was its role in obtaining Treasury Managed Fund professional indemnity cover for VMOs providing services to public patients in New South Wales public hospitals in 2001. At that time the medical profession in New South Wales was facing a medical indemnity crisis – soaring medical indemnity premiums were placing many VMOs in a position whereby they considered they had no choice but to withdraw their services (from both the public and private sectors) – particularly those practising in obstetrics and neurosurgery. AMA(NSW) engaged NSW Health in discussions which ultimately resulted in the extension of TMF cover to VMOs treating public patients in public hospitals and ensured the ongoing provision of services to public patients in New South Wales.

6. THE MARKET

6.1. AMA(NSW) seeks authorisation to collectively negotiate on the part of all VMOs in New South Wales. It is not proposed that VMOs must be a party to any agreement negotiated by AMA(NSW) with NSW Health. Individual VMOs would be entitled to attempt to negotiate on their own behalf, or participate in another arrangement (as they are now).

6.2. AMA(NSW) currently represents the interests of VMOs in metropolitan hospitals and those in regional and rural hospitals, both specialists and general practitioners. While there are differences in the interests of different groups, there are also interests common to all VMOs. To the extent that there are differing interests, AMA(NSW) has the necessary resources to ensure that those differing interests are heard and represented. In this regard, we refer the Commission to paragraphs 3.40 to 3.44 and 5.5 to 5.7 above.

7. CONCLUSION

7.1. AMA(NSW) seeks authorisation to collectively negotiate with NSW Health and PHOs on behalf of VMOs in the New South Wales Public Hospital System. Authorisation is sought to ensure that the current system in place under the regime currently governed by the HSA continues. That system has ensured that the rights and interests of VMOs are represented and protected while the rights and interests of the New South Wales public

in the ongoing delivery of health services of the highest quality in a cost effective manner are also protected.

7.2. AMA(NSW) seeks to preserve the current status quo which is history, both recently and in the past, reflects has operated to ensure the efficient, effective and cost effective delivery of health services in the New South Wales Public Health System.

Dated:

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TressCox Lawyers
Per: Dominique Egan

ANNEXURE A

NSW Health Policy Directive PD 2007_032: Visiting Medical Officers – Remuneration

Policy Directive

NSW HEALTH

Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

Visiting Medical Officers - Remuneration

Document Number PD2007_032

Publication date 18-May-2007

Functional Sub group Personnel/Workforce - Industrial and Employee Relations
Personnel/Workforce - Salaries

Summary This Policy Directive prescribes the remuneration rates for Visiting Medical Officers engaged under the Health Services Act 1997.

Replaces Doc. No. Sessional Visiting Medical Officers (VMOs) - Increased Remuneration [PD2005_420]
Visiting Medical Officers (VMOs) Fee for Service - Increased Remuneration [PD2005_422]

Author Branch Employee Relations

Branch contact Employee Relations 9391 9357

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Health System Support Division

Audience Administration, clinical

Distributed to Public Health System, Health Associations Unions, NSW Department of Health

Review date 18-May-2012

File No. 06/758

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

REMUNERATION FOR VISITING MEDICAL OFFICERS

1. Scope of Policy

This Policy Directive applies to Visiting Medical Officers appointed from time to time under service contracts with public health organisations, other than those Visiting Medical Officers who are:

(a) entitled to the arrangements set by the Rural Doctors Settlement Package;
(b) appointed as a specialist radiologist or a pathologist.

2. Purpose

This Policy Directive sets out revised remuneration rates which public health organisations are authorised to pay to Visiting Medical Officers. The revised rates reflect the outcome of lengthy consultations with the Australian Medical Association (NSW) Ltd arising out of its claim for revised terms and conditions for Visiting Medical Officers.

The revised remuneration rates set out in this Policy Directive are effective from 1 January 2007 (and are valid until varied by a further Policy Directive or by a determination made by an arbitrator under the Health Services Act).

This Policy Directive does not deal with other agreed variations in Visiting Medical Officer arrangements arising out of the Australian Medical Association's claim, which will be advised in a further Policy Directive.

3. Definitions

Emergency after hours medical services are services initiated by or on behalf of patients whose medical conditions require immediate treatment, and where those services take place on a weekend, a public holiday, or other than between 8 am and 6 pm on a weekday not being a public holiday.

Public Health Organisation means an area health service, or a statutory health corporation, or an affiliated health organisation in respect of its recognised establishments and recognised services.

Regional Visiting Medical Officer means a Visiting Medical Officer who is appointed:

(a) for a continuous period of at least 12 months under a service contract in respect of one or more of the regional hospitals listed at Attachment B to this Policy Directive; and
(b) under a service contract with terms and conditions that are in accordance with the standard arrangements approved by the Department of Health.

Visiting Medical Officer means a medical practitioner appointed under a service contract to provide services as a visiting practitioner for monetary remuneration for or on behalf of a public health organisation.

Visiting Practitioner means a medical practitioner who is appointed by a public health organisation (otherwise than as an employee) to practice as a medical practitioner in accordance with the conditions of appointment at any of its public hospitals or health institutions, or in relation to any health service it provides.

4. Accountabilities

Chief Executives are accountable for ensuring that only the remuneration authorised in this Policy Directive, or otherwise specifically approved by the Department, is paid to Visiting Medical Officers.

5. Sessional Visiting Medical Officer Remuneration

5.1 The ordinary hourly rates and on call rates which public health organisations are authorised to pay to sessional Visiting Medical Officers are increased by 13% with effect from 1 January 2007. Background practice costs are also being increased to reflect annual CPI increases. The details of the revised authorised rates are set out at Attachment A to this Policy Directive.

5.2 Where a sessional Visiting Medical Officer is called back to duty, public health organisations are authorised to pay additional remuneration as follows:

(a) for services provided during a call-back within the hours of 8.00 am to 6.00 pm Monday to Friday inclusive (other than on a public holiday) - at the Visiting Medical Officer's ordinary hourly rate of remuneration plus a loading of 10 percent;

(b) for services provided during a call-back outside the hours of 8.00 am to 6.00 pm Monday to Friday inclusive - at the Visiting Medical Officer's ordinary hourly rate of remuneration plus a loading of 25 percent;

(c) for services provided during a call-back on a public holiday - at the Visiting Medical Officer's ordinary hourly rate of remuneration plus a loading of 50 percent.

6. Fee for Service Visiting Medical Officer Remuneration

6.1 The fee which public health organisations are authorised to pay to fee for service Visiting Medical Officers for routine work has been increased to 100% of the relevant Commonwealth Medicare Benefits Schedule fee.

6.2 The authorised fee payable to fee for service Visiting Medical Officers where services are provided in situations where there is neither a Resident Medical Officer, nor a Registrar, nor a Career Medical Officer at a hospital on a 24 hour, 7 day week basis available as doctor of first contact, remains 110% of the relevant Commonwealth Medicare Benefits Schedule fee.

6.3. The authorised fee payable to fee for service Visiting Medical Officers for emergency after hours medical services remains 110% of the relevant Commonwealth Medicare Benefits Schedule fee.

6.4. Public health organisations are authorised to pay a flat daily fee of $98.45 to individual fee for service Visiting Medical Officers specialist surgeons and anaesthetists who are required by the relevant public health organisation to remain available for emergency surgery during December and January, or during the Easter holiday period, when access by the Visiting Medical Officer to operating theatres in the relevant hospital is available only for genuine emergency operations for a period of at least 7 consecutive days, including at least one day of which is a public holiday.

7. Regional Visiting Medical Officers

7.1 The authorised fee payable to a sessional regional Visiting Medical Officer:

(a) who provides a call-back service at a regional hospital listed at Attachment B to this Policy Directive; and
(b) whose usual place of residence is within a 50 kilometre radius of the regional hospital where the call-back service is provided,

is a further 10% loading on the amount that would otherwise have been payable (as provided for at paragraph 5.2) in respect of that occasion of service.

7.2 The authorised fee payable to a fee for service regional Visiting Medical Officer:

(a) who provides an emergency after hours service at a regional hospital listed at Attachment B to this Policy Directive, and
(b) whose usual place of residence is within a 50 km radius of the regional hospital where the service is provided,

is 120% of the relevant Commonwealth Medicare Benefits Schedule fee in respect of that occasion of service.

8. Funding

Budget supplementation for the revised authorised fees will be provided by the Department based on existing public health organisation budgets for Visiting Medical Officers. Any additional costs which are attributable to making the rates payable to sessional Visiting Medical Officer with 5 to 10 years' experience the same as those applying to sessional Visiting Medical Officers with over ten years' experience are to be internally funded by public health organisations from within existing budgetary allocations.

9. Non-standard arrangements

Public health organisations are not to offer or to provide remuneration to Visiting Medical Officers which is not in accordance with the rates authorised by the Department without the specific approval of the Department.

Robert D McGregor AM
A/Director General

Attachment A

SESSIONAL VMO RATES

ORDINARY HOUR REMUNERATION

A sessional Visiting Medical Officer shall be paid the following hourly rate of remuneration for each ordinary hour (and on a proportionate basis to the nearest quarter hour) specified in a sessional contract:

Classification	Sessional Rate (per hour)			
	1 January 2007 13%	1 January 2008 2.5%	1 January 2009 2.5%	1 January 2010 2.5%
a) General Practitioner	$115.10	$118.00	$120.95	$124.00
i) with less than 5 years experience	$147.85	$151.55	$155.35	$159.25
ii) with at least 5 years experience and/or who has been admitted to Fellowship of the Royal Australian College of General Practitioners and/or Fellowship of the Australian College of Rural and Remote Medicine				
b) Specialist	$167.45	$171.65	$175.95	$180.35
c) Senior Specialist	$179.75	$184.25	$188.85	$193.55

BACKGROUND PRACTICE COSTS

Classification	Rate per hour			
	1 January 2007	1 January 2008	1 January 2009	1 January 2010
a) Anaesthetist, Physician and General Practitioner	$21.05	Rate as at 1 January 2007 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)
b) Surgeon	$35.10	Rate as at 1 January 2007 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)

And on a proportionate basis to the nearest quarter hour.

ON-CALL

A sessional visiting medical officer shall be paid an amount as shown below for each hour (or part thereof) the officer is rostered to be on-call or whilst travelling or rendering services pursuant to a call-back.

Rate of Allowance (per hour)			
1 January 2007	1 January 2008	1 January 2009	1 January 2010
$10.60	$10.85	$11.10	$11.40

Attachment B

Regional Hospitals

Albury Base Hospital
Armidale Hospital
Bathurst Base Hospital
Blue Mountains District ANZAC Memorial Hospital
Broken Hill Health Service
Coffs Harbour Base Hospital
Dubbo Base Hospital
Goulburn Base Hospital
Grafton Base Hospital
Griffith Base Hospital
Kempsey District Hospital
Lismore Base Hospital
Maitland Hospital
Manning Base Hospital
Murwillumbah Hospital
Orange Base Hospital
Port Macquarie Base Hospital
Shoalhaven Hospital
Tamworth Base Hospital
Tweed Heads District Hospital
Wagga Wagga Base Hospital

ANNEXURE B

NSW Health Information Bulletin IB 2007_044: Visiting Medical Officers – New Determinations

Information Bulletin

NSW HEALTH

Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
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http://www.health.nsw.gov.au/policies/

Visiting Medical Officers - New Determinations

Document Number IB2007_044

Publication date 28-Sep-2007

Functional Sub group Personnel/Workforce - Industrial and Employee Relations

Summary This Information Bulletin provides notification of the new sessional and fee-for-service Visiting Medical Officer determinations.

Author Branch Employee Relations

Branch contact Employee Relations 9391 9357

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Health System Support Division

Audience Administration, clinical

Distributed to Public Health System, Health Associations Unions, NSW Department of Health

Review date 28-Sep-2012

File No. 07/3746

Status Active

Director-General

NEW DETERMINATIONS FOR SESSIONAL AND FEE-FOR-SERVICE VISITING MEDICAL OFFICERS

Purpose

The purpose of this Information Bulletin is to provide notification of the making of Determinations setting the terms and conditions of work, and rates of remuneration, for sessional Visiting Medical Officers and for fee-for-service Visiting Medical Officers.

Attachments

Attached are copies of the *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007* and the *Public Hospitals (Visiting Medical Officers Fee-For-Service Contracts) Determination 2007*.

Scope of the Determinations

The determinations apply to Visiting Medical Officers appointed from time to time under sessional or fee-for-service service contracts pursuant to Chapter 8 of the *Health Services Act 1997* by a public health organisation to any facility in the NSW public health system, **except for** those Visiting Medical Officers who are:

(a) entitled to the arrangements set by the Rural Doctors Settlement Package;

(b) appointed as a specialist radiologist or a pathologist.

Remuneration Rates

The revised rates of remuneration embodied in the Determinations were brought into effect by administrative action (with effect from 1 January 2007). These rates were advised in Policy Directive PD2007_032, which remains valid.

Effect on Previous Documents Setting Visiting Medical Officer Terms and Conditions

The new sessional Determination replaces the previous sessional Determination made in 1994.

The new fee-for-service Determination replaces the arrangements arising out of the agreement between the Department of Health and the Australian Medical Association made in 1995, which were notified to the public health system, along with a model contact, by the Department in that year.

Effect on existing Service Contracts

Section 98 of the *Health Services Act* provides that any provision of any service contract that is inconsistent with a determination is, to the extent of the inconsistency, of no effect on and from the date of effect of the determination,

and the contract is taken to be varied so as to include the terms of the determination.

Existing sessional Visiting Medical Officers should be advised that their contracts have been varied by the substitution of the new sessional Determination for the previous Determination as an attachment to their service contracts, and that the terms and conditions of the new Determination now form part of their service contracts. The provisions of existing sessional service contracts, such as the term of the contract and the provisions of the schedules, that are not inconsistent with the new Determination remain applicable.

For existing fee-for-service Visiting Medical Officers, the main source for their terms and conditions of engagement will be the new fee-for-service Determination (rather than as at present their service contracts). Again, the provisions of existing fee-for-service service contracts, such as the term of the contract and the provisions of the schedules, that are not inconsistent with the new Determination remain applicable.

All Visiting Medical Officers should be provided with copies of this Information Bulletin and a copy of the relevant Determination.

Summary of Major Changes made by the new Determinations

The most significant changes include:

1. at the time of a Visiting Medical Officer's annual review, the public health organisation shall also:
   (a) review a Visiting Medical Officer's service and performance under the sessional contract during the preceding 12 month period; and
   (b) consult the Visiting Medical Officer regarding his or her on-call commitment, and the scope of the officer's practice and the resources required to support that officer's practice;
2. eligibility for payment under certain circumstances where pre-arranged theatre lists are cancelled by a public health organisation;
3. a rural incentive package applying at specified regional hospitals under which regional Visiting Medical Officers:
   (a) who provide a defined level of services over the preceding 12 months (450 hours for sessional Visiting Medical Officers or fees of at least $100,000 for fee-for-service Visiting Medical Officers) are entitled to claim reimbursement for professional support expenses up to $10,000 per calendar year;
   (b) who participate in a one in four or more frequent basis on an on call (sessional) or emergency after hours (fee-for-service) roster, are entitled to claim reimbursement for professional support expenses up to $5,000 per calendar year;
   (c) are eligible for a loading for call back/emergency after hours services;
4. an entitlement to interest where payment to a Visiting Medical Officer does not occur within 45 days after the receipt of an account for payment;
5. a simplified disputes procedure;

6. (sessional Visiting Medical Officers only) provision is made for salary sacrifice of remuneration to superannuation;
7. (sessional Visiting Medical Officers only) on call allowances are payable during a call back;
8. (fee-for-service Visiting Medical Officers only) there is an explicit entitlement to sessional payments for time spent participating in the teaching and training of postgraduate medical officers, participating on committees, or where there is an eligibility to payment for cancelled theatre lists.

Date of Commencement

The new Determinations commenced and have effect from 9 October 2007.

Obligations of Public Health Organisations

It is a requirement of the *Accounts and Audit Determination for Public Health Organisations* that Public Health Organisations do not, without the specific approval of the Director General or authorised delegate, provide to any Visiting Medical Officer remuneration or conditions of service under arrangements other than in accordance with the rates or conditions specified in Policy Directives or Information Bulletins issued by the Department. It is a requirement that Public Health Organisations comply with the Determinations in the terms and conditions that are provided to Visiting Medical Officers unless there has been specific approval to provide different terms and conditions.

Enquiries

Any enquiries regarding this Information Bulletin should be directed to the human resource or medical administration staff in the relevant public health organisation. Only staff in public health organisations from such areas are to contact the Department.

Professor Debora Picone AM
Director-General

PUBLIC HOSPITALS (VISITING MEDICAL OFFICERS SESSIONAL CONTRACTS) DETERMINATION 2007

1. TITLE

This Determination shall be known as the "Public Hospitals (Visiting Medical Officers - Sessional Contracts) Determination 2007".

2. ARRANGEMENT

This Determination is arranged as follows:

3. DEFINITIONS

In this Determination:

"AMA (NSW)" means the Australian Medical Association (NSW) Ltd;

"appointment" means appointment as a visiting medical officer and includes reappointment and promotion; and appointed, re-appointed and promoted have a corresponding meaning;

"approved contract of liability coverage" means a contract for professional indemnity cover by the NSW Treasury Managed Fund in a form approved by the NSW Department of Health and offered by public health organisations to visiting medical officers;

"approved professional indemnity insurance" is as defined in the *Health Care Liability Act 2001;*

"call-back" means called to attend a hospital, whether or not rostered on-call, at a time when the visiting medical officer would not otherwise have attended the hospital, in response to a request from the relevant hospital or public health organisation to attend for the purpose of providing services;

"clinical privileges" means the clinical privileges as defined in the *Health Services Act 1997*;

"general practitioner" means a medical practitioner who is not a specialist;

"hospital" means a hospital as defined in the *Health Services Act 1997*;

"medical practitioner" means a person registered for the time being under the *Medical Practice Act 1992*;

"on-call" means rostered to be available to attend public patients pursuant to an on-call roster prepared by a public health organisation in consultation with the relevant clinical department;

"private patient" means a patient who is not a public patient;

"public health organisation" is as defined in Chapter 2 of the *Health Services Act 1997*;

"public patient" means a patient in respect of whom the public health organisation provides comprehensive care, including all necessary medical, nursing and diagnostic services, by means of its own staff or by other agreed arrangements;

"regional hospital" means a hospital listed in Schedule 1 to this Determination;

"regional visiting medical officer" means a visiting medical officer:

(i) who is appointed for a continuous period of at least 12 months under one or more service contracts in respect of one or more regional hospitals; and
(ii) who is engaged under standard contract arrangements approved by the NSW Department of Health.

"senior specialist" means a specialist who has practiced as such in a speciality for at least seven years and who is required under a sessional contract to render services the adequate performance of which services requires a specialist of that status;

"services" means medical services provided to a public patient by a visiting medical officer under a sessional contract, including teaching, training and participation on committees, but excluding attendance at meetings of a medical staff council (howsoever called);

"service contract" means a service contract as defined in the *Health Services Act 1997*;

"sessional contract' means a sessional contract as defined in the *Health Services Act 1997*;

"specialist" means a medical practitioner, other than a general practitioner, who -is a specialist as defined in the *Health Insurance Act 1973* (Commonwealth) and who is required under a sessional contract to render services the adequate performance of which services requires a medical practitioner of that status;

"visiting medical officer" means a visiting medical officer as defined in the *Health Services Act* 1997 who provides services under a sessional contract, but excluding a pathologist and a radiologist; and

"visiting practitioner" means a visiting practitioner as defined in the *Health Services Act* 1997.

4. CONTRACT FOR SERVICES

(1) A visiting practitioner who is to be appointed as a visiting medical officer to provide services under a service contract on a sessional basis shall be so appointed by a written sessional contract between the officer and public health organisation. The sessional contract shall specify the terms and conditions to which the officer is to be subject, including the clinical privileges of the officer as determined or varied from time to time by the public health organisation in accordance with any applicable Act, regulation or by-law and after advice from the appropriate credentials committee in respect of the hospital or hospitals at which the visiting medical officer provides services.

(2) Except as otherwise affected by this Determination, the period for which a visiting medical officer may be appointed to a public health organisation is to be such period (not exceeding the maximum term specified in the *Health Services Regulation*) as the public health organisation may determine and as is specified in the sessional contract.

(3) A visiting medical officer appointed to a public health organisation is, if otherwise qualified, eligible for but not entitled to re-appointment upon the expiry of the existing sessional contract. In the event of re-appointment, a new sessional contract shall be made.

(4) A sessional contract shall not establish the relationship of employer and employee as between the respective parties thereto, and a visiting medical officer shall, in providing services under a sessional contract, be and be regarded as an independent contractor.

(5) A visiting medical officer shall provide the services specified in the sessional contract to

public patients at the relevant hospital or hospitals, consistent with the clinical privileges granted to the officer under the sessional contract.

(6) A visiting medical officer shall participate in the teaching and training of postgraduate medical officers as may reasonably be required by the public health organisation.

(7) A visiting medical officer shall participate in committees expressly established or authorised by the public health organisation to which the officer is appointed where reasonably required by the public health organisation for the proper and efficient functioning of the hospital or hospitals concerned.

(8) A visiting medical officer shall participate in an on-call roster for the provision of services as may reasonably be required by the public health organisation, and when so rostered the officer shall be readily contactable at all times and be able and prepared to attend the hospital concerned within a reasonable period of time.

(9) A visiting medical officer:

(a) shall be professionally responsible for the proper clinical management and treatment of public patients under the officer's care in the hospital concerned;

(b) shall take reasonable steps to ensure that the clinical records related to the services provided by the officer, and those provided for patients under the officer's care, are maintained adequately and that such completed records include details of diagnosis, treatments and operations performed and a discharge summary completed in the manner determined by the hospital.

(c) shall comply with all rules and by-laws in force from time to time at the public health organisation, not being inconsistent with any of the rights and obligations of the visiting medical officer under this agreement.

(10) The public health organisation where reasonably practicable shall provide:

(a) all ancillary, medical, nursing and clerical assistance and facilities, instruments and equipment reasonably necessary for the proper performance of the services to be rendered by a visiting medical officer under a sessional contract; and

(b) to the visiting medical officer upon request and free of charge, sufficient suitable and serviceable outer uniforms and duty garments, which shall remain the property of the public health organisation and which shall be laundered at the expense of the public health organisation.

5. SERVICES

(1) The ordinary hours during which a visiting medical officer is to render services (other than those pursuant to a call-back or an on-call roster) shall be as agreed between the officer and the public health organisation, and shall be specified in the sessional contract on an annual basis or on the basis of a lesser specified period if the contract terminates sooner or if it is otherwise agreed; provided that a public health organisation shall only

allocate work to the visiting medical officer which can reasonably be performed within the agreed number of ordinary hours.

(2) In establishing the annual ordinary hours, or the ordinary hours on the basis of another specified period, under subclauses (1), (5) or (6) regard shall be had to:

(a) the services to public patients recorded as having been provided and the hours recorded as having been worked by the visiting medical officer during the previous twelve months, or if the officer has been appointed for less than twelve months the preceding period of appointment, taking into account information available on each aspect of that officer's work such as, but not limited to, ward rounds, consultations, operating theatre sessions, other procedures, outpatient clinics, postgraduate teaching and committees to which the officer is appointed under clause 4(7);

(b) the clinical service needs and available resources of the public health organisation;

(c) the views of the visiting medical officer;

(d) the nature of the visiting medical officer's appointment;

(e) the experience, knowledge and ability of the visiting medical officer;

(f) any periods of leave which the visiting medical officer proposes or is required to take during the ensuing twelve months or relevant lesser period;

(g) any other relevant fact or circumstance.

Remuneration - options

(3) In respect of remuneration for ordinary hours of services one of the following options shall apply:

Option 1 - Budgeted actual hours remuneration

(a) (i) Where agreed by the parties, a visiting medical officer may be remunerated, to the limit of ordinary hours specified in the sessional contract, for the ordinary hours of services actually performed.

(ii) The visiting medical officer shall be paid upon submission of a record and account to the public health organisation in accordance with clause 14.

(iii) Under this option a plan of the services to be provided by the officer shall be specified.

Option 2 - Specified procedures remuneration

(b) (i) For the purposes of this option, in establishing ordinary hours, or a portion thereof, the public health organisation and visiting medical officer

may agree, and specify in the sessional contract, in respect of the following twelve months or relevant lesser period if the contract is to terminate sooner, the matters set out below:-

- types of procedures that the officer is to perform on public patients;

- numbers of each such type of procedure.

(ii) The visiting medical officer and the public health organisation shall make a reasonable assessment of the average time taken for the types of procedures concerned. The total ordinary hours shall be the sum of the hours thus assessed for each type of procedure multiplied by the number specified for each such procedure.

(iii) The visiting medical officer shall be remunerated for the procedures actually performed, up to the numbers of each type of procedure specified in the sessional contract. For the purpose of calculating ordinary hours attracting remuneration, each such procedure shall be deemed to have taken the time assessed for such a procedure in accordance with sub-paragraph (ii).

(iv) Any portion of ordinary hours specified in the sessional contract which is not established under sub-paragraph (i) shall be remunerated as follows:

- the portion of ordinary hours established under subparagraph (i) shall be deducted from the total ordinary hours established under clause 5(1), (5) or (6); and

- the balance of ordinary hours then remaining shall be paid in twelve equal, or otherwise agreed, monthly instalments.

Option 3 - Agreed hours remuneration

(c) Where Option 1 or 2 is not agreed upon by the parties, the visiting medical officer shall be remunerated for the number of ordinary hours specified in the officer's sessional contract in twelve equal, or otherwise agreed, monthly instalments.

Variation

(4) The number of ordinary hours specified in a sessional contract may be varied at any time, either for a specified period or until the next anniversary date of the sessional contract, by an agreement in writing between the visiting medical officer and the public health organisation.

Annual Review

(5) Not later than six weeks prior to each anniversary date of a sessional contract, the public health organisation and the visiting medical officer shall consult in a review of the number of ordinary hours of services specified in the sessional contract in respect of the

next following year or of such lesser period until the termination of the sessional contract. If agreement is reached for a variation to that number of ordinary hours then the agreement shall be reduced to writing and the sessional contract shall be varied accordingly with effect as from the first day of the year or of such lesser period, as the case may be, to which the review related. Provided that this subclause shall not apply if a sessional contract was made for a period of one year or less.

(6) If agreement is not reached as a result of the review of the number of ordinary hours as contemplated in subclause (5) of this clause, then the public health organisation concerned may decide the number of ordinary hours of services to be provided by the visiting medical officer under the sessional contract for the next following year, or for such lesser period until the next anniversary date or termination of the sessional contract, whichever occurs first. Where a public health organisation decides the number of ordinary hours pursuant to this subclause it shall notify the officer in writing of its decision and the sessional contract shall be deemed to be varied so as to include the terms of that decision, unless the visiting medical officer notifies a dispute under subclause (8).

(7) If by the anniversary date of a sessional contract the visiting medical officer's ordinary hours of services for the next following year, or relevant lesser period, have not been established either by agreement under subclause (5) or decision under subclause (6), the visiting medical officer shall continue to provide services and shall be remunerated each month under the sessional contract on the basis of the average number of ordinary hours of services performed per calendar month in the twelve months prior to the anniversary date, until agreement as to such ordinary hours is reached or a decision is made under subclause (6).

Dispute

(8) (a) Where a visiting medical officer is dissatisfied with a decision made in accordance with subclause (6) of this clause the visiting medical officer shall give notice in writing to the public health organisation of a dispute within 14 days of the receipt of written notification of such decision, such dispute to be dealt with in accordance with clause 18.

(b) Where such dispute is notified by the visiting medical officer in accordance with paragraph (a) of this subclause, then pending resolution of the dispute, the visiting medical officer shall continue to provide services and be remunerated each month under the sessional contract on the basis of the average number of hours of services performed per calendar month in the twelve months prior to the anniversary date; provided that if the dispute has not been resolved within three months of notification of such dispute (or within such further period as may be agreed between the parties), then paragraph (c) of this subclause shall apply.

(c) If, within three months of notification of such dispute (or within such further period as may be agreed between the parties), the dispute has not been resolved and is not the subject of mediation or arbitration under clause 18, then the decision of the public health organisation referred to in paragraph (a) of this subclause shall apply and the sessional contract shall be deemed to be varied

so as to include the terms of that decision.

Other Matters for Annual Review

(9) At the time of the review of ordinary hours under subclause (5), the public health organisation shall also:

(a) review the visiting medical officer's service and performance under the sessional contract during the preceding 12 month period;

(b) consult with the visiting medical officer on the scope of the officer's practice within the public health organisation and the resources required to support the officer in such practice in the next following year; and

(c) consult with the visiting medical officer on the officer's level of participation in the on-call roster in the next following year. If a visiting medical officer is dissatisfied with the level of participation in the on-call roster proposed by the public health organisation, then the dispute provisions set out at subclause (8) can be invoked.

Cancelled Operating Theatre Time

(10) Where a visiting medical officer has a pre-arranged operating theatre session cancelled by the public health organisation:

(a) in the case of an anaesthetist, with less than 28 days notice of such cancellation; or

(b) in the case of a regional visiting medical officer who is not an anaesthetist, with less than 14 days notice of such cancellation; or

(c) in the case of a visiting medical officer other than of a kind referred to in paragraph (a) or (b), with less than 7 days notice of such cancellation,

the visiting medical officer is entitled to be paid for that portion of the cancelled time that is reasonably estimated would have involved the treatment of public patients at the hourly rates specified in clauses 7 and 8 of this Determination, on the condition that the officer attends the public health organisation to provide services for the relevant period in lieu of the cancelled theatre session unless excused from such attendance by the public health organisation. For the purposes of this clause, services includes:

(a) undertaking clinics or procedures within the scope of the officer's clinical privileges;

(b) undertaking quality assurance or review activities specified by the public health organisation; or

(c) undertaking training and education activities specified by the public health organisation.

(11) Where a visiting medical officer cancels a pre-arranged operating theatre session, and

the cancellation is not due to illness, the officer is required to make up the cancelled time over the ensuing 14 day period at time/s of mutual convenience to the officer and the public health organisation. If such mutually convenient time is unavailable the visiting medical officer will cooperate with the public health organisation in examining the feasibility of alternate arrangements with another medical practitioner for the performance of operations or procedures upon public patients affected by such cancellation.

6. CLASSIFICATIONS

(1) A visiting medical officer on appointment by a public health organisation shall be classified as a general practitioner, specialist or senior specialist for the purposes of the officer rendering services under a sessional contract and in ascertaining the officer's remuneration, such classification is to be based on the officer's qualifications and experience and according to the criteria contained in the respective definitions in this Determination of those classifications.

(2) A visiting medical officer may apply to the public health organisation for promotion to a higher classification of specialist or senior specialist, as appropriate, and the application shall be considered within eight weeks and according to the criteria contained in the respective definitions in this Determination of those higher classifications.

(3) Such promotion will be considered by the public health organisation after considering the advice of the credentials committee.

7. REMUNERATION FOR SERVICES

A visiting medical officer shall be paid the hourly rates of remuneration for each ordinary hour specified in a sessional contract (and on a proportionate basis to the nearest quarter hour) as set out in Annexure A of this Determination.

8. BACKGROUND PRACTICE COSTS

A visiting medical officer shall be paid the background practice costs hourly rates as set out in Annexure B to this Determination (and on a proportionate basis to the nearest quarter hour) during which the officer provides services at a public health organisation during ordinary hours, on a public holiday and on a call-back, as an allowance for expenses incurred in background practice costs.

9. SUPERANNUATION

(1) Superannuation shall be payable as per the *Superannuation Guarantee (Administration) Act* 1992 as varied from time to time.

(2) Subject to any relevant Commonwealth legislation, NSW Department of Health Policy Directives, and any ruling or determination by the Australian Taxation Office, a visiting medical officer may elect, subject to the agreement of the public health organisation, to

sacrifice all or part of the payments made to him or her as additional superannuation contributions.

10. ON-CALL AND CALL-BACK

(1) A visiting medical officer shall be paid the hourly on-call allowance as set out in Annexure B to this Determination for each hour (or part thereof) the officer is rostered to be on call and while travelling or rendering services pursuant to a call back.

(2) The on-call allowance shall not be payable during periods a visiting medical officer is on leave of absence.

(3) Where a visiting medical officer is rostered to be on-call to more than one hospital at the same time the officer shall be entitled to receive an on-call allowance only from that hospital to which the officer has the greatest on-call commitment, or where the on-call commitments are equal the officer shall receive an on-call allowance only from one hospital.

(4) Subject to sub-clause (5), in respect of a call-back, a visiting medical officer shall be remunerated as follows:

(a) as to services provided during a call-back within the hours of 8.00 am to 6.00 pm Monday to Friday inclusive - at the officer's ordinary hourly rate of remuneration plus a loading of 10 percent, except as to a call-back on a public holiday when the loading shall be 50 percent;

(b) as to services provided during a call-back outside the hours of 8.00 am to 6.00 pm Monday to Friday inclusive - at the officer's ordinary hourly rate of remuneration plus a loading of 25 percent, except as to a call-back on a public holiday when the loading shall be 50 percent;

(c) the duration of a call-back shall include the actual travelling time from the place of contact to the hospital concerned and return, subject to a maximum of 20 minutes travel each way;

(d) the minimum payment for any one call-back, including travelling time, shall be one hour at the officer's ordinary hourly rate of remuneration plus the appropriate loading.

(5) A regional visiting medical officer who:

(a) provides a call-back service at a regional hospital; and

(b) whose usual place of residence is with a 50 kilometre radius of the regional hospital where the call-back service is provided,

shall be paid a further loading as specified in Annexure C of this Determination on the rates payable under sub-clause (4) for the call-back.

11. PUBLIC HOLIDAY REMUNERATION

Where a visiting medical officer is required by the public health organisation to render services on a public holiday, other than during on-call and call-back, the officer shall be paid at the ordinary hourly rate of remuneration plus a loading of 50 percent.

12. UNPAID LEAVE OF ABSENCE

(1) A visiting medical officer shall be entitled to unpaid leave of absence on a public holiday unless the public health organisation has given reasonable notice that it requires the officer to render services on any such day.

(2) A visiting medical officer shall be entitled to unpaid leave of absence during any period the officer is unable to render services due to illness, provided that the officer shall notify the public health organisation of such incapacity as soon as it is reasonably practicable.

(3) Unpaid leave of absence shall be granted to a visiting medical officer as annual holidays in one or more periods aggregating five calendar weeks per year at times agreed between the officer and the public health organisation. Such leave shall not accrue from year to year and it must be taken within six months of becoming due.

(4) Unpaid leave of absence shall be granted to a visiting medical officer as study and conference leave in one or more periods to a maximum in the aggregate of two calendar weeks per year at times agreed between the officer and the public health organisation. Such leave may be accumulated from year to year to a maximum of four weeks.

(5) Unpaid leave of absence shall be granted to a visiting medical officer as long service leave aggregating two calendar months after providing services for a period of ten years. Thereafter, further unpaid leave of absence shall be granted on the basis of one calendar month for each additional period of two years during which the officer renders services. Such leave shall be allowed at times agreed between the officer and the public health organisation.

(6) Additional periods of unpaid leave of absence may be granted to a visiting medical officer at times agreed between the officer and the public health organisation.

13. PROFESSIONAL SUPPORT FOR REGIONAL VISITING MEDICAL OFFICERS

(1) As at 1 January each year (commencing on 1 January 2008), a regional visiting medical officer:

(a) who has held an appointment continuously for the immediately preceding 12 months; and

(b) who has provided at least 450 ordinary and/or call-back hours of services over

the preceding 12 months at one or more regional hospitals; and

(c) whose usual place of residence is within a 50 kilometre radius of at least one regional hospital where such services are provided;

shall be entitled to claim reimbursement for expenses incurred in respect of the professional support of the visiting medical officer up to the amount set out at Annexure C of this Determination.

(2) As at 1 January each year (commencing on 1 January 2008), a regional visiting medical officer:

(a) who has held an appointment as such continuously for the immediately preceding 12 months; and

(b) who has participated in a one in four or more frequent basis over the preceding 12 months in an on call roster applying in at least one regional hospital;

(c) whose usual place of residence is within a 50 kilometre radius of such hospital

shall be entitled to claim reimbursement for expenses incurred in respect of the professional support of the visiting medical officer up to the amount set out in Annexure C of this Determination.

(3) A visiting medical officer may be eligible for grants under both sub-clauses (1) and (2).

(4) For the purposes of this clause, professional support expenses include:

(a) travel, accommodation, conference or course costs in respect of continuing medical education;

(b) costs of locum cover while the visiting medical officer is on unpaid leave;

(c) such other item/s in connection with the ongoing professional support of the visiting medical officer as a public health organisation may approve in any particular case.

(5) Reimbursement of expenses under this clause will be made upon production of verification of expenses.

(6) Any entitlements under either sub-clause (1) or (2) shall be able to accrue for up to two years, provided the officer continues over that two year period to satisfy the criteria set out in subclauses 13(1) and (2) above.

(7) A visiting medical officer is not eligible to receive a grant under either sub-clause (1) or (2) from more than one public health organisation per calendar year. Where a visiting medical officer would otherwise satisfy the criteria for eligibility for a grant under sub-clauses (1) or (2) in respect of more than one public health organisation, the grant is payable by that public health organisation at which the officer has the greatest service commitment, or in the case of an equal service commitment at each organisation, by

any public area health organisation.

14. RECORD OF SERVICES

(1) Subject to subclause (2), a visiting medical officer shall maintain a record, in a form prescribed and provided by the relevant public health organisation, of services rendered by the officer under the sessional contract. Such record shall indicate in respect of each of the services so rendered:

(a) the date, commencing and finishing times, full name and/or medical record number of the patient and nature of service;

(b) particulars of on-call periods;

(c) for call-backs, the name and/or designation of the person requesting the call-back, and appropriate entry by the visiting medical officer in the medical record of the relevant attendance and/or treatment;

(d) particulars of teaching, training and committee work;

(e) particulars of leave of absence.

(2) Where a public health organisation and a visiting medical officer agree that sufficient information is otherwise available to the public health organisation from the medical records or the visiting medical officer's personal records, then so long as such information continues to be available there is no requirement for the visiting medical officer to provide the full name and/or medical record number of patients.

(3) Where sufficient information to satisfy subclause (1) is not provided or where sufficient information ceases to be otherwise available from the medical records or the visiting medical officer's personal records to satisfy subclause (2), then future payments to the officer for a specified period will require the provision by the officer of additional details, such details and period to be determined by the public health organisation.

(4) The record referred to in subclause (1) of this clause shall be maintained for each calendar month during which services are provided by an officer, and it shall be submitted to the public health organisation no later than the fifteenth day of the next succeeding calendar month.

(5) The record when so submitted pursuant to subclause (4) of this clause shall be accompanied by an account for payment. The public health organisation shall make payment to the visiting medical officer in respect of the account within 30 days of its receipt.

(6) Should a public health organisation fail to make payment to the visiting medical officer within 45 days of receipt of an account for payment in accordance with subclauses (1) – (5), interest shall accrue on the outstanding account from the date as specified in subclause (5) for payment at the Supreme Court interest rate applicable at the time.

(7) The public health organisation in making payment of an account to an officer shall advise details of how the payment is made up as between the various services rendered.

15. SUSPENSION OF SESSIONAL CONTRACT

(1) Subject to Part 4 of Chapter 8 of the *Health Services Act 1997*, the public health organisation may suspend the appointment of a visiting medical officer in accordance with any applicable by-laws where the public health organisation considers it necessary in the interests of the hospital to which the officer is appointed.

(2) Where the visiting medical officer is so suspended, the respective rights and obligations of the parties under the sessional contract shall be suspended for the duration of that suspension.

16. TERMINATION OF SESSIONAL CONTRACT

(1) A sessional contract shall be terminated:

(a) upon the expiry of the period for which it was made or on such earlier date as may be agreed between the visiting medical officer and the public health organisation;

(b) by three months' notice in writing given by either the visiting medical officer or the public health organisation;

(c) by four weeks' notice in writing given by the visiting medical officer if dissatisfied with a decision as to the fixation of ordinary hours by the public health organisation pursuant to clause 5(6) of this Determination following an annual review, provided that the notice of termination is given within seven days of the officer receiving notification in writing of the decision;

(d) if the visiting medical officer ceases to be registered as a medical practitioner;

(e) if a condition is placed on the visiting medical officer's registration as a medical practitioner which substantially precludes the officer from providing services under the sessional contract;

(f) if the visiting medical officer becomes permanently mentally or physically incapable of rendering services under the sessional contract;

(g) if the visiting medical officer commits serious and wilful misconduct; or

(h) if the visiting medical officer's appointment is terminated by operation of any Act or regulation.

(2) On the termination of a sessional contract, any amount due and payable to the visiting medical officer pursuant to the sessional contract shall be paid at the time of such

termination or as soon thereafter as reasonably practicable.

17. PROFESSIONAL INDEMNITY COVER

(1) Subject to sub-clauses (2) and (3) below, a public health organisation must offer a medical practitioner proposed for appointment as a visiting medical officer, who is eligible for professional indemnity cover from the New South Wales Treasury Managed Fund under the applicable policies of the NSW Department of Health as issued from time to time, an approved contract of liability coverage covering the term of the practitioner's proposed appointment as a visiting medical officer at the same time it provides a written service contract.

(2) Where the proposed term of the sessional contract is for longer than 6 months, the approved contract of liability coverage and the written sessional contract must be provided to the practitioner not less than 14 days prior to the commencement of the term of the sessional contract.

(3) A visiting medical officer must have approved professional indemnity insurance in respect of civil liability arising from the officer's practice of medicine at a public health organisation, including in respect of persons who elect to be private patients, to the extent that such liability is not covered by an approved contract of liability coverage.

18. DISPUTE RESOLUTION PROCEDURE

(1) For the purposes of this clause a 'dispute' means any dispute arising between a visiting medical officer and the public health organisation at any time as to any matter of any nature arising under or in connection with a sessional contract, including but not limited to matters relating to clinical privileges but excluding a matter relating to the non-reappointment, suspension or termination of appointment of the visiting medical officer.

(2) A party who wishes to invoke the provisions of this clause must give written notice to the other party/parties to the dispute specifying the nature of the dispute.

(3) On receipt of written notice specifying the nature of the dispute, the parties to the dispute must, within 14 days of receipt of the notice, seek to resolve the dispute by conference.

(4) If the dispute is not resolved within 14 days, or within such further period as agreed between the parties, after the convening of a conference under sub-clause (3) then the dispute is to be referred to mediation. Each party must serve upon the other the name(s) of a mediator(s).

(5) The mediator shall be agreed upon between the parties, or failing agreement, appointed by the President of the Law Society of NSW.

(6) The mediator's fees shall be shared equally between the parties.

(7) The parties to the mediation may be supported by persons of the parties' choice.

(8) In the event that the dispute has not been settled within 28 days, or such other time as agreed to in writing between the parties after the appointment of a mediator, either party may refer the dispute to arbitration.

(9) The arbitrator is not to be the same person as the mediator.

(10) Such arbitration shall be conducted by a single arbitrator. The arbitrator shall be a legal practitioner of at least seven years' post qualification experience. The arbitrator shall be agreed upon between the parties, or failing agreement, appointed by the President of the Law Society of NSW. The parties may be legally represented.

(11) At the request of the visiting medical officer, the AMA (NSW) shall be entitled to appear and be represented in the arbitration.

(12) At the request of the public health organisation, the NSW Department of Health shall be entitled to appear and be represented in the arbitration.

(13) In the event of either the AMA (NSW) or the NSW Department of Health appearing in the arbitration pursuant to sub-clauses (11) or(12), the other organisation shall be entitled to appear and be represented as of right.

(14) The arbitrator's fees shall be shared equally between the parties unless otherwise ordered by the arbitrator.

(15) It is agreed between the parties that the arbitrator shall determine all questions arising for determination in the course of the arbitration by reference to considerations of general justice and fairness.

(16) The determination of the arbitrator shall be final and binding upon the visiting medical officer and the public health organisation.

19. NOTICES

Any notice required by a sessional contract to be given in writing shall be properly served if delivered by hand to the addressee personally or if sent by prepaid registered mail, facsimile or telex transmission to the addressee at the address furnished in writing to the addressor, and shall be deemed to have been received by the addressee on the date of hand delivery or on the date the facsimile or telex transmission was recorded or seven days after the date of posting.

20. OPERATION AND EFFECTIVE DATE

(1) This Determination shall rescind and replace the provisions of all previous determinations made by an arbitrator under Section 29M(I) of the *Public Hospitals Act 1929*.

(2) This Determination shall apply to all visiting medical officer appointments under sessional contracts throughout the State of New South Wales, other than those for pathologists and radiologists.

(3) This Determination shall have effect on and from 9 October 2007.

.....
The Honourable Justice M. J. Walton
Arbitrator

SCHEDULE 1

Regional Hospitals

(As at 9 October 2007)

Albury Base Hospital
Armidale Hospital
Bathurst Base Hospital
Blue Mountains District ANZAC Memorial Hospital
Broken Hill Health Service
Coffs Harbour Base Hospital
Dubbo Base Hospital
Goulburn Base Hospital
Grafton Base Hospital
Griffith Base Hospital
Lismore Base Hospital
Kempsey District Hospital
Maitland Hospital
Manning Base Hospital
Murwillumbah Hospital
Orange Base Hospital
Port Macquarie Base Hospital
Shoalhaven Hospital
Tamworth Base Hospital
Tweed Heads District Hospital
Wagga Wagga Base Hospital

ANNEXURE A

SESSIONAL VMO RATES

REMUNERATION FOR SERVICES

A visiting medical officer shall be paid the following hourly rate of remuneration for each ordinary hour (and on a proportionate basis to the nearest quarter hour) specified in a sessional contract:

Classification		Sessional Rate (per hour)			
		9 October 2007 13%	1 January 2008 2.5%	1 January 2009 2.5%	1 January 2010 2.5%
a)	General Practitioner				
i)	with less than 5 years experience	$115.10	$118.00	$120.95	$124.00
ii)	with at least 5 years experience and/or who has been admitted to Fellowship of the Royal Australian College of General Practitioners and/or Fellowship of the Australian College of Rural and Remote Medicine	$147.85	$151.55	$155.35	$159.25
b)	Specialist	$167.45	$171.65	$175.95	$180.35
c)	Senior Specialist	$179.75	$184.25	$188.85	$193.55

ANNEXURE B

BACKGROUND PRACTICE COSTS

Classification	Rate per hour			
	9 October 2007	1 January 2008	1 January 2009	1 January 2010
a) Anaesthetist, Physician and General Practitioner	$21.05	Rate as at 9 October 2007 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)
b) Surgeon	$35.10	Rate as at 9 October 2007 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at 30 June in the preceding year)

And on a proportionate basis to the nearest quarter hour.

ON-CALL AND CALL BACK

Rate of Allowance (per hour)			
9 October 2007	1 January 2008	1 January 2009	1 January 2010
$10.60	$10.85	$11.10	$11.40

ANNEXURE C

REGIONAL VISITING MEDICAL OFFICER ARRANGEMENTS

Clause reference	Item	Amount
10(5)	Additional call-back loading	10%
13(1)	Professional support for regional practitioners	Up to $10,000 (inclusive of GST) per calendar year
13(2)	Professional support for regional practitioners	Up to $5,000 (inclusive of GST) per calendar year

PUBLIC HOSPITALS (VISITING MEDICAL OFFICERS FEE-FOR-SERVICE CONTRACTS) DETERMINATION 2007

1. TITLE

This Determination shall be known as the 'Public Hospitals (Visiting Medical Officers - Fee-for-Service Contracts) Determination 2007'.

2. ARRANGEMENT

This Determination is arranged as follows:

3. DEFINITIONS

In this Determination:

"AMA (NSW)" means the Australian Medical Association (NSW) Ltd;

"appointment" means appointment as a visiting medical officer and includes reappointment and promotion, and appointed, re-appointed and promoted have a corresponding meaning;

"approved contract of liability coverage" means a contract for professional indemnity cover by the NSW Treasury Managed Fund in a form approved by the NSW Department of Health and offered by public health organisations to visiting medical officers;

"approved professional indemnity insurance" is as defined in the *Health Care Liability Act* 2001;

"clinical privileges" means the clinical privileges as defined in the *Health Services Act 1997*;

"Commonwealth Medical Benefits Schedule" is the scale of fees, as amended from time, for medical services for which a patient rebate is available under arrangements established pursuant to the *Health Insurance Act 1973* (Cth);

"emergency after-hours medical services" means services initiated by or on behalf of public patients whose medical conditions require immediate treatment and which take place on a public holiday, on a weekend, or at any time other than between 8.00 am and 6.00 pm on a weekday not being a public holiday;

"established rates" means the rates set out at Annexure A of this Determination in respect of medical services provided by visiting medical officers under fee-for-service contracts;

"fee-for-service contract' means a fee-for-service contract as defined in the *Health Services Act 1997*;

"hospital" means a hospital as defined in the *Health Services Act 1997*;

"medical practitioner" means a person registered for the time being under the *Medical Practice Act 1992*;

"private patient" means a patient who is not a public patient;

"public health organisation" is as defined in Chapter 2 of the *Health Services Act* 1997;

"public patient" means a patient in respect of whom the public health organisation provides comprehensive care, including all necessary medical, nursing and diagnostic services, by means of its own staff or by other agreed arrangements;

"regional hospital" means a hospital listed in Schedule 1 to this Determination;

"regional visiting medical officer" means a visiting medical officer:

(i) who is appointed for a continuous period of at least 12 months under one or more service contracts in respect of one or more regional hospitals; and

(ii) who is engaged under standard contract arrangements approved by the NSW Department of Health;

"Rural Doctors Settlement Package hospital" means a hospital specified by the Department of Health as one where the terms and conditions and rates of remuneration for visiting medical officers are to be in accordance with those known as the Rural Doctors Settlement Package as determined from time to time by the NSW Department of Health following consultation with the NSW Rural Doctors Association;

"services" means medical services provided to a public patient by a visiting medical officer under a fee-for-service contract, including teaching, training and participation on committees, but excluding attendance at meetings of a medical staff council (howsoever called);

"service contract" means a service contract as defined in the *Health Services Act 1997*;

"sessional contract' means a sessional contract as defined in the *Health Services Act 1997*;

"visiting medical officer" means a visiting medical officer as defined in the *Health Services Act 1997* who provides services under a fee-for-service contract, but excluding a pathologist and a radiologist; and

"visiting practitioner" means a visiting practitioner as defined in the *Health Services Act 1997*.

4. CONTRACT FOR SERVICES

(1) A visiting practitioner who is to be appointed as a visiting medical officer to provide services under a service contract on a fee-for-service basis shall be so appointed by a written fee-for-service contract between the officer and public health organisation. The fee-for-service contract shall specify the terms and conditions to which the officer is to be subject, including the clinical privileges of the officer as determined or varied from time to time by the public health organisation in accordance with any applicable Act, regulation or by-law and after advice from the appropriate credentials committee in respect of the hospital or hospitals at which the visiting medical officer provides services.

(2) Except as otherwise affected by this Determination, the period for which a visiting medical officer may be appointed by a public health organisation is to be such period (not exceeding the maximum term specified in the *Health Services Regulation*) as the public health organisation may determine and as is specified in the fee-for-service contract.

(3) A visiting medical officer appointed by a public health organisation is, if otherwise qualified, eligible for but not entitled to re-appointment upon the expiry of the existing fee-for-service contract. In the event of re-appointment, a new fee-for-service contract shall be made.

(4) A fee-for-service contract shall not establish the relationship of employer and employee

as between the respective parties thereto, and a visiting medical officer shall, in providing services under a fee-for-service contract, be and be regarded as an independent contractor.

(5) A visiting medical officer shall provide the services specified in the fee-for-service contract to public patients at the relevant hospital or hospitals, consistent with the clinical privileges granted to the officer under the fee-for-service contract.

(6) A visiting medical officer shall participate in the teaching and training of postgraduate medical officers as may reasonably be required by the public health organisation.

(7) A visiting medical officer shall participate in committees expressly established or authorised by the public health organisation where reasonably required by the public health organisation for the proper and efficient functioning of the hospital or hospitals concerned.

(8) A visiting medical officer shall participate in an emergency after-hours medical services roster for the provision of services as may reasonably be required by the public health organisation, and when so rostered the officer shall be readily contactable at all times and be able and prepared to attend the hospital concerned within a reasonable period of time.

(9) A visiting medical officer:

(a) shall be professionally responsible for the proper clinical management and treatment of public patients under the officer's care in the hospital concerned;

(b) shall take reasonable steps to ensure that the clinical records related to the services provided by the officer, and those provided for patients under the officer's care, are maintained adequately and that such completed records include details of diagnosis, treatments and operations performed and a discharge summary completed in the manner determined by the hospital.

(c) shall comply with all rules and by-laws in force from time to time at the public health organisation, not being inconsistent with any of the rights and obligations of the visiting medical officer under this agreement.

(10) The public health organisation where reasonably practicable shall provide:

(a) all ancillary, medical, nursing and clerical assistance and facilities, instruments and equipment reasonably necessary for the proper performance of the services to be rendered by a visiting medical officer under a fee-for-service contract; and

(b) to the visiting medical officer upon request and free of charge, sufficient suitable and serviceable outer uniforms and duty garments, which shall remain the property of the public health organisation and which shall be laundered at the expense of the public health organisation .

5. SERVICES AND REMUNERATION

(1) The services, other than emergency after-hours medical services, which the visiting medical officer is to provide under his or her fee-for-service contract, and a services plan (including budget) for the provision of such services, shall be as agreed between the officer and the public health organisation, and shall be specified in the fee-for-service contract on an annual basis or on the basis of a lesser specified period if the contract terminates sooner or if it is otherwise agreed; provided that the public health organisation shall only allocate work to the visiting medical officer which can reasonably be performed in accordance with the services plan.

(2) In establishing the annual services plan or the services plan on the basis of another specified period, under subclauses (1), (7) or (8) of this clause regard shall be had to:

(a) the services to public patients recorded as having been provided by the visiting medical officer during the previous twelve months, or if the officer has been appointed for less than twelve months the preceding period of appointment;

(b) the clinical service needs and available resources of the public health organisation;

(c) the views of the visiting medical officer;

(d) the nature of the visiting medical officer's appointment;

(e) the experience, knowledge and ability of the visiting medical officer;

(f) any periods of leave which the visiting medical officer proposes or is required to take during the ensuing twelve months or relevant lesser period;

(g) any other relevant fact or circumstance.

Remuneration

(3) A visiting medical officer shall be remunerated in accordance with the established rates, to the limit of the budget forming part of the agreed services plan specified in the fee-for-service contract, for the services, other than emergency after-hours medical services, actually provided under a service contract.

(4) A visiting medical officer shall be remunerated, in accordance with the established rates, for emergency after-hours medical services actually provided to public patients under a service contract.

(5) A visiting medical officer shall be remunerated for his or her time spent participating in teaching and training (as required under subclause 4(6)) and participating in committees (as required under subclause 4(7)) in accordance with the hourly remuneration rates applying at that time under sessional contracts.

(6) Where, under subclauses 5(5) and 5(14) of this Determination, a visiting medical officer is entitled to be remunerated in accordance with the hourly rates applying at that time

under the sessional contracts, a specialist with more than 7 years experience in his or her area of speciality is entitled to be remunerated at the senior specialist rate then applicable under sessional contracts.

(7) A visiting medical officer shall be paid upon submission of a record and account to the public health organisation concerned in accordance with clause 8.

Variation

(8) The services plan specified in the fee-for-service contract may be varied at any time by an agreement in writing between a visiting medical officer and the public health organisation concerned.

Annual Review

(9) Not later than six weeks prior to each anniversary date of a fee-for-service contract, the public health organisation and the visiting medical officer shall consult in a review of the services plan specified in the fee-for-service contract in respect of the next following year or of such lesser period until the termination of the fee-for-service contract. If agreement is reached for a variation to the services plan then the agreement shall be reduced to writing and the fee-for-service contract shall be varied accordingly with effect as from the first day of the year or of such lesser period, as the case may be, to which the review related. Provided that this subclause shall not apply if a fee-for-service contract was made for a period of one year or less.

(10) If agreement is not reached as a result of the review of the services plan as contemplated in subclause (9) of this clause, then the public health organisation may decide the services plan for the visiting medical officer's services under the fee-for-service contract for the next following year, or for such lesser period until the next anniversary date or termination of the fee-for-service contract, whichever occurs first. Where a public health organisation decides the services plan pursuant to this subclause it shall notify the officer in writing of its decision and the fee-for-service contract shall be deemed to be varied so as to include the terms of that decision unless the visiting medical officer notifies a dispute under subclause (12).

(11) If by the anniversary date of a fee-for-service contract the visiting medical officer's services plan for the next following year, or relevant lesser period, has not been established either by agreement under subclause (9) or decision under subclause (10), the visiting medical officer shall continue to provide services and be remunerated on a fee-for-service basis in accordance with the existing services plan until agreement as to the services plan is reached or a decision is made under subclause (10).

Dispute

(12) (a) Where a visiting medical officer is dissatisfied with a decision made in accordance with subclause (10) of this clause the visiting medical officer shall give notice in writing to the public health organisation of a dispute within 14 days of the receipt of written notification of such decision, such dispute to be dealt with in accordance with clause 12.

(b) Where such dispute is notified by the visiting medical officer in accordance with paragraph (a) of this subclause, then pending resolution of the dispute, the visiting medical officer shall continue to provide services and be remunerated in accordance with the previous year's service plan; provided that if the dispute has not been resolved within three months of notification of such dispute (or within such further period as may be agreed between the parties) then paragraph (c) of this subclause shall apply.

(c) If, within three months of notification of such dispute (or within such further period as may be agreed between the parties), the dispute has not been resolved and is not the subject of mediation or arbitration under clause 12, then the decision of the public health organisation referred to in paragraph (a) of this subclause shall apply and the fee-for-service contract shall be deemed to be varied so as to include the terms of that decision.

Other Matters for Annual Review

(13) At the time of the review of the services plan under subclause (9), the public health organisation shall also:

(a) review the visiting medical officer's service and performance under the fee-for-service service contract during the preceding twelve month period;

(b) consult with the visiting medical officer on the scope of the visiting medical officer's practice within the public health organisation and the resources required to support the officer in such practice in the next following year; and

(c) consult with the visiting medical officer on the officer's level of participation in the emergency after hours medical services roster in the next following year. If a visiting medical officer is dissatisfied with the level of participation in the emergency after hours medical services roster proposed by the public health organisation, then the dispute provisions set out in subclause (12) can be invoked.

Cancelled Operating Theatre Time

(14) Where a visiting medical officer has a pre-arranged operating theatre session cancelled by the public health organisation:

(a) in the case of a regional visiting medical officer, with less than 14 days notice of such cancellation; or

(b) in the case of a visiting medical officer other than of a kind referred to in paragraph (a), with less than 7 days notice of such cancellation,

the visiting medical officer is entitled to be paid for that portion of the cancelled time that is reasonably estimated would have involved the treatment of public patients in accordance with the total hourly rates applying at that time under sessional contracts, on the condition that the officer attends the public health organisation to provide services for the relevant period in lieu of the cancelled theatre session unless excused from such

attendance by the public health organisation. For the purposes of this clause, services includes:

(a) undertaking clinics or procedures within the scope of the officer's clinical privileges

(b) undertaking quality assurance or review activities specified by the public health organisation; or

(c) undertaking training and education activities specified by the public health organisation.

(15) Where a visiting medical officer cancels a pre-arranged operating theatre session, and the cancellation is not due to illness, the officer is required to make up the cancelled time over the ensuing 14 day period at time/s of mutual convenience to the officer and the public health organisation. If such mutually convenient time is unavailable the visiting medical officer will co-operate with the public health organisation in examining the feasibility of alternative arrangements with another medical practitioner for the performance of operations or procedures upon public patients affected by such cancellation.

6. UNPAID LEAVE OF ABSENCE

(1) A visiting medical officer shall be entitled to unpaid leave of absence on a public holiday unless the public health organisation has given reasonable notice that it requires the officer to render services on any such day.

(2) A visiting medical officer shall be entitled to unpaid leave of absence during any period the officer is unable to render services due to illness, provided that the officer shall notify the public health organisation of such incapacity as soon as it is reasonably practicable.

(3) Unpaid leave of absence shall be granted to a visiting medical officer as annual holidays in one or more periods aggregating five calendar weeks per year at times agreed between the officer and the public health organisation. Such leave shall not accrue from year to year and it must be taken within six months of becoming due.

(4) Unpaid leave of absence shall be granted to a visiting medical officer as study and conference leave in one or more periods to a maximum in the aggregate of two calendar weeks per year at times agreed between the officer and the public health organisation. Such leave may be accumulated from year to year to a maximum of four weeks.

(5) Unpaid leave of absence shall be granted to a visiting medical officer as long service leave aggregating two calendar months after providing services for a period of ten years. Thereafter, further unpaid leave of absence shall be granted on the basis of one calendar month for each additional period of two years during which the officer renders services. Such leave shall be allowed at times agreed between the officer and the public health organisation.

(6) Additional periods of unpaid leave of absence may be granted to a visiting medical officer at times agreed between the officer and the public health organisation.

7. PROFESSIONAL SUPPORT FOR REGIONAL VISITING MEDICAL OFFICERS

(1) As at 1 January each year (commencing on 1 January 2008), a regional visiting medical officer:

(a) who has held an appointment continuously for the immediately preceding 12 months; and

(b) who has provided services (including planned services and emergency after hours medical services) to the public health organisation involving fees of at least $100,000 in total over the preceding 12 months at one or more regional hospitals; and

(c) whose usual place of residence is within a 50 kilometre radius of at least one regional hospital where such services are provided,

shall be entitled to claim reimbursement for expenses incurred in respect of the professional support of the visiting medical officer up to the amount set out at Annexure B of this Determination.

(2) As at 1 January each year (commencing on 1 January 2008), a regional visiting medical officer:

(a) who has held an appointment as such continuously for the immediately preceding 12 months

(b) who has participated in a one in four or more frequent basis over the preceding 12 months in an emergency after-hours medical services roster applying in at least one regional hospital; and

(c) whose usual place of residence is within a 50 kilometre radius of such hospital,

shall be entitled to claim reimbursement for expenses incurred in respect of the professional support of the visiting medical officer up to the amount set out at Annexure B of this Determination.

(3) A visiting medical officer may be eligible for grants under both sub-clauses (1) and (2).

(4) For the purposes of this clause, professional support expenses include:

(a) travel, accommodation, conference or course costs in respect of continuing medical education;

(b) costs of locum cover while the visiting medical officer is on unpaid leave;

(c) such other item/s in connection with the ongoing professional support of the

visiting medical officer as the public health organisation may approve in any particular case.

(5) Reimbursement of expenses under this clause will be made upon production of verification of expenses.

(6) Any entitlement under either sub-clause (1) or (2) shall be able to accrue for up to two years provided the officer continues over that two year period to satisfy the criteria set out in subclauses 7(1) and (2) above.

(7) A visiting medical officer is not eligible to receive a grant under either sub-clause (1) or (2) from more than one public health organisation per calendar year. Where a visiting medical officer would otherwise satisfy the criteria for eligibility for a grant under sub-clause (1) or (2) in respect of more than one public health organisation the grant is payable by that public health organisation at which the officer provides the most number of services, or in the case of an equal service commitment at each organisation, by one public health organisation.

8. RECORD OF SERVICES

(1) Subject to subclause (2), a visiting medical officer shall maintain a record, in a form prescribed and provided by the public health organisation, of services rendered by the officer under the fee-for-service contract. Such record shall indicate in respect of each of the services so rendered:

(a) the date, full name and/or medical record number of the patient and nature of service;

(b) for emergency after-hours medical services, the name and/or designation of the person requesting the service, and appropriate entry by the visiting medical officer in the medical record of the relevant attendance and/or treatment;

(c) particulars of teaching, training and committee work.

(d) particulars of leave of absence.

(2) Where a public health organisation and a visiting medical officer agree that sufficient information is otherwise available to the public health organisation from the medical records or the visiting medical officer's personal records, then so long as such information continues to be available there is no requirement for the visiting medical officer to provide the full name and/or medical record number of patients.

(3) Where sufficient information to satisfy subclause (1) is not provided or where sufficient information ceases to be otherwise available from the medical records or the visiting medical officer's personal records to satisfy subclause (2), then future payments to the officer for a specified period will require the provision by the officer of additional details, such details and period to be determined by the public health organisation.

(4) The record referred to in subclause (1) of this clause shall be maintained for each calendar month during which services are provided by an officer, and it shall be submitted to the public health organisation no later than the fifteenth day of the next succeeding calendar month.

(5) The record when so submitted pursuant to subclause (4) of this clause shall be accompanied by an account for payment. The public health organisation shall make payment to the visiting medical officer in respect of the account within 30 days of its receipt.

(6) Should a public health organisation fail to make payment to the visiting medical officer within 45 days of receipt of an account for payment in accordance with subclauses (1) – (5), interest shall accrue on the outstanding account for payment from the date specified in subclause (5) at the Supreme Court interest rate applicable at the time.

(7) The public health organisation in making payment of an account to an officer shall advise details of how the payment is made up as between the various services rendered.

9. SUSPENSION OF FEE-FOR-SERVICE CONTRACT

(1) Subject to Part 4 of Chapter 8, of the *Health Services Act 1997*, the public health organisation may suspend the appointment of a visiting medical officer in accordance with any applicable by-laws where the public health organisation considers it necessary in the interests of the hospital to which the officer is appointed.

(2) Where the visiting medical officer is so suspended, the respective rights and obligations of the parties under the fee-for-service contract shall be suspended for the duration of that suspension.

10. TERMINATION OF FEE-FOR-SERVICE CONTRACT

(1) A fee-for-service contract shall be terminated:

(a) upon the expiry of the period for which it was made or on such earlier date as may be agreed between the visiting medical officer and the public health organisation;

(b) by three months' notice in writing given by either the visiting medical officer or the public health organisation;

(c) by four weeks' notice in writing given by the visiting medical officer if dissatisfied with a decision as to the fixation of the services plan by the public health organisation pursuant to clause 5(8) of this Determination following an annual review, provided that the notice of termination is given within seven days of the officer receiving notification in writing of the decision;

(d) if the visiting medical officer ceases to be registered as a medical practitioner;

(e) if a condition is placed on the visiting medical officer's registration as a medical practitioner which substantially precludes the officer from providing services under the fee-for-service contract;

(f) if the visiting medical officer becomes permanently mentally or physically incapable of rendering services under the fee-for-service contract;

(g) if the visiting medical officer commits serious and wilful misconduct; or

(h) if the visiting medical officer's appointment is terminated by operation of any Act or regulation.

(2) On the termination of a fee-for-service contract, any amount due and payable to the visiting medical officer pursuant to the fee-for-service contract shall be paid at the time of such termination or as soon thereafter as reasonably practicable.

11. PROFESSIONAL INDEMNITY COVER

(1) Subject to sub-clauses (2) and (3) below, a public health organisation must offer a medical practitioner proposed for appointment as a visiting medical officer, who is eligible for professional indemnity cover from the New South Wales Treasury Managed Fund under the applicable policies of the NSW Department of Health as issued from time to time, an approved contract of liability coverage covering the term of the practitioner's proposed appointment as a visiting medical officer at the same time it provides a written service contract.

(2) Where the proposed term of the fee-for-service contract is for longer than 6 months, the approved contract of liability coverage and the written fee-for-service contract must be provided to the practitioner not less than 14 days prior to the commencement of the term of the fee-for-service contract.

(3) A visiting medical officer must have approved professional indemnity insurance in respect of civil liability arising from the officer's practice of medicine at a public health organisation, including in respect of persons who elect to be private patients, to the extent that such liability is not covered by an approved contract of liability coverage.

12. DISPUTE RESOLUTION PROCEDURE

(1) For the purposes of this clause a 'dispute' means any dispute arising between a visiting medical officer and the public health organisation at any time as to any matter of any nature arising under or in connection with a fee-for-service contract, including but not limited to matters relating to clinical privileges but excluding a matter relating to the non-reappointment, suspension or termination of appointment of the visiting medical officer.

(2) A party who wishes to invoke the provisions of this clause must give written notice to the other party/parties to the dispute specifying the nature of the dispute.

(3) On receipt of written notice specifying the nature of the dispute, the parties to the dispute must, within 14 days of receipt of the notice, seek to resolve the dispute by conference.

(4) If the dispute is not resolved within 14 days, or within such further period as agreed between the parties, after the convening of a conference under sub-clause (3) then the dispute is to be referred to mediation. Each party must serve upon the other the name(s) of a mediator(s).

(5) The mediator shall be agreed upon between the parties, or failing agreement, appointed by the President of the Law Society of NSW.

(6) The mediator's fees shall be shared equally between the parties.

(7) The parties to the mediation may be supported by persons of the parties' choice.

(8) In the event that the dispute has not been settled within 28 days, or such other time as agreed to in writing between the parties after the appointment of a mediator, either party may refer the dispute to arbitration.

(9) The arbitrator is not to be the same person as the mediator.

(10) Such arbitration shall be conducted by a single arbitrator. The arbitrator shall be a legal practitioner of at least seven years' post qualification experience. The arbitrator shall be agreed upon between the parties, or failing agreement, appointed by the President of the Law Society of NSW. The parties may be legally represented.

(11) At the request of the visiting medical officer, the AMA (NSW) shall be entitled to appear and be represented in the arbitration.

(12) At the request of the public health organisation, the NSW Department of Health shall be entitled to appear and be represented in the arbitration.

(13) In the event of either the AMA (NSW) or the NSW Department of Health appearing in the arbitration pursuant to sub-clauses (11) or(12), the other organisation shall be entitled to appear and be represented as of right.

(14) The arbitrator's fees shall be shared equally between the parties unless otherwise ordered by the arbitrator.

(15) It is agreed between the parties that the arbitrator shall determine all questions arising for determination in the course of the arbitration by reference to considerations of general justice and fairness.

(16) The determination of the arbitrator shall be final and binding upon the visiting medical officer and the public health organisation.

13. NOTICES

Any notice required by a fee-for-service contract to be given in writing shall be properly served if delivered by hand to the addressee personally or if sent by prepaid registered mail, facsimile or telex transmission to the addressee at the address furnished in writing to the addressor, and shall be deemed to have been received by the addressee on the date of hand delivery or on the date the facsimile or telex transmission was recorded or seven days after the date of posting.

14. OPERATION AND EFFECTIVE DATE

(1) This Determination shall apply to all visiting medical officer appointments under fee-for-service contracts throughout the State of New South Wales, other than those for pathologists and radiologists and Rural Doctors Settlement Package hospitals.

(4) This Determination shall have effect on and from 9 October 2007.

.....
The Honourable Justice M. J. Walton
Arbitrator

SCHEDULE 1

Regional Hospitals

(As at 9 October 2007)

Albury Base Hospital
Armidale Hospital
Bathurst Base Hospital
Blue Mountains District ANZAC Memorial Hospital
Broken Hill Health Service
Coffs Harbour Base Hospital
Dubbo Base Hospital
Goulburn Base Hospital
Grafton Base Hospital
Griffith Base Hospital
Lismore Base Hospital
Kempsey District Hospital
Maitland Hospital
Manning Base Hospital
Murwillumbah Hospital
Orange Base Hospital
Port Macquarie Base Hospital
Shoalhaven Hospital
Tamworth Base Hospital
Tweed Heads District Hospital
Wagga Wagga Base Hospital

ANNEXURE A

Established Rates for fee-for-service contracts

1. Except as provided for below, the rate of remuneration for the provision of a medical service under a fee-for-service contract is 100% of the relevant Commonwealth Medical Benefits Schedule fee.

2. The rate of remuneration for the provision of a medical service under a fee-for-service contract where the medical service is provided in a hospital which has no Resident Medical Officer, Registrar or Career Medical Officer available as medical practitioner of first contact on a 24 hour a day 7 days a week basis, is 110% of the relevant Commonwealth Medical Benefits Schedule fee.

3. The rate of remuneration under a fee-for-service contract for the provision of an emergency after hours medical service is 110% of the relevant Commonwealth Medical Benefits Schedule fee.

4. The rate of remuneration payable to a regional visiting medical officer:

   (a) who provides an emergency after hours service at a regional hospital listed at Schedule 1 to this Determination, and
   (b) whose usual place of residence is within a 50 kilometre radius of the regional hospital where the service is provided,

   is 120% of the relevant Commonwealth Medical Benefits Schedule fee in respect of that occasion of service.

ANNEXURE B

REGIONAL VISITING MEDICAL OFFICERS

Clause reference	Item	Amount
7(1)	Professional support for regional practitioners	Up to $10,000 (inclusive of GST) per calendar year
7(2)	Professional support for regional practitioners	Up to $5,000 (inclusive of GST) per calendar year

ANNEXURE C

NSW Health Information Bulletin IB2008_007: Visiting Medical Officers – Remuneration

Information Bulletin

NSW HEALTH

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http://www.health.nsw.gov.au/policies/

Visiting Medical Officers - Remuneration

Document Number IB2008_007

Publication date 08-Feb-2008

Functional Sub group Personnel/Workforce - Industrial and Employee Relations

Summary This Information Bulletin provides notification of the new background practice costs applying to sessional Visiting Medical Officers.

Author Branch Employee Relations

Branch contact Employee Relations 9391 9357

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared

Audience Administration, clinical

Distributed to Public Health System, Health Associations Unions, NSW Department of Health

Review date 08-Feb-2013

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Status Active

Director-General

REVISED RATES FOR SESSIONAL VISITING MEDICAL OFFICERS

Purpose

The purpose of this Information Bulletin is to provide notification of the new background practice cost rates for sessional Visiting Medical Officers.

Background

Revised remuneration rates for sessional Visiting Medical Officers were advised in PD2007_032 and given formal effect in the *Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2007*. These documents indicated that:

1. sessional rates were to increase on 1 January 2008, 2009 and 2010;
2. background practice cost rates for sessional Visiting Medical Officers were to increase on 1 January 2008, 2009 and 2010 in line with the increase in the All Groups Consumer Price Index for Sydney as at the June quarter in the preceding year.

Revised Background Practice Cost Rates

The new background practice cost rates are as follows:

Anaesthetist, Physician and General Practitioner:	$21.40
Surgeon:	$35.70

Current Sessional Visiting Medical Officer Remuneration Rates

The provisions of PD2007_032 remain current except as regards the revised background practice cost rates.

For ease of reference, the current remuneration rates for sessional Visiting Medical Officers are set out in Attachment A.

Enquiries

Any enquiries regarding this Information Bulletin should be directed to the human resource or medical administration staff in the relevant public health organisation. Only staff in public health organisations from such units are to contact the Department.

Professor Debora Picone AM
Director-General

Attachment A

SESSIONAL VMO RATES

ORDINARY HOUR REMUNERATION

A sessional Visiting Medical Officer shall be paid the following hourly rate of remuneration for each ordinary hour (and on a proportionate basis to the nearest quarter hour) specified in a sessional contract:

Classification	1 January 2008 2.5%	1 January 2009 2.5%	1 January 2010 2.5%
a) General Practitioner	$118.00	$120.95	$124.00
i) with less than 5 years experience	$151.55	$155.35	$159.25
ii) with at least 5 years experience and/or who has been admitted to Fellowship of the Royal Australian College of General Practitioners and/or Fellowship of the Australian College of Rural and Remote Medicine			
b) Specialist	$171.65	$175.95	$180.35
c) Senior Specialist	$184.25	$188.85	$193.55

BACKGROUND PRACTICE COSTS

Classification	1 January 2008	1 January 2009	1 January 2010
a) Anaesthetist, Physician and General Practitioner	$21.40	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)
b) Surgeon	$35.70	Rate as at 1 January 2008 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)	Rate as at 1 January 2009 adjusted in line with the annual increase in the All Groups Consumer Price Index for Sydney (as at the June quarter in the preceding year)

And on a proportionate basis to the nearest quarter hour.

ON-CALL

A sessional visiting medical officer shall be paid an amount as shown below for each hour (or part thereof) the officer is rostered to be on-call or whilst travelling or rendering services pursuant to a call-back.

1 January 2008	1 January 2009	1 January 2010
$10.85	$11.10	$11.40

ANNEXURE D

NSW Health Policy Directive PD2008_002: VMOs in Rural Doctors' Settlement Package Hospitals Indexation of Fees from 1 August 2007

Policy Directive

NSW HEALTH

Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

VMO's in Rural Doctors' Settlement Package Hospitals Indexation of Fees from 1 August 2007

Document Number	PD2008_002
Publication date	03-Jan-2008
Functional Sub group	Personnel/Workforce - Industrial and Employee Relations Personnel/Workforce - Salaries
Summary	Indexation of Fees - VMO's in Rural Doctors Settlement Package Hospitals.
Replaces Doc. No.	VMO's in Rural Doctors' Settlement Package Hospitals Indexation of Fees from 1 August 2006 [PD2007_001] Rural Doctors Settlement Package - amendment to schedule of fees [PD2007_060]
Author Branch	Employee Relations
Branch contact	Employee Relations 9391 9357
Applies to	Area Health Services/Chief Executive Governed Statutory Health Corporation, Public Hospitals
Audience	Administration
Distributed to	Public Health System, NSW Ambulance Service, NSW Department of Health, Public Hospitals
Review date	03-Jan-2009
File No.	07/8571
Status	Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

PAYMENT OF VISITING MEDICAL OFFICERS IN RURAL DOCTORS' SETTLEMENT PACKAGE HOSPITALS INDEXATION OF FEES FROM 1 AUGUST 2007

This Policy Directive rescinds and replaces Policy Directive PD2007_001 and Policy Directive PD2007_060, which provided the 2006 schedule of fees and the revised arrangements following the outcome of a review of the Rural Doctors Settlement Package. This Policy Directive provides the schedule of fees effective from 1 August 2007.

The Rural Doctors Settlement Package was implemented on 1 August 1988, arising from the 1987 NSW Country Doctors' Dispute. The package only applies at listed hospitals in all affected Area Health Services. Fees under that package are indexed from 1 August each year according to an agreed formula.

These fees are only applicable to Visiting Medical Officer specialists (who have elected to be so remunerated) and general practitioners in hospitals listed in the Settlement Package. Any fees not listed in the schedules are to be paid in accordance with the 1 August, 1987 Medical Benefits Schedule, calculated as 2.240194% of the stated full schedule fee rounded off to the nearest ten cents (ie equivalent to multiplying 85% of the 1987 fee by a factor of 2.635522).

Item Nos 1190 Antenatal Visit and 1070 post natal visit have been increased in line with Item 1004 which was increased as part of the review of the Rural Doctors Settlement Package.

Please note that the following rates for the transport allowance have also been increased effective from 1 August 2007:

- Item 11.2A (under New Clarification Rates) Mileage 35.4 c/km
- Item 11.2B (under New Clarification Rates) Mileage 29.6 c/km

The current Medical Benefits Schedule and any future revisions to that Schedule by the Commonwealth Government have no relevance to general practitioner fee-for-service payments at hospitals listed in the Settlement Package. Further, where the 1987 Medical Benefits Schedule states that a procedure is included with the associated consultation, the one fee is paid, but where the schedule is silent and the procedure is not elective both a consultation and a procedure fee may be paid.

Professor Debora Picone AM
Director-General

SCHEDULE OF FEES FOR GENERAL PRACTITIONER MODIFIED FEE FOR SERVICE HOSPITAL PATIENTS PAYMENTS IN NSW RURAL PUBLIC HOSPITALS

AS FROM 1 AUGUST, 2007

SPECIAL NSW ITEMS (EXTRACT FROM ATTACHED SCHEDULE)

ITEM NO	SERVICE	FEE ($)
201	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery. This item covers those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby; but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery.	349.60
1000	ON CALL	6.60 per hour
1001	ON CALL AFTER HOURS (outside Monday to Friday 7.00am to 6.00pm; Saturday 7.00am to Midday). Includes public holidays.	9.90 per hour
	ATTENDANCE IN HOURS (Mon to Friday, 7.00am to 6.00pm; Saturday, 7.00am to Midday)	
	In-patients:	
1002	Where only one in-patient (including a nursing home type patient) is seen	58.20
1004	Where two or more in-patients are seen on the one occasion.	44.00
	Out-patients:	
1010	All in-hours non-inpatients, regardless of duration of consultation (any number)	44.00
1012	**NON EMERGENCY/NON ROUTINE PATIENTS** In hours attendance for the first patient seen, neither routine nor emergency (as defined), where the VMO is requested, or determines there is a definite clinical need following contact from the hospital to return to the hospital primarily for this attendance.	77.00

ITEM NO	SERVICE	FEE ($)
	ATTENDANCE AFTER HOURS (Mon to Friday, 6.00pm to 10.00pm; Saturday, 12.00 Midday to 10.00pm; Sunday, 7.00am to 10.00pm)	
	After hours consultation during a ward round (in and non-inpatients – any number):	
1016	Sunday and public holidays (any number)	52.70
1018	All other	44.00
	After hours consultation	
	In patient and out-patient not in the course of a ward round, all days except Saturdays, Sundays and public holidays:	
1024	First patient	91.00
1026	Subsequent patients.	65.90
	In-patient and out-patient not in the course of a ward round, Saturdays patients seen on the one occasion, Sundays and public holidays:	
1031	First three	91.00
1034	Subsequent patients.	65.90
	LATE NIGHT CONSULTATION (All days, 10.00pm to Midnight)	
1039	First patient	158.10
1042	Subsequent patients	91.00
	ANTI SOCIAL HOURS CONSULTATION (All days, 12.00 Midnight to 7.00am)	
1046	First patient	197.70
1050	Subsequent patients	91.00

ITEM NO	SERVICE	FEE ($)
	EMERGENCY CONSULTATION (AS DEFINED)	
1054	Anti-social hours emergency, first patient	197.70
1056	All other emergency consultations (except items 160 to 164), including nursing home type patients	158.10
	Prolonged emergency attendances:	
160	Item 160	156.80
161	Item 161	255.40
162	Item 162	354.00
163	Item 163	459.20
164	Item 164	548.80
165	Prolonged professional attendance not less than one hour - ventilated patient awaiting transfer	$57.20 per 15 minutes
	AMBULANCE ESCORT for severely ill patients	
1058	Escort	229.30 per hour
1060	Expenses	Reasonable return journey & out of pocket expenses
	PROCEDURES	
	Obstetrics:	
1190	Antenatal care attendance	44.00
1062	Confinement only, including '9 days' normal post natal care.	751.20
1064	Caesarean section, including '9 days' normal post natal care.	751.20
1070	All normal post natal attendances other than those included in 1062 & 1064 to be paid at the standard consultation rate. (This includes attendances following an incomplete confinement (Item 201) to and attendances on a sick neonate except where a referral would be made to a paediatrician, were one available).	44.00

ITEM NO	SERVICE	FEE ($)
1066	Management of labour and delivery, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management one, or more, of the following conditions is present, including postnatal care for 7 days; multiple pregnancy;, recurrent antepartum haemorrhage from 20 weeks gestation;, grades 2,3 or 4 placenta praevia;, baby with a birth weight less than or equal to 2500gm;, pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring;, trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1 + proteinuria on urinalysis, prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; foetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; or, conditions that pose a significant risk of maternal death.	1543.10
	COMMITTEE ATTENDANCES	
1076	Payment for attendance to meetings covered by the agreed schedule and where required to attend by Area or Hospital. A one hour payment is made if meetings are cancelled by the Area Health Service with less than 24 hour's notice.	159.40 per hour (to nearest 15 min)
1077	Payment for travel for meetings under item 1076 (where distance to the meeting is greater than 25 km from the rural health facility of appointment and return journey is greater than 25km each way). Payment is made for the return journey from the rural health facility to meeting or actual travel, whichever is the lesser.	159.40 per hour (to nearest 15 min)

ITEM NO	SERVICE	FEE ($)
	SEXUAL ASSAULT FORENSIC CONSULTATION	
1500	Sexual assault forensic consultation taking less than 2 hours Consultation other than in anti social hours	315.00
1502	Sexual assault forensic consultation taking less than 2 hours Consultation during anti social hours	354.40
1504	Sexual assault forensic consultation taking between 2 and 3 hours Consultation other than in anti social hours	413.60
1506	Sexual assault forensic consultation taking between 2 and 3 hours Consultation during anti social hours	453.00
1508	Sexual assault forensic consultation taking over 3 hours Consultation other than in anti social hours	512.20
1510	Sexual assault forensic consultation taking over 3 hours Consultation during anti social hours	551.60

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Committee Meeting fee: Is payable for meetings concerned with hospital patient management, clinical privileges, credentialling, clinical planning and Quality Assurance where these meetings are of a type recommended by the Health Service Medical Council and approved by the Health Service Chief Executive Officer or Delegate. Approved meetings do not include meetings of the Medical Staff Council or local/Health Service Boards.

Anaesthetic fee: The definition of emergency attendance permits the additional payment of a fee equivalent to the emergency consultation fee to GP anaesthetists required to attend at non-booked surgical procedures.

N.S.W. Rural Hospital Sample Item List. Check August 1987 M.B.S. Book for full details. Effective 1st August 2007

ITEM	SERVICE	FEE	ANAES.
27	See 1002		
28	See 1002		
32	CnNH 2IP	$ 33.60	
34	CnNH >2IP	$ 28.20	
82	PreOpExam	$ 39.40	
88	SpCon1st^	$112.00	
94	SpCon2nd^	$ 56.00	
160	ConPr>1<2	$156.80	
161	ConPr>2<3	$255.40	
162	ConPr>3<4	$354.00	
163	ConPr>4<5	$459.20	
164	ConProl>5	$548.80	
165	VP4Tfr/15 min	$57.20	
190	See 1190		
192	See 1190		
194	See 1062		
198	ConfRfrd^	$448.00	
201	ConfIncmp	$349.60	
204	See 1062		
210	CaesRefrd	$806.50	9039
242	Misc-Injn	$ 28.20	
246	Preg-T/Ab	$ 28.20	
247	Preg-Twin	$ 28.20	
248	Preg-Prem	$ 28.20	
250	CervStrng	$212.80	407
258	CervStrn^	$282.30	407
267	CervStrRo	$ 81.80	406
273	Preg-Tox.	$ 28.20	
274	Induct2Tr	$309.10	
275	Induct2T^	$380.80	
290	CTGnotLab	$ 47.00	
295	VersExtGA	$ 81.80	407
298	VersIntGA	$147.90	407
362	ProdConRo	$ 98.60	9035
363	PPH-PackU	$ 98.60	9035
365	Invert Ut	$358.40	9037
383	Sut3dTear	$163.50	9035
401	Anaest.1U	$ 21.30	
403	Anaest.2U	$ 42.60	
404	Anaest.3U	$ 63.80	
405	Anaest.4U	$ 85.10	
406	Anaest.5U	$106.40	
407	Anaest.6U	$127.70	
408	Anaest.7U	$150.10	
409	Anaest.8U	$170.30	
443	Anaest.9U	$192.70	
450	Anaest10U	$212.80	
453	Anaest11U	$233.00	
454	Anaest12U	$255.40	
457	Anaest13U	$277.80	
458	Anaest14U	$300.20	
459	Anaest15U	$318.10	
460	Anaest16U	$340.50	
461	Anaest17U	$362.90	
462	Anaest18U	$385.30	
463	Anaest19U	$403.20	
464	Anaest20U	$425.60	
465	Anaest21U	$448.00	
466	Anaest22U	$470.40	
467	Anaest23U	$492.80	
468	Anaest24U	$515.20	
469	Anaest25U	$537.60	
470	Anaest26U	$548.80	
471	Anaest27U	$571.20	
472	Anaest28U	$593.70	
481	An/Conf++	$150.10	
482	An/OpDisl	1.50 x	ITEM
483	An/OpOp #	1.33 x	ITEM
484	An/OpComd	1.50 x	ITEM
485	An/OpCmpl	1.75 x	ITEM
486	An-NoItem	$ 21.30	
487	An/Therap	$212.80	
566	An/Dental	$ 85.10	
568	An/D-Tth.	$127.70	
570	An/D-Tth&	$170.30	
572	An/D-<30m	$127.70	
574	An/D->30m	$212.80	
576	An/D-Othr	$150.10	
748	NrveBl-Rg	$118.70	
751	NrveBlMnt	$ 51.50	
752	InjEpidNc	$ 65.00	
753	InjEpidLA	$ 65.00	
760	NrveBl-IV	$ 89.60	
791	U/S xSnoR	$ 62.70	
793	U/S xSRfd	$179.20	
794	U/S UniDm	$108.60	
895	IVlineNeo	$ 73.90	
897	IAlineUmb	$108.60	
907	VPinfant+	$ 36.70	
908	See 1908		
909	See 1909		
916	ECGstress	$217.30	
917	DC Vers.	$125.50	405
921	Spiromtry	$ 26.40	
932	Cytot.Adm	$ 77.30	
944	BloodTran	$107.50	
949	BloodAuto	$ 62.70	
956	ArtBld.Ro	$ 29.60	
960	HormImpIn	$ 66.10	
963	HormImpCn	$ 45.90	
974	Gast.Lvge	$ 77.30	
980	Acupunct.	$ 39.40	
1000	OCF IH/Hr	$ 6.60	
1001	OCF AH/Hr	$ 9.90	
1002	CnIhIP 1	$ 58.20	
1004	CnIhIP >1	$ 44.00	
1010	CnIh OP	$ 44.00	
1012	CnIhNotRt	$ 77.00	
1016	CnAhWrSun	$ 52.70	
1018	CnAhWrOth	$ 44.00	
1024	CnAhWD1st	$ 91.00	
1026	CnAhWD 2+	$ 65.90	
1031	CnAhWE1-3	$ 91.00	
1034	CnAhWE 4+	$ 65.90	
1039	CnLn 1st	$158.10	
1042	CnLn 2+	$ 91.00	
1046	CnAs 1st	$197.70	
1050	CnAs 2+	$ 91.00	
1054	CnEmAs1st	$197.70	
1056	CnEm Oth	$158.10	
1058	Ambul /Hr	$229.30	
1060	Ambul Exp		
1062	Conf&AftC	$751.20	
1064	Caes&AftC	$751.20	9039
1066	Conf>Risk	1543.10	9039
1068	Obs Grant		
1070	CnPostNat	$ 44.00	
1072	IVlineOrd	$ 46.80	9023
1074	IVlineOpn	$ 77.40	9025
1076	Committee	$159.40	
1077	ComTvl/Hr	$159.40	
1078	Ans Grant		
1190	CnAntenat	$ 44.00	
1407	WrtGA<45m	$214.50	407
1408	WrtGA>45m	$333.30	409
1409	TempArtBx	$439.00	409
1430	HartmanOp	1337.80	462
1431	HartmRest	1955.30	467
1441	LapAppend	$622.30	453
1442	LapHernia	$603.00	453
1444	LapEctopP	$839.10	454
1445	LapCholec	1056.00	459
1446	LapChol&L	1056.00	461
1447	LapC&CdcD	1263.30	462
1448	LapC&CdcC	1404.80	464
1500	SexAss<2S	$315.00	
1502	SexAss<2A	$354.40	
1504	SexAs2-3S	$413.60	
1506	SexAs2-3A	$453.00	
1508	SexAss>3S	$512.20	
1510	SexAss>3A	$551.60	
1908	ECG & RPT	$ 63.00	
1909	ECG / RPT	$ 31.00	
2502	X/R Digit	$ 56.00	
2508	X/R Wrist	$ 56.00	
2516	X/R Elbow	$ 76.20	

'1.33 x ITEM' indicates 1.33 times Initial Item Fee. NOT ALL ITEMS are applicable to ALL Hospitals AND/OR Doctors.

N.S.W. Rural Hospital Sample Item List. Check August 1987 M.B.S. Book for full details. Effective 1st August 2007

ITEM	SERVICE	FEE	ANAES.	ITEM	SERVICE	FEE	ANAES.	ITEM	SERVICE	FEE	ANAES.	ITEM	SERVICE	FEE	ANAES.
2524	X/R Ankle	$ 61.60		3135	BiopDeep.	$152.30	407	3320	PlWart.Ro	$ 61.60	406	3664	BrstCtRo^	$331.50	408
2532	X/R Knee.	$ 93.00		3142	BiopDeep^	$192.70	407	3349	Tum1&+ Dx	$ 81.80	405	3668	BrstC&Ro.	$336.00	409
2539	X/R Shoul	$ 76.20		3148	BiopDpDrl	$ 62.70	406	3350	SkFzCa< 4	$163.50	407	3673	BrstC&Ro^	$421.20	409
2551	X/R Pelv.	$114.20		3157	BiopBMopn	$141.10	406	3351	SkFzCa<11	$412.20	443	3678	Mast.Par.	$336.00	409
2557	X/R Femur	$188.20		3158	BiopBMtre	$ 76.20		3352	SkFzCa>10	$526.40	457	3683	Mast.Par^	$421.20	409
2625	X/R Chest	$ 67.20		3160	BiopBMasp	$ 38.10	406	3356	SkinLsInj	$ 57.10		3698	Mast.SimE	$761.70	454
2655	X/R Ribs.	$ 81.80		3168	BiopScNde	$237.50	406	3363	KelInj GA	$210.60	406	3700	Mast.Sub.	$705.70	454
2762	HystSgphy	$125.50		3173	SinusSExc	$116.50	407	3366	Asp Haem.	$ 35.40	405	3702	Mast.Rad.	1120.10	460
2837	IVP Injtn	$ 58.20		3178	SinusDExc	$192.70	408	3371	AbscInc .	$ 35.40		3707	NippleEvr	$192.70	408
2951	Asst>$385	$112.00		3183	SinusDEx^	$237.50	408	3379	AbscIncGa	$152.30	406	3713	LaparOth.	$492.80	443
2953	Asst>$685	0.20	x ITEM	3194	GanglnExc	$201.60	407	3384	AbscIncG^	$210.60	406	3718	LaparOth^	$627.30	443
3004	Optn.Othr	$ 23.70		3199	GanglnEx^	$282.30	407	3391	MscleLoRo	$192.70	407	3722	Laparot.&	$672.10	453
3006	Burn LOC.	$ 39.40		3208	BursaLExc	$367.40	407	3399	MscleExRo	$354.00	408	3726	LaparAdh.	$672.10	453
3012	Burn EXT.	$ 60.50		3213	BursaLEx^	$481.60	407	3404	MscleRprL	$291.20	408	3734	LaparHmge	$430.10	453
3016	BurnLocGA	$ 78.40	408	3217	BakerCExc	$481.60	408	3407	MscleRprE	$380.80	408	3739	LaparVisc	$660.90	454
3022	BurnLocG^	$ 95.20	408	3219	Tum< 4Ro.	$125.50	407	3417	FasciaRpr	$192.70	408	3745	LaparVis^	$817.70	454
3027	BurnExtGA	$168.00	450	3220	Tum< 4Ro^	$163.50	407	3425	TumBoneRo	$459.20	408	3750	SubPhAbsc	$672.10	450
3033	BurnExtG^	$201.60	450	3221	Tum<11Ro.	$327.10	443	3450	ParotdLRo	1075.30	458	3752	BxLiverPc	$224.00	407
3038	Burn<10GA	$421.20	450	3222	Tum<11Ro^	$421.20	443	3465	SalGlndDx	$ 76.20	407	3754	TumLivrRo	$761.70	457
3039	Burn>10GA	$817.70	459	3223	Tum<21Ro.	$434.60	457	3468	SalGlStRo	$152.30	408	3764	LiverAbsc	$672.10	453
3041	DebLgeWnd	$421.20	450	3224	Tum<21Ro^	$526.40	457	3472	SalGlStR^	$192.70	408	3783	HydatidDr	$761.70	453
3046	Sut E<7S.	$ 67.20	406	3225	Tum<51Ro.	$649.70	459	3477	SalGlFRpr	$192.70	408	3789	OperChol.	$241.90	450
3050	Sut E<7D.	$116.50	407	3226	Tum>50Ro.	$896.10	461	3480	TongueExc	$380.80	408	3793	Cholecyst	$761.70	453
3058	Sut F<7S.	$106.40	408	3233	Tum>3CmRo	$183.70	407	3496	TongueTie	$ 60.50	407	3798	Cholecys^	$952.10	453
3063	Sut F<7D.	$152.30	408	3237	Tum>3CmR^	$224.00	407	3505	Ton.Tie>2	$154.60	407	3820	Choledoc.	1120.10	457
3073	Sut E>7S.	$116.50	407	3247	TumOthrRo	$255.40	409	3509	MthCystRo	$201.60	443	3822	Choledoc&	1310.50	462
3082	Sut E>7D.	$185.90	408	3253	TumOthrR^	$318.10	409	3516	MthCystR^	$264.30	443	3825	OddiTranD	1310.50	459
3087	Sut E>7D^	$237.50	408	3261	Tum DpRo.	$421.20	409	3526	BraCystRo	$515.20	443	3831	Cholduomy	1120.10	459
3092	Sut F>7S.	$152.30	408	3265	Tum DpRo^	$481.60	409	3530	BraFistRo	$649.70	443	3847	Gastrospy	$264.30	407
3098	Sut F>7D.	$192.70	409	3271	TumMalRo.	$515.20	409	3576	TumThyrRo	$672.10	450	3849	GastroInj	$327.10	408
3101	Sut F>7D^	$241.90	409	3276	TumMalRo&	1075.30	457	3581	ThglCstRo	$504.00	450	3851	Gastro&Dx	$416.70	408
3104	LacFullTh	$327.10	450	3281	TumExtRo.	$649.70	409	3591	ThglCt&Ro	$750.50	450	3875	Vagotmy T	$761.70	453
3106	SutDresGA	$ 95.20	406	3289	TumExtRo&	$761.70	450	3618	LmpGlNLRo	$481.60	443	3882	Vagotmy S	$907.30	454
3110	PstOpH-GA	$185.90	407	3295	TumMlRdRo	1075.30	457	3622	LmpGlNRRo	1276.90	464	3889	VagotmyHS	1075.30	457
3113	FbSupfRo.	$ 30.50	406	3301	TumMlLtRo	$515.20	409	3634	LmpGlALRo	$318.10	443	3891	VagotmyH&	1276.90	457
3116	FbSubcRo.	$141.10	407	3306	LipeWgTrv	$593.70	450	3638	LymGlARRo	$929.70	457	3894	GastroEnt	$672.10	454
3120	FbDeepRo.	$291.20	408	3307	LipeWdg1E	$593.70	450	3647	Mast.Sim.	$421.20	443	3898	GastroE ^	$907.30	454
3124	FbDeepRo^	$358.40	408	3308	LipeWg>1E	$896.10	454	3652	Mast.Sim^	$571.20	443	3900	GastrErpr	1153.70	458
3130	BiopSkin.	$ 67.20	406	3310	LipeUnUmb	$896.10	454	3654	BrstCtRo.	$255.40	408	3902	PancCstDn	$907.30	457

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3922	GastrecPt	1276.90	459	4249	HernUmbR^	$459.20	409	4544	AnalFiss^	$327.10	407	4993	Ampt1Toe^	$185.90	407
3930	GastrecTt	1612.90	463	4251	HernUm>9.	$385.30	409	4552	AnlFistSc	$295.70	408	4995	Ampt2Toes	$228.50	408
3937	GastreStR	1624.10	463	4254	HernUm>9^	$526.40	409	4557	AnlFistS^	$380.80	408	4997	Ampt2Toe^	$282.30	408
3938	GastreTtR	1915.40	465	4258	HernAbdR.	$571.20	450	4568	AnlFist+.	$421.20	408	4999	Ampt3Toes	$264.30	409
3976	ColosClEp	$385.30	453	4262	HernAbdR^	$672.10	450	4573	AnlFist+^	$515.20	408	5002	Ampt3Toe^	$327.10	409
3981	ColosClE^	$492.80	453	4265	HCoeleTap	$ 45.90		4590	Faec.Fist	$907.30	454	5024	AmptMTars	$185.90	408
3986	ColosClIn	$672.10	453	4269	HCoeleRo.	$304.70	408	4611	PnidSinRo	$385.30	409	5029	AmptMTar^	$237.50	408
4003	IntussDrn	$304.70		4273	HCoeleRo^	$376.40	408	4617	PnidSinR^	$492.80	409	5034	AmptFt/An	$459.20	409
4012	IntussLpr	1232.10	458	4288	Orchidect	$385.30	408	4622	InjPnidSn	$125.50	407	5038	AmptFt/Mt	$380.80	408
4018	Colectomy	1164.90	459	4293	Orchidec^	$526.40	408	4633	InjVVeins	$181.50		5050	AmptLeg .	$672.10	450
4039	BowelRes.	$929.70	459	4296	Orchid+SC	$672.10	409	4637	VV ligatn	$349.50	408	5059	EarFb Ro	$106.40	405
4043	BowelRes^	1232.10	459	4307	UndescTst	$672.10	409	4641	VV&ExcL/S	$638.50	450	5062	EarFb+IRo	$309.10	407
4046	Hemicolec	1276.90	459	4319	Circ<6mth	$ 60.50	407	4649	VV&ExcL&S	$963.30	454	5066	EarPlp Ro	$185.90	405
4048	ColectT&A	1612.90	464	4327	Circ<10yr	$138.90	407	4651	VV&disSPJ	$421.20	407	5172	Grommetts	$309.10	408
4074	Appendect	$459.20	409	4338	Circ> 9yr	$192.70	407	4655	VV&ligSPJ	$421.20	407	5182	EarExamMs	$141.10	408
4080	Appendec^	$571.20	409	4345	Circ> 9y^	$241.90	407	4658	VV&lig 1P	$259.90	407	5186	EarExamGA	$141.10	408
4084	Append&Op	$159.10	406	4351	Paraph.GA	$ 61.60	406	4662	VV&lig>1P	$649.70	408	5192	NosExamGA	$ 93.00	407
4087	PeritLap.	$515.20	450	4354	Sgmdoscpy	$ 70.60		4664	VV-Reoper	$694.50	457	5196	NosePackP	$159.10	409
4093	PeritLap^	$638.50	450	4363	Sgmdpy-GA	$107.50	406	4778	EmbolArtN	$907.30	454	5201	NoseFb Ro	$100.80	407
4109	PancomyPt	1545.70	459	4366	SgmdpyDx.	$183.70	408	4784	EmbolArtT	1164.90	459	5205	NosePpRo.	$106.40	
4131	PancAbsc.	$660.90	453	4367	SgmdpyDx^	$241.90	408	4789	EmbolVein	$817.70	454	5210	NosePpARo	$224.00	408
4133	PancDtAna	1612.90	462	4380	RectBx-GA	$210.60	407	4832	OstmyA Ph	$159.10	408	5214	NosePpAR^	$282.30	408
4141	SplenectT	$929.70	457	4383	ColonscpS	$163.50	407	4838	OstmyA St	$264.30	450	5229	NosCautGA	$129.90	407
4144	SplenectO	$952.10	457	4386	ColonscS+	$295.70	409	4844	OstmyA Hu	$459.20	450	5230	NosePack.	$116.50	408
4165	ViscMultR	1422.50	462	4388	ColonscpL	$481.60	409	4860	OstmyC Sc	$459.20	454	5245	AntLavag+	$ 42.10	407
4173	TumRetpRo	1120.10	459	4394	ColonscL+	$672.10	450	4864	OstmyC Hu	$459.20	453	5254	AntLav+GA	$118.70	407
4179	TumPresRo	1120.10	457	4397	TumRct3Ro	$515.20	443	4927	Ampt1Fgr.	$201.60	407	5264	AntLavage	$ 35.40	407
4185	AbscDRetp	$604.90	443	4399	TumRctTRo	$817.70	457	4930	Ampt1Fgr^	$250.90	407	5348	ExamPNSp.	$159.10	408
4192	LaparosDg	$282.30	408	4413	RectProlR	1064.10	457	4934	Ampt2Fgrs	$304.70	408	5363	Tonsl<12y	$282.30	408
4193	LaparosBx	$367.40	408	4455	AnalDilGA	$ 90.70	405	4940	Ampt2Fgr^	$371.90	408	5366	Tonsl<12^	$380.80	408
4194	LaparosDx	$526.40	408	4467	AnalProl.	$152.30	407	4943	Ampt3Fgrs	$358.40	409	5389	Tonsl>11y	$358.40	409
4197	Abdoparac	$ 67.20		4482	AnalStric	$362.90	408	4948	Ampt3Fgr^	$434.60	409	5392	Tonsl>11^	$481.60	409
4202	RectRes1s	1599.20	461	4490	AnalSphin	$345.00	407	4950	Ampt4Fgrs	$403.20	443	5396	TonslHgGA	$147.90	443
4209	RectRes2s	1310.50	460	4492	AnalIncon	$739.30	454	4954	Ampt4Fgr^	$492.80	443	5401	TonslHgG^	$185.90	443
4222	HerniaRpr	$459.20	409	4509	HmoidsLig	$ 70.60	406	4957	Ampt5Fgrs	$459.20	450	5407	AdenoidEx	$152.30	407
4227	HerniaRp^	$604.90	409	4523	HmoidsExc	$371.90	409	4961	Ampt5Fgr^	$571.20	450	5411	AdenoidE^	$210.60	407
4233	HernStrRr	$672.10	450	4527	HmoidsEx^	$470.40	409	4972	AmptMcarp	$295.70	408	5445	QuinsyInc	$ 90.70	408
4238	HernDiapR	1008.10	461	4534	PileExtRo	$129.90	406	4976	AmptMcar^	$380.80	408	5464	Oesophag.	$241.90	407
4246	HernUmbR.	$345.00	409	4537	AnalFiss.	$259.90	407	4990	Ampt1Toe.	$152.30	407	5470	Oesop+Dil	$470.40	408

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5480	Oesop+Bx.	$309.10	408	6033	ProstAbsc	$627.30	408	6411	CervixDx.	$ 82.90	406	7143	NveTransp	$571.20	409
5486	OesopFbRo	$459.20	408	6036	UrethSnds	$ 62.70	406	6413	CervixPlp	$ 81.80	406	7148	NveTumExc	$241.90	409
5490	OesStrDil	$ 67.20	407	6039	UrethStrc	$106.40	406	6415	Colposcpy	$ 82.90	406	7152	NveTumEx^	$304.70	409
5520	ExamLaryx	$241.90	409	6041	UrethRpr.	1232.10	450	6430	CervixRpr	$224.00	408	7178	Neurlysis	$336.00	408
5524	ExamLarBx	$354.00	409	6044	UrethFist	$371.90	409	6431	CervixRp^	$277.80	408	7182	Neurlysi^	$421.20	408
5530	LarxTumRo	$380.80	443	6066	UrethMeat	$125.50	405	6446	CervixDil	$105.30	406	7184	SubdurTap	$106.40	407
5572	Tracheost	$237.50	450	6140	UrethDx..	$250.90	405	6451	Hystercpy	$138.90	408	7212	Burr-Hole	$616.10	453
5598	Tracheos^	$309.10	450	6146	UrethProl	$250.90	408	6460	D & C GA.	$174.70	406	7397	DislMand.	$ 61.60	405
5601	TrachFbRo	$228.50	408	6189	Penis Rpr	$627.30	409	6464	D & C GA^	$237.50	406	7410	DislClav.	$ 95.20	405
5605	Bronchopy	$228.50	408	6199	Penis Inj	$ 62.70		6469	Preg-D&C.	$282.30	406	7412	DislSh<3.	$116.50	405
5611	Bronch+Bx	$304.70	409	6218	TestisBx.	$250.90	407	6508	HystotAbd	$694.50	450	7416	DislSh>2G	$ 95.20	405
5613	BroncFbRo	$470.40	443	6221	EpidCyst.	$304.70	407	6513	Hystectmy	$694.50	453	7419	DislSh>2.	$ 76.20	
5691	KidnStRo.	1232.10	454	6224	EpidCyst^	$371.90	407	6517	Hystectm^	$873.70	453	7423	DislElbow	$141.10	405
5699	KidnStRo+	1422.50	454	6228	TestisExp	$371.90	406	6532	Hystect+.	$907.30	454	7426	DislCarp.	$ 90.70	405
5705	UretStnRo	1120.10	453	6249	Vasectomy	$250.90	406	6533	Hystect+^	1153.70	454	7430	DislCarp+	$183.70	405
5715	Nephrost.	1008.10	453	6253	Vasectom^	$309.10	406	6553	EctopicPr	$548.80	443	7432	DislCar+^	$228.50	405
5744	KidneyRpr	1232.10	457	6258	EUA Alone	$105.30	406	6557	EctopicP^	$694.50	443	7435	DislFingr	$ 38.50	405
5840	CathBladd	$ 42.10	405	6262	IUD Ins	$ 69.40	406	6585	UterSusp.	$459.20	409	7436	DislThumb	$116.50	405
5841	Ureteropy	$560.00	406	6264	IUD Ro GA	$ 69.40	406	6594	UterSusp^	$604.90	409	7440	DislHip .	$295.70	406
5843	Ureterpy+	$918.50	407	6271	Hymenecty	$116.50	406	6611	Tub Lig..	$421.20	409	7443	DislHip ^	$380.80	406
5845	Cystoscpy	$190.40	406	6274	BarthCExc	$233.00	408	6612	Tub Lig.^	$515.20	409	7446	DislKnee.	$215.10	405
5851	Cystoscp+	$282.30	406	6277	BarthCEx^	$286.70	408	6631	Tuboplast	$828.90	453	7451	DislKnee^	$264.30	405
5864	Cyst&FbRo	$371.90	407	6278	BarthCMar	$150.10	407	6643	Oophoremy	$470.40	443	7457	DislPatel	$ 90.70	405
5868	Cyst&BxTm	$309.10	407	6280	BarthCMa^	$188.20	407	6644	Oophorem^	$582.50	443	7461	DislAnkle	$152.30	406
5871	Cyst&DxTm	$434.60	407	6284	BarthAbsc	$ 75.00	406	6648	Oophor>1.	$560.00	450	7464	DislToe .	$ 45.90	405
5878	Cyst&Meat	$354.00	406	6290	UrethCcau	$ 75.00	405	6649	Oophor>1^	$705.70	450	7468	DislTars.	$116.50	405
5885	Cyst&RoSt	$571.20	407	6292	UrethCexc	$150.10	407	6655	OvTumRad.	$873.70	460	7480	DislOpOpL	$154.60	482
5891	BladdRpr.	$761.70	457	6296	UrethCex^	$188.20	407	6657	OvTum2ndL	$873.70	457	7483	DislOpOpO	1.50 x ITEM	
5894	BladdRpr^	$929.70	457	6299	AmptClit.	$349.50	408	6686	ExamEyeGA	$132.20	406	7505	#TerPhal.	$ 57.10	405
5897	CystotSP.	$459.20	409	6313	VaginaDil	$ 56.00	405	6754	TarsalCEx	$107.50	407	7508	#ProPhal.	$118.70	405
5901	CystotSP^	$571.20	409	6321	VaginaTum	$277.80	409	6802	TearDctLv	$ 62.70	405	7512	#ProPhal^	$177.00	405
5903	CystotStb	$106.40	407	6332	VaginaSep	$515.20	454	6818	SclerFbRo	$ 93.00	409	7516	#MidPhal.	$ 78.40	405
5964	Asp Bladd	$ 62.70		6336	VaginaEnl	$208.30	443	6837	Pteryg.Ro	$354.00	407	7520	#M/Cs1&+.	$177.00	405
5977	Urethrpxy	$896.10	443	6347	VagA/Prpr	$448.00	450	6848	LensExtrn	1008.10	453	7524	#M/Cs1&+^	$241.90	405
6001	ProstecOp	1411.30	457	6352	VagA/Prp^	$548.80	450	6940	Asp Chest	$ 89.60		7527	#Bennets.	$201.60	405
6005	ProstecEn	1467.30	450	6358	VagA&Prpr	$548.80	450	6953	CathChest	$145.60	408	7530	#Bennets^	$282.30	405
6022	ProstOpBx	$380.80	407	6363	VagA&Prp^	$694.50	450	7085	LumbPunct	$ 98.60	406	7533	#Carpus .	$ 90.70	406
6027	ProstEnBx	$571.20	407	6396	VagSuspAb	$694.50	443	7118	NvCutRpr1	$309.10	409	7535	#Scaphoid	$177.00	406
6030	ProstNdBx	$185.90	406	6406	StrIncSlg	$873.70	454	7119	NvCutRpr2	$398.80	443	7538	#Scaphoi^	$210.60	406

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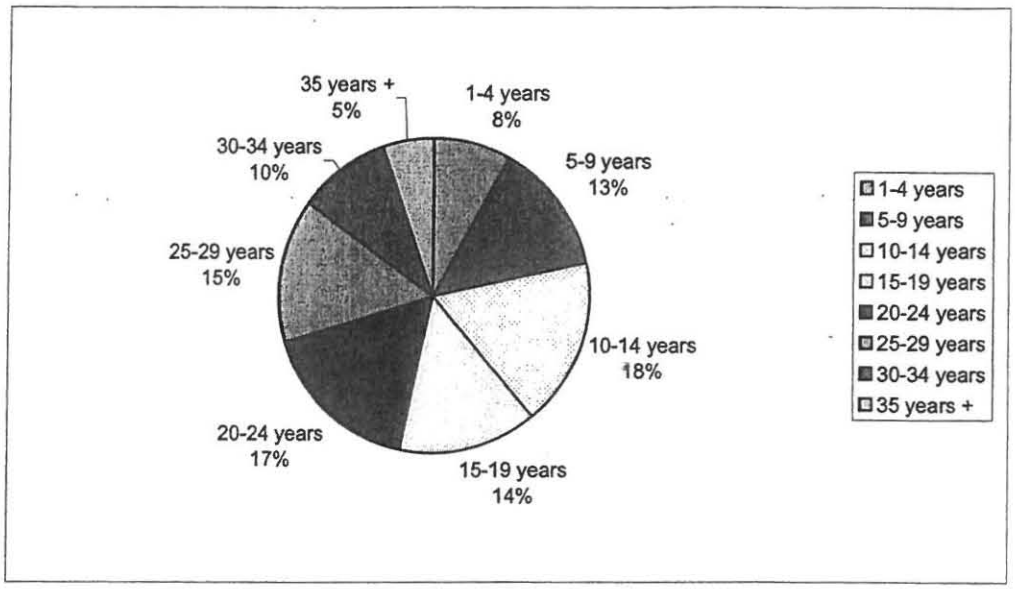
7540	#Colles .	$237.50	406	7719	#Mandible	$203.90		8017	ShoulAply	$952.10	453	8298	DupuytCRa	$593.70	443
7544	#Colles ^	$354.00	406	7764	#Zygoma .	$154.60	408	8022	ArthrecSJ	$425.60	406	8428	LigtExtrD	$ 62.70	405
7547	#R/U Dist	$177.00	406	7766	#Zygoma ^	$210.60	408	8026	ArthrotSJ	$118.70	406	8430	AmptDgtEx	$159.10	407
7550	#Radius .	$201.60	406	7774	#SPnotVB.	$ 39.40		8040	ArthrotLJ	$434.60	409	8432	DermdNRo.	$228.50	409
7552	#Radius ^	$282.30	406	7777	#SPnotVB^	$ 56.00		8053	ArthropHp	1075.30	450	8434	DermdNRo^	$295.70	409
7559	#Ulna .	$183.70	406	7781	#SPincVB.	$ 39.40		8080	KneeArspy	$291.20	407	8436	DermdOrRo	$627.30	409
7563	#Ulna ^	$224.00	406	7785	#SPincVB^	$ 56.00		8082	KneeFb/Lb	$526.40	407	8440	DermdN+Ro	$739.30	409
7567	#R&U/Hum.	$264.30	407	7802	# OpenOpL	$154.60	483	8085	KneeMenis	$627.30	409	8480	SknFlSml1	$367.40	408
7572	#R&U/Hum^	$385.30	407	7803	# OpenOpO	1.33 x ITEM		8105	Asp Joint	$ 42.10	406	8484	SknFlLge.	$526.40	450
7588	#Clav/Stm	$125.50	407	7808	# IntFixL	$154.60	484	8113	JointStab	$526.40	408	8485	DirFlCaS1	$616.10	453
7593	#Clav/St^	$177.00	407	7809	# IntFixO	1.50 x ITEM		8120	CalcSprRo	$470.40	407	8486	DirFlCaS2	$304.70	453
7597	#Scapula.	$152.30	407	7815	# Cmpd. L	$154.60	484	8131	KellersOp	$660.90	408	8487	DirFlClS1	1310.50	457
7601	#Ribs1&+.	$ 39.40	408	7817	# Cmpd. O	1.50 x ITEM		8135	KellersO+	$896.10	409	8488	DirFlClS2	$593.70	443
7605	#Ribs1&+^	$ 56.00	408	7821	# Cmpl. L	$154.60	485	8151	HammerToe	$291.20	407	8490	DirFlapS1	$336.00	408
7608	#Pelvis .	$228.50	409	7823	# Cmpl. O	1.75 x ITEM		8153	HammerTo^	$358.40	407	8492	DirFlapS2	$152.30	408
7610	#Pelvis ^	$304.70	409	7828	# InitRdn	0.50 x ITEM		8169	BunionExc	$291.20	407	8494	IndirFlap	$571.20	450
7615	#SymPubis	$177.00	408	7834	# 2nd Rdn	0.50 x ITEM		8173	BunionEx^	$358.40	407	8504	SknGftSFG	$264.30	408
7619	#SymPubi^	$228.50	408	7839	# Fin Rdn	1.00 x ITEM		8179	ExostLgBn	$354.00	407	8508	SknGftLFG	$526.40	453
7624	#Femur .	$526.40	409	7847	# Jnt Inv	1.33 x ITEM		8182	ExostLgB^	$434.60	407	8509	SknGftSFB	$385.30	409
7627	#Femur ^	$672.10	409	7853	SesamBnRo	$367.40	407	8185	OsteotMCa	$367.40	407	8511	SknGftLFB	$817.70	457
7632	#Fib/Tars	$132.20	407	7855	InjBoneCt	$264.30	409	8187	OsteotMC+	$385.30	407	8512	SknGftSF.	$367.40	409
7637	#Fib/Tar^	$190.40	407	7861	Nail Ro	$ 45.90	406	8190	OsteotRad	$385.30	408	8516	SknGftLF.	$761.70	453
7641	#Tib/Pat.	$210.60	407	7864	Paron Inc	$ 38.50	406	8193	OsteotRa+	$470.40	408	8518	SknGftFul	$616.10	443
7643	#Tib/Pat^	$282.30	407	7868	ThenarDrn	$ 93.00	407	8219	SutTdnFH.	$371.90	409	8608	Bat Ear	$672.10	409
7647	#T&F/Pott	$345.00	408	7872	WdgeResN.	$215.10	407	8222	SutTdnFH^	$470.40	409	8614	LipWdgeEx	$421.20	409
7652	#T&F/Pot^	$459.20	408	7878	WdgeResN^	$282.30	407	8225	SutTdnFH2	$526.40	443	9023	An/IV Ord	$ 85.10	
7673	#M/Ts1&+.	$121.00	406	7883	Pin Ins	$159.10	406	8227	SutTdnEH.	$192.70	409	9025	An/IV Opn	$106.40	
7677	#M/Ts1&+^	$177.00	406	7886	WirePinRo	$241.90	409	8230	SutTdnEH^	$237.50	409	9035	An/PPHetc	$150.10	
7681	#ToeEx1 1	$ 48.20	405	7898	#FemurFix	1276.90	453	8233	SutTdnEH2	$367.40	443	9037	An/Ut Inv	$170.30	
7683	#ToeEx1>1	$ 76.20	405	7911	ManipJtGA	$147.90	405	8235	SutAchTdn	$470.40	443	9039	An/Caesar	$399.90	
7687	#Toe1stDP	$118.70	405	7915	ManipJtG^	$183.70	405	8238	SutAchTd^	$593.70	443	New 'CLARIFICATION' Rates			
7691	#Toe1stPP	$118.70	405	7975	BnGftFem.	1120.10	453	8241	SutTdnFt.	$237.50	409	4.1	RDA/MBS Ratio	142.59%	
7694	#Skull .	$ 39.40		7977	BnGftTib.	$896.10	450	8243	SutTdnFt2	$354.00	409	11.2A	Mileage	35.4 c/km	
7697	#Skull ^	$ 56.00		7983	BnGftHR&U	1120.10	450	8246	TenotomSc	$147.90	405	11.2B	Mileage	29.6 c/km	
7701	#Nose .	$ 39.40		7993	BnGftRorU	$784.10	409	8249	TenotomOp	$358.40	408	18.1.1	Minimum 2951	$385.00	
7706	#Nose ^	$ 56.00		7999	BnGftScap	$739.30	443	8267	TendonSIn	$291.20	407	18.1.2	Maximum 2951	$685.00	
7709	#NoseRed.	$224.00	407	8001	BnGftOthr	$649.70	409	8275	TenolysFT	$421.20	409	18.1.4	On 100%	* 2.240194	
7712	#NoseRed^	$309.10	407	8009	ShoulCalR	$367.40	409	8279	TenolysET	$241.90	408		On 85%	* 2.635522	
7715	#NoseRed+	$627.30	409	8014	ShoulAtmy	$385.30	408	8296	DupuytCSc	$237.50	409				

'1.33 x ITEM' indicates 1.33 times Initial Item Fee. NOT ALL ITEMS are applicable to ALL Hospitals AND/OR Doctors.

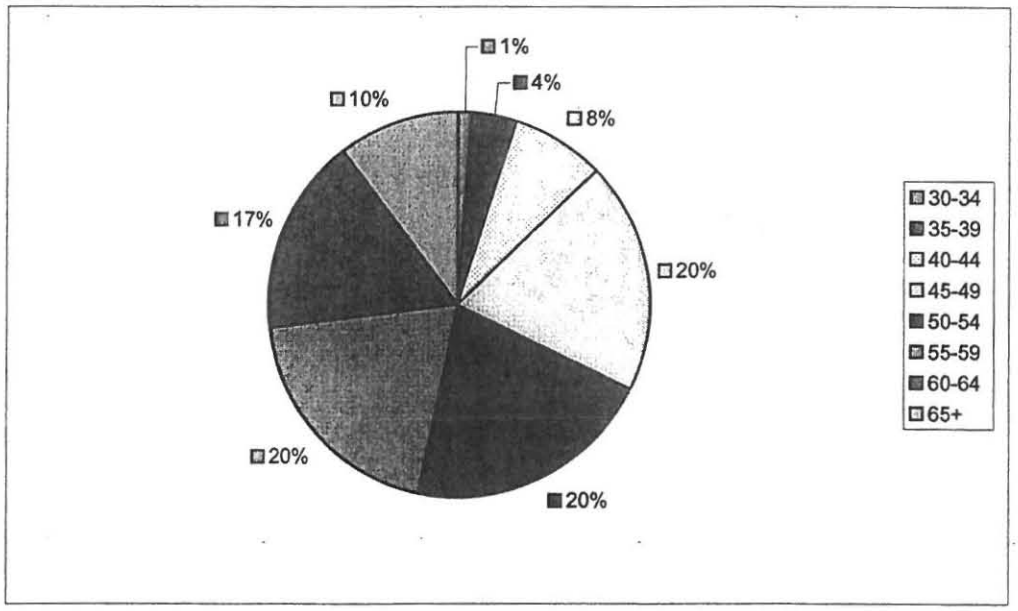
ANNEXURE E

Rural and Regional VMO Survey

Question 2. How long have you provided services in your current hospital?

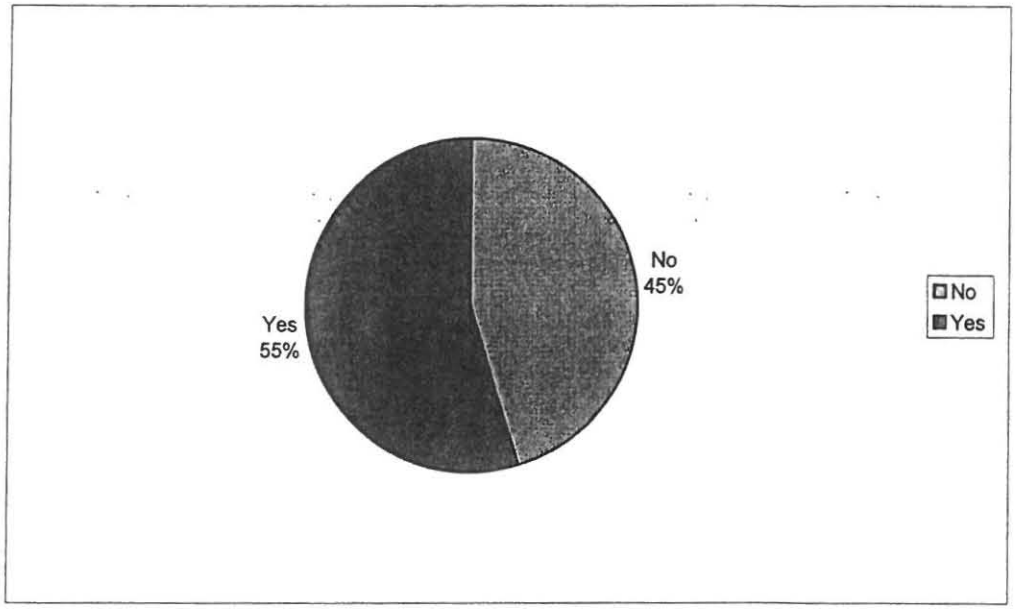


Question 3. Age

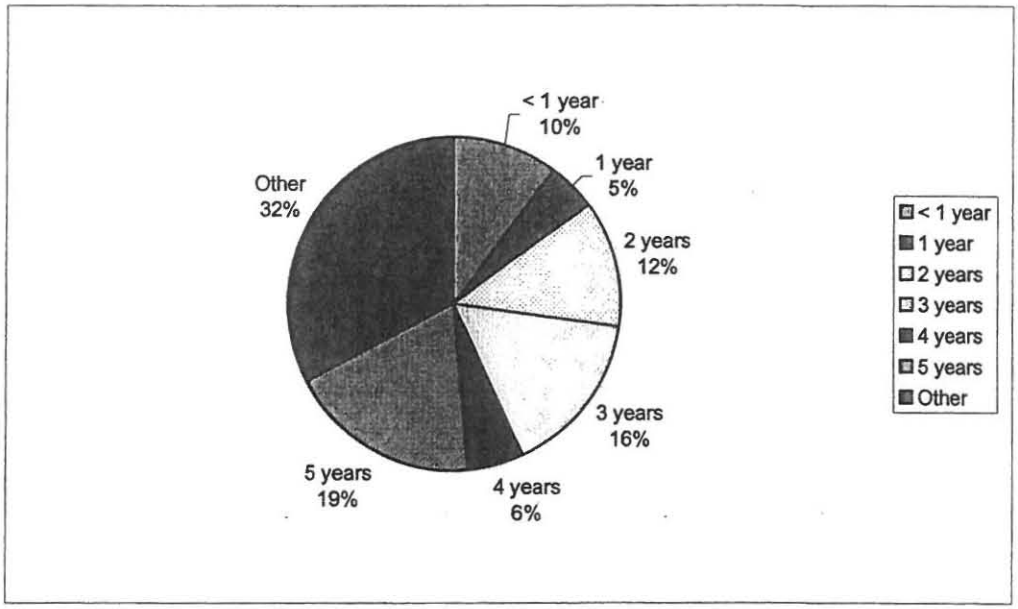


Rural and Regional VMO Survey

Question 5. Are you planning on retiring or reducing practice in the next 5 years?

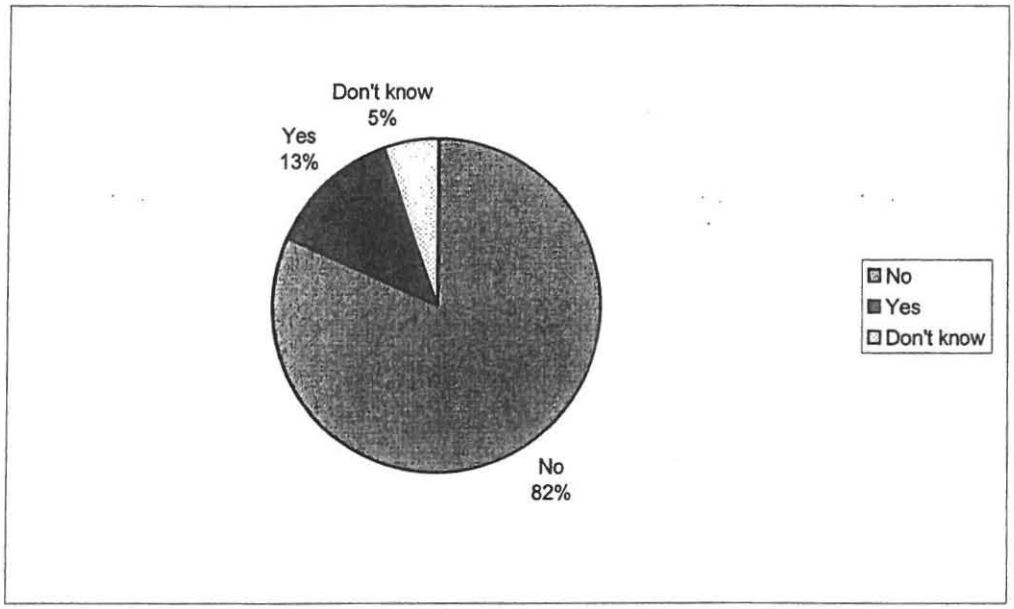


Question 5.1 If yes, when do you plan to retire?

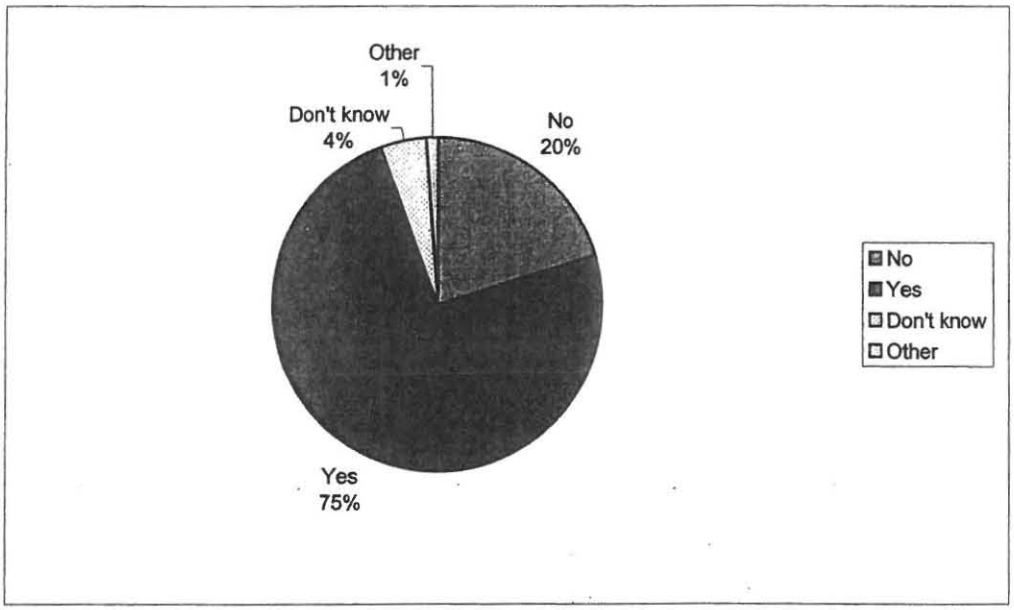


Rural and Regional VMO Survey

Question 6. Does your Hospital/Area have any arrangements for succession planning?

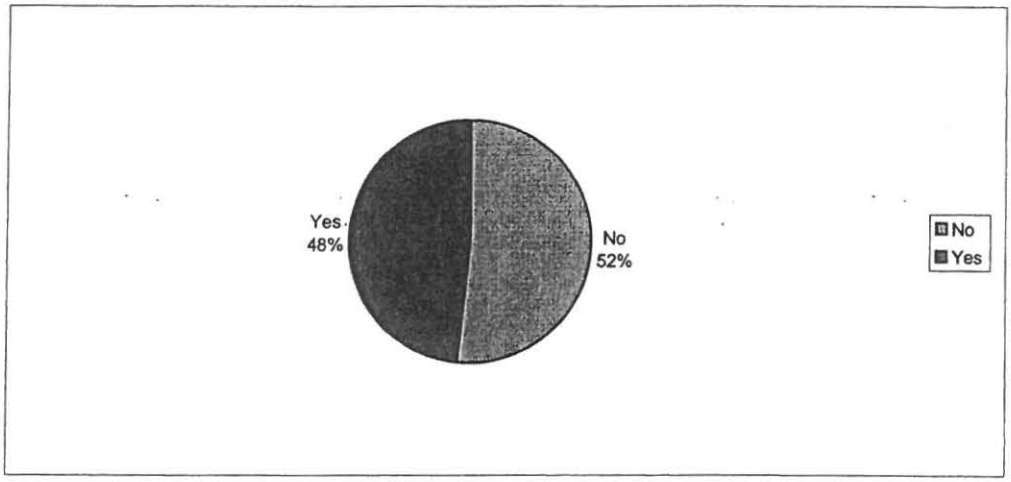


Question 8. Do you believe that more flexible local contract arrangements would attract and retain VMO to regional and rural NSW?

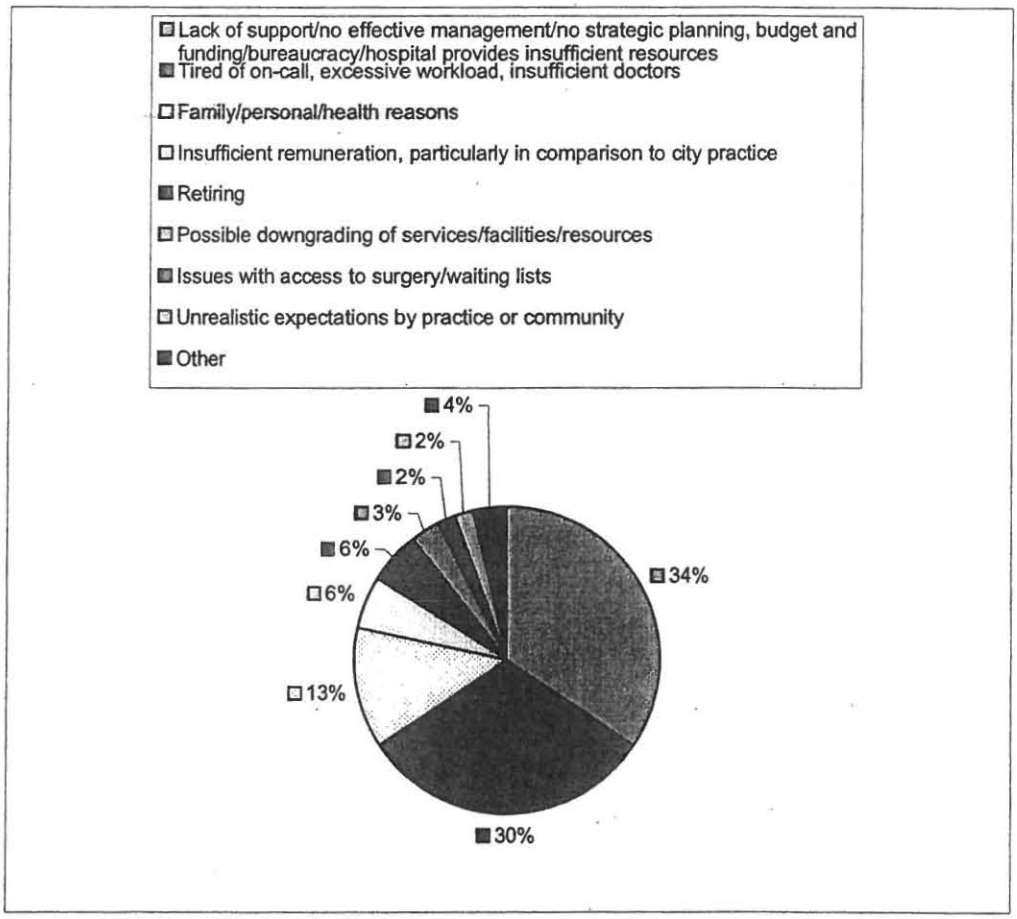


Rural and Regional VMO Survey

Question 7. Have you considered leaving rural/regional practice?

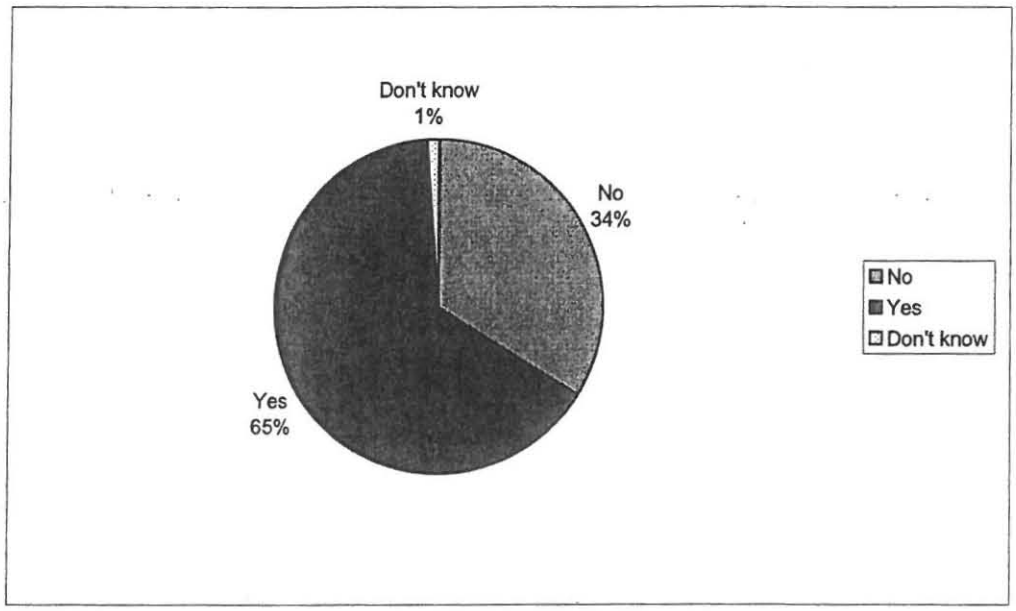


Question 7.1 If yes, please give reasons



Rural and Regional VMO Survey

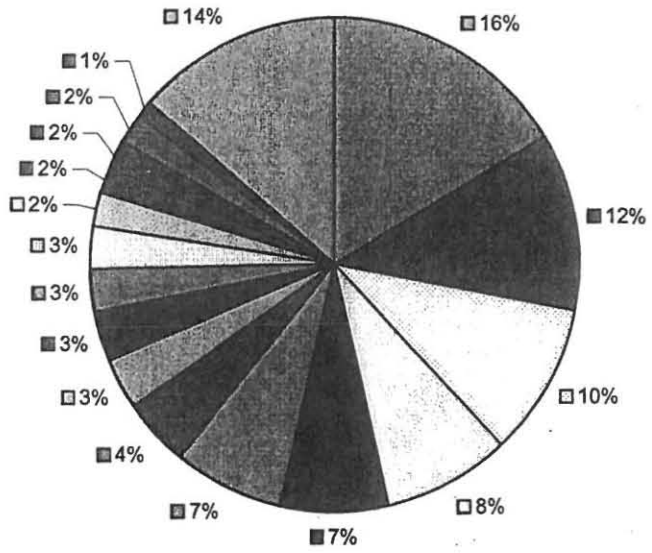
Question 10. Has your hospital lost services in the past 5 years?



Rural and Regional VMO Survey

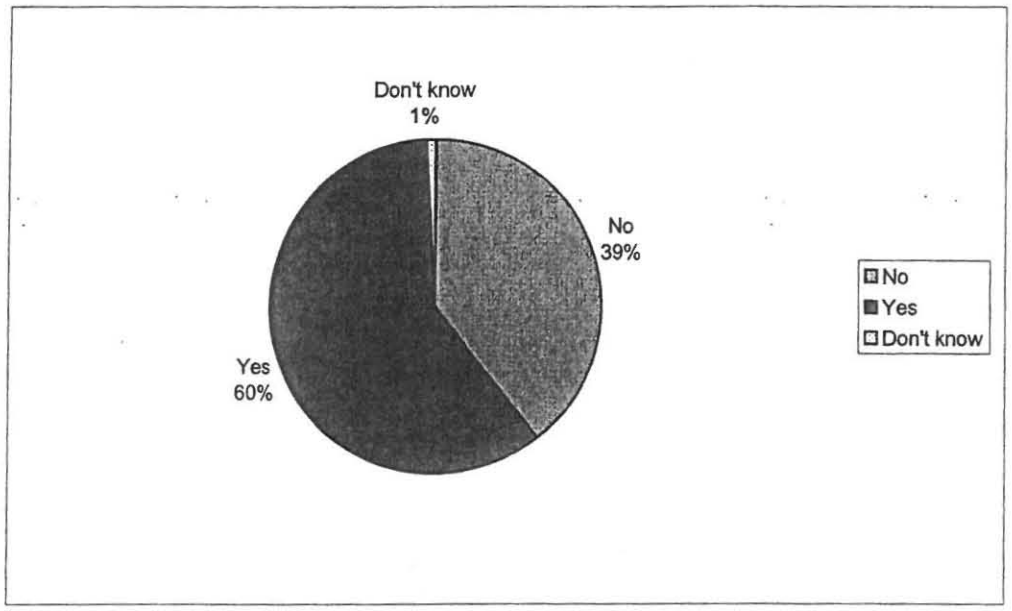
Question 10.1 If yes, please give details

- Obstetrics & Gynaecology/private O&G/obstetrican and gynaecologist/O&G Cover
- Surgical services/specialist surgeon/surgical related specialists/on site emergency cover for general surgery/aged women surgery/plastic & reconstructive surgery/elective surgical list
- Lost services due to retired, semi-retired and leaving
- Urology/urologist/shift of urologist
- Orthopaedic surgeons/lists
- Anaesthetics/anaesthetic cover/anaeshetist
- On site specialists, physicians, and residents
- Psychiatry/resident psychiatrist/no specific planning for psychiatric services
- Rehabilitation
- Vascular surgeon
- Paediatric/paediatrician
- ENT Consultant/surgeon
- Gastroenterology/gastroenterologist
- Pathology/pathologist/pathology services reduced to bare minimum
- Radiology/resident radiologist/X-rays/radiograph
- Bed closures/reduced beds
- Other



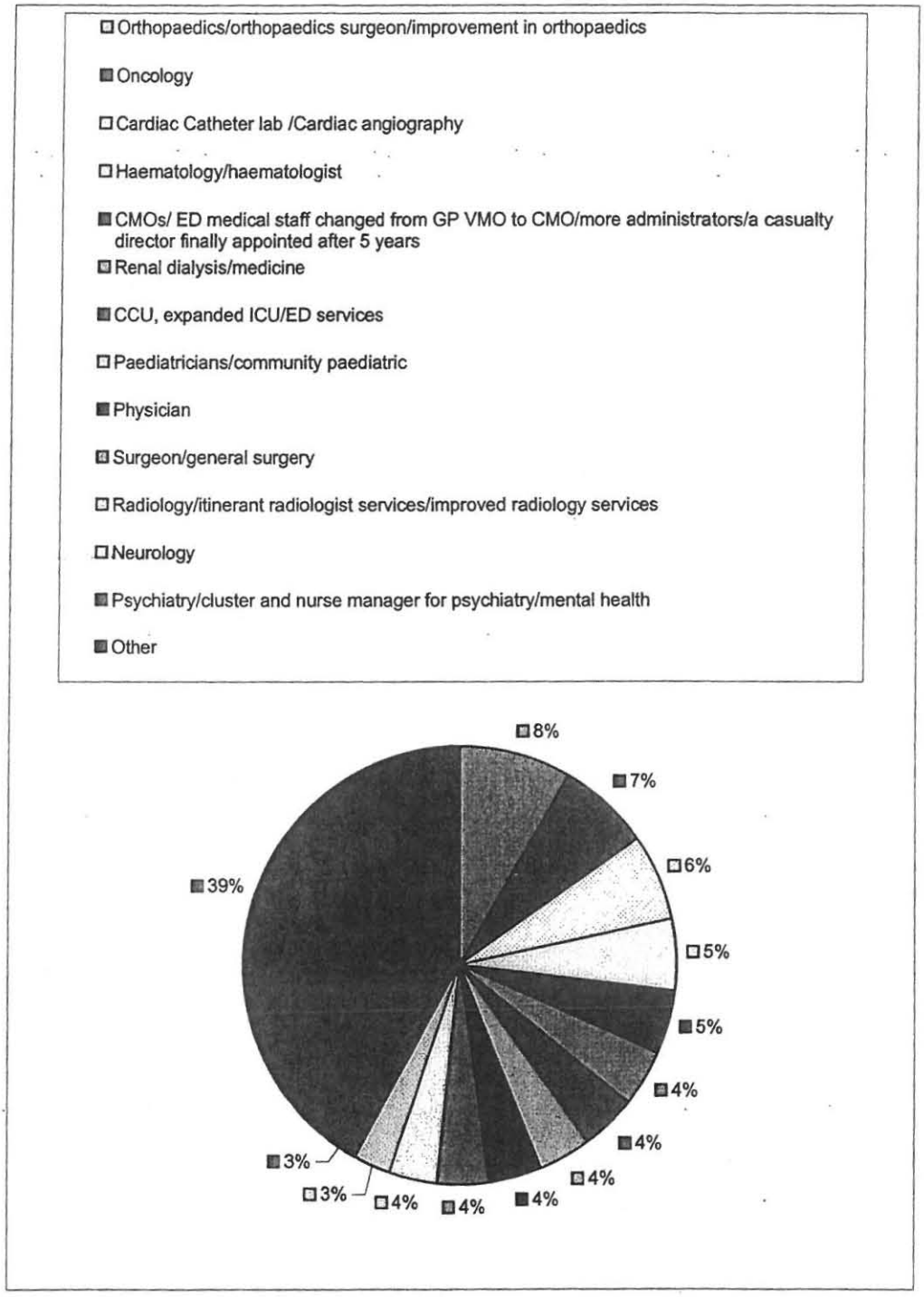
Rural and Regional VMO Survey

Question 11. Have new services been added to your hospital in the past 5 years?



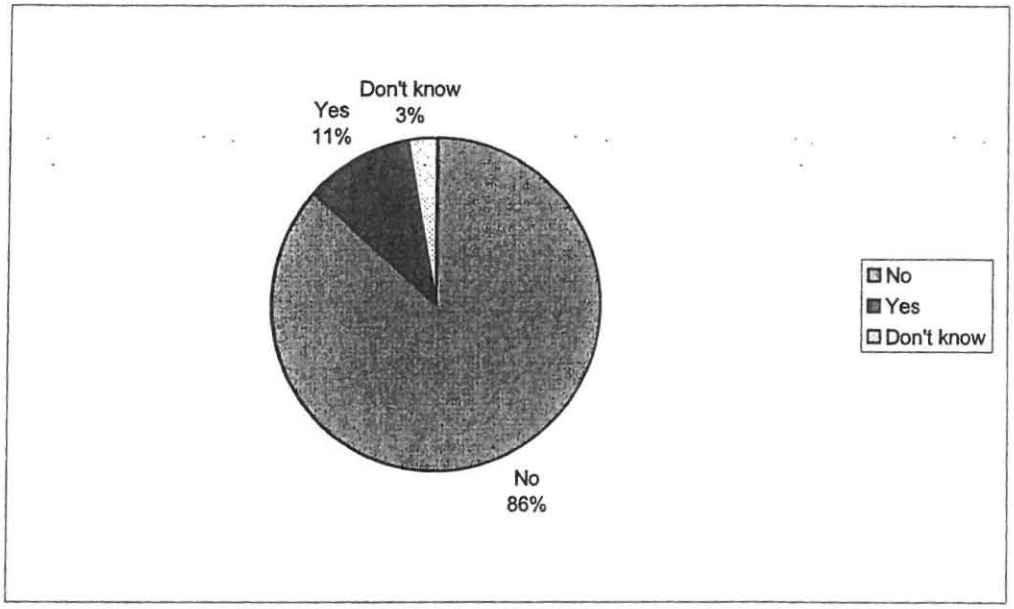
Rural and Regional VMO Survey

Question 11.1 If yes, what new services have been added to your hospita in the past 5 years?

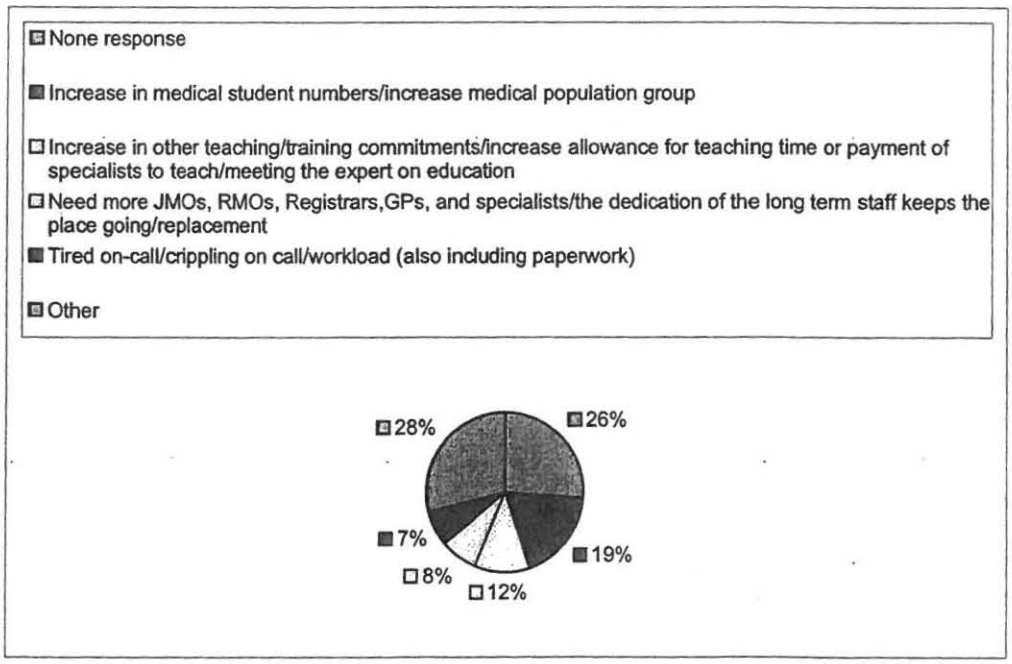


Rural and Regional VMO Survey

Question 13. Area Amalgamation promised an increase in frontline services as a result of administrative and staffing economies. Have you seen any direct improvements in frontline services since area amalgament?



Question 14. Are there any other issues which have impacted on your practice over the past 5 years? (E.g increase in medical student number, increase/decrease in other teaching/training commitments)



ANNEXURE F

WORKPLACE
RESEARCH CENTRE

Working Conditions of Doctors and Nurses in NSW Public Hospitals

Submitted to Australian Medical Association (NSW)
Australian Salaried Medical Officers' Federation (NSW)
NSW Nurses' Association
20th March 2008

Informing • Advising • Educating

The University of Sydney
Faculty of Economics and Business

Acknowlegements

This study is the result of the cumulative efforts of many people.

From the Workplace Research Centre, John Buchanan, Damian Oliver and Sarah Wise were responsible for the development of the survey. Damian Oliver, in particular was responsible for liaising with the organisations involved to develop sampling frames and testing and revising the survey instrument. Damian was also responsible for collating the three data sets and setting up and providing the initial detailed analysis. Finally, Gillian Considine and Michelle Jakubauskas were responsible for conducting subsequent analysis, and writing and preparing this report.

In the participating organisations, Ryan Bondar from the AMA, Anna Claude from the NSW Nurses' Association, and Sim Mead from the ASMOF were chiefly responsible for overseeing the administration of the surveys and co-ordinating the team effort required to have a random sample of members of their organisations notified and encouraged to complete the survey.

Finally, the participation and co-operation over 1,500 very busy public hospital nurses and doctors has been invaluable.

Table of Contents

1. Background

A wide-ranging Commission of Inquiry (the *Garling Inquiry*) is being undertaken into the NSW public health system. The New South Wales Australian Medical Association (AMA) and the Australian Salaried Medical Officers' Federation (NSW) (ASMOF) and the NSW Nurses' Association, commissioned the Workplace Research Centre, University of Sydney to examine the views and experiences of doctors and nurses in the NSW public hospital system. In particular the study collected sample survey information on the adequacy, or as it revealed, the inadequacies, of current working conditions and arrangements within the public health system. This report summarises the findings from this survey.

The report is structured into four subsequent sections. The next section, Section 2, outlines the methodology used to conduct the study. Section 3 profiles the characteristics of the sample with regard to profession, facility, area health service and department or specialist area. Section 4 examines hours of work among the members surveyed. Section 5 reports on perceived working conditions of public hospital nurses and doctors.

2. Approach

This section outlines the methodology used to generate the original data underpinning this report.

Sampling Frame

The population studied in this project was

1. Doctors (including registrars) working for NSW public hospitals, across specialist areas and role categories who are members of AMA and/or ASMOF; and
2. Nurses working for NSW public hospitals who are members of the NSW Nurses' Association.

The majority of doctors and nurses belong to one of the associations listed above. The views presented in this report can, therefore, be regarded as being representative of these professions more generally. Random samples of members working in the public hospital sector were drawn from the AMA and the NSW Nurses' Association databases, whilst a full enumeration of members from ASMOF was included in the overall sampling frame. In total, a response rate of 31 per cent was achieved. Table 1 provides a breakdown of the sampling frame and the response rates by each sub-sample.

Table 1. Sample and Response Rates

	NSWNA	ASMOF	AMA	Total Doctors	Total Study
Total Sample Size*	668	1542	650	2192	2860
Usable responses	588	800	176	976	1564
Response rate	88%	52%	28%	45%	55%

*Total sample size for NSWNA includes total persons contacted by phone who refused. All other groups were contacted by email, and sample size includes all who did not complete the survey after receiving an email request.

Developing the Questionnaire

The primary question of interest in this study was *'What are working conditions like for doctors and nurses in NSW public hospitals'*. To help answer this question data were collected on the following subjects:

1. Role – job category, metro/regional/rural;
2. Working Hours – time spent, and unpaid hours worked, in public hospitals;
3. Resources – perceptions of staffing levels, equipment, beds, and working environment;
4. Morale –involvement in decisions, intentions to remain, and feeling valued; and
5. Problems and proposed solutions.

Three questions from the national Australia@Work survey were also included. These allowed us to benchmark NSW doctors' and nurses' attitudes and frustrations, as well as experiences of consultation and work intensification with those prevailing amongst the Australia-wide workforce.

A pilot study of the draft survey was conducted over the phone with 26 nurses and 26 doctors before the survey was finalised. During the pilot study respondents were asked about problems in the public hospital system. These responses were especially helpful for developing coding frames used in many of the questions. In addition, they helped refine a series of open-ended survey questions seeking ideas for possible solutions to these problems. Due to time constraints this report does not include an analysis of these open-ended questions, rather the responses were provided verbatim to the organisations involved for their consideration in the subsequent submission.

Survey administration

The survey was administered to AMA and ASMOF members between Monday 3rd March and 11th March 2008. Potential participants were emailed a web-link to an on-line survey and followed-up via email 2 days after the commencement of the survey to remind them of the importance of completing the survey. The NSW Nurses' Association members were surveyed by phone between Monday 3rd March and Tuesday 11th March. These phone survey interviews were conducted by the ACTU's "membership connect".

3. Profile of Respondents

This section provides an analysis of the key personal characteristics and workplace details of the doctors and nurses who responded to the survey. For the purpose of this analysis a group referred to in this report as 'Junior Doctors' was formed combining responses from interns, resident medical officers, senior resident medical officers and registrars into a single sub-group. Responses from staff specialists were combined with those of career medical officers (CMOs) because of the relatively small number of CMOs (n = 42, or 3%) and the similar responses provided by each of these groups. Just over 3 per cent of all doctors are employed in managerial or academic roles and almost 3 per cent of nurses are employed as either managers or Assistants in Nursing (AiNs). These groups were separated out from the main sub-groups and classified as either 'Other doctors' or 'Other nurses'. A total of 21 people did not provide a sufficient description of their role to be able to be classified so were therefore removed from any analysis that was dependent of a role description (see Table 2).

Staff Specialists were the largest single response group in the sample (48.4%) and combined with career medical officers (CMOs) formed 51 per cent of all respondents. Overall, 62.5 per cent of respondents were doctors and the remaining 37.5 per cent were enrolled or registered nurses, or midwives.

Table 2. Current role performed

Current Role	Count	Percent
Junior Doctors	57	3.7
Staff Specialists/CMOs	793	51.1
VMOs	69	4.4
Enrolled Nurses	115	7.4
Registered nurses/midwifes - Yrs 1-7	100	6.4
Registered nurses/midwifes - Yr 8	210	13.5
Senior Nurse roles	114	7.3
Other doctors	52	3.3
Other nurses	43	2.8
Total	1553	100.0
Missing	21	
Total	1574	

Population: All respondents

Just over half of all respondents (52%) worked in a major teaching hospital and a further fifth (21%) worked in either a regional or rural hospital (see Table 3).

Table 3. Type of Facility

Facility type	Count	Percent
Major teaching hospital	823	52.4
Metropolitan/ urban hospital	261	16.6
Regional hospital	194	12.4
Rural hospital	140	8.9
Community services	82	5.2
Ambulance Service	3	.2
Justice Health	21	1.3
Other	46	2.9
Total	1570	100.0

Population: All respondents

Table 4 provides the numbers and proportions of all respondents by the main department in which they work. Doctors and nurses working in medical units are the largest sub-group with regard to department of specialist area worked (33%; see Table 4).

Table 4. Main department of work

Department	Count	Percent
Medical	520	33.4
Surgical	128	8.2
Emergency department	159	10.2
Intensive care	57	3.7
Operating theatres/perioperative	105	6.7
Maternity	99	6.4
Paediatrics	82	5.3
Mental health	141	9.1
Community health	53	3.4
Diagnostics (Radiology, pathology, nuclear medicine, etc)	124	8.0
Other	64	4.1
Administration/Management	24	1.5
Total	1556	100.0

Population: All respondents

Table 5 shows that approximately one fifth of all respondents work in either the South Eastern Sydney/Illawarra or Sydney South West Area Health Services (22 per cent, respectively). Just over 1 in 10 work in either in the Northern Sydney/Central Coast, Sydney West, or Hunter/New England Area Health Services.

Table 5. Area Health Service

Area Health Service	Count	Percent
Northern Sydney/ Central Coast	208	13.6
South Eastern Sydney/ Illawarra	333	21.8
Sydney South West	343	22.4
Sydney West	195	12.7
Childrens Hospital at Westmead	54	3.5
North Coast	67	4.4
Hunter/ New England	182	11.9
Greater Western	81	5.3
Greater Southern	68	4.4
Total	1531	100.0

Population: All respondents

4. Hours of work

There has been significant public and media debate about the extended hours doctors work for some years now. A report released by the AMA in 1998 on extreme working hours of junior doctors defined 'long hours' as over 50 hours a week. This takes into consideration European Union, UK, and Australian federal and state industrial award definitions of hours. The impact of long working hours for doctors is serious. A 1998 study by Nocera and Khursandi has shown that long working hours can lead to fatigue which can impair decisions, judgment and competence. In turn, this may then impact on patient treatment and quality of care. While this report does not intend to elaborate on the extensive research that has been undertaken on the implications of long work hours, it should be noted that there are many studies that have this as its central tenant.

In this survey, doctors and nurses were asked how many hours they usually work a week in their main job, including paid and unpaid hours. On average full-time doctors work 53 hours per week, and part-time doctors work, on average, 33 hours per week[1]. Full-time nurses work, on average, 43 hours a week, while part-time nurses work, on average, 29 hours a week. However describing the average hours worked hides a large part of the working hours story, and does not indicate the extreme hours worked by both doctors and nurses working full- and part-time.

Table 6, below, shows a categorised breakdown of the usual hours worked of both nurses and doctors. While the majority (60%) of full-time nurses work between 40 and 50 hours a week, a further 8 per cent work more than 50 hours a week. However, this is a small proportion compared to doctors, of which one quarter (26%) work between 40 and 50 hours a week, and nearly three quarters (72%) work more than 50 hours a week. To disaggregate this further, (though not demonstrated in the table below) 39 per cent of full-time doctors work between 50 and 59 hours, 24 per cent work between 60 and 69 hours and 9 per cent work more than 70 hours.

[1] This is based on 'usual' hours worked per week.

Part-time work does not appear to be a remedy for long working hours for either doctors or nurses. The widely accepted definition of part-time employment is working less than 35 hours a week, however 11 per cent of nurses contracted to work part-time are working more than 40 hours a week. Yet, once again, doctors are under even more working time pressure than nurses. Nearly one third (31%) of doctors contracted to work part-time are working more than 40 hours a week, and of these 11 per cent are working more than 50 hours per week.

Table 6. Hours worked, nurse and doctors by employment status, per cent

	Nurses		Doctors	
Hours Worked	Part-time	Full-time	Part-time	Full-time
Less than 30	50.4	0	35.8	1.5
30 to 40	38.6	32.2	33.7	0.7
40 to 50	10.1	59.8	19.3	25.9
More than 50	0.9	8.0	11.2	71.9

Population: All respondents

When establishing the significance of long hours worked in the public hospital system, it is important to situate extreme hours in the context of the departments in which they are worked. Table 7, below, displays usual hours worked by doctors and the department in which they work. The table includes two categories for long hours, 50-59 hours, and 60 or more hours. The purpose of this breakdown is to look at both 'long hours' (50-59) and what will, from here on, be classified as 'extreme hours' (60+).

While the majority of doctors are working long hours, regardless of their department, particular departments are more likely to be working extreme hours. More than 40 per cent of doctors in medical, surgical/operating, and maternity/paediatrics departments are working extreme hours. Nearly one in five doctors working in emergency department/intensive care and mental health/diagnostics work extreme hours. Of particular concern is that 90 per cent of doctors in maternity/paediatrics are working over 50 hours a week.

Table 7. Hours of work by department*, per cent

	Hours of work: Doctors				
	Full time				Part time
Department	<40	40 - 49	50 - 59	60+	40+
Medical	1.9	16.8	34.1	47.1	14.9
Surgical/Operating	0	23.1	34.6	42.3	9.7
Emergency department/Intensive care	2.8	36.1	41.7	19.4	17.6
Maternity/Paediatrics	1.5	9.0	49.3	40.3	31.4
Mental health/Diagnostics**	2.3	40.5	39.7	17.6	29.4

Population: All full-time doctors regardless of hours worked, and all part-time doctors working over 40 hours
*Administrative and management have been removed as the sample size was too small to disaggregate
**Diagnostics includes radiology, pathology, nuclear medicine etc

When discussing long working hours, it is important to dedicate a section to junior doctors. It is widely accepted in the medical profession that junior doctors will work long

and extreme hours. Some more senior doctors see this as a 'toughening up' process (Holmes, 1998). However, this explanation ignores or excuses the long-established systemic and structural factors that contribute to a continued acceptance of unhealthy and dangerous hours of work within the public hospital system. These include understaffing and reliance on teaching positions for care service delivery. Nevertheless, this survey confirms that junior doctors are working longer hours than other groups of doctors.

The average total hours full-time doctors work each week equates to around 53 hours, which holds true for staff specialists, CMOs, and other doctors. Yet full-time junior doctors are working an average of nearly 57 hours a week. Further, 16 per cent of junior doctors usually worked more than 70 hours a week, a higher proportion than any other sub-group of doctors, and in line with previous research (AMA, 1998). However, the fact that this figure confirms research conducted 10 years ago is particularly worrying, as it indicates that despite the calls and campaigns for safer working hours of junior doctors (Holmes, 1998) in the past ten years, little has been achieved in NSW public hospitals.

A further concern with the long hours worked by junior doctors is that both this study, and earlier (AMA, 1998) research, has shown that these extra hours consist of direct patient care. As discussed earlier, research has established the relationship between long working hours, fatigue, and poor patient care. Therefore it is important to not only reconsider the working hours expected of junior doctors, but actually implement change. It appears that long working hours are firmly entrenched in the current system and it would take more than mere agreement that there is a problem to change. Not only must policy be directed towards change, the attitudes of those currently practising long working hours, and the attitudes of those encouraging, or not actively discouraging, long hours must be altered. Most importantly staffing levels and proper workplace training arrangements need to be established to make desired policy in this area a reality.

Unpaid Work

Two thirds (64%) of nurses undertake unpaid work. Of these, two thirds work on average 3.4 extra unpaid hours a week. While it was outside the scope of this study to collect data on the amount of unpaid hours of work done by doctors it is evident from the long hours that are worked, that they are doing extra hours outside of contractual or salaried arrangements.

Whilst we didn't collect actual unpaid hours, doctors were asked about activities undertaken that are outside of contracted working hours. Table 8, outlines the activities that make up the majority of unpaid work for different groups of doctors. As discussed earlier, junior doctors spend the majority (61%) of their unpaid work undertaking direct clinical work. For all other groups of doctors the activity which takes up the majority of their time (approximately 40% for all) is clinical-related administration.

Table 8. Position by Unpaid work activities, per cent

	Direct clinical work*	Clinical-related administration	Teaching and related activities	Research and related activities	Activities related to your profession	Does not work extra hours	Total
Junior Doctors	61.4	15.8	5.3	1.8	10.5	5.3	100
Staff Specialists/CMOs	31.8	41.6	7.3	8.6	5.0	5.7	100
VMOs	13.0	40.6	11.6	2.9	11.6	20.3	100
Other doctors	27.5	41.2	3.9	13.7	7.8	5.9	100

Population: All doctors
*Not including teaching or administration

An exhausted public hospital system

With such high average working hours, it is not surprising that levels of reported exhaustion are extremely high in the survey population. Indeed only 6 per cent of public hospital doctors and nurses reported that they are 'rarely' or 'never' exhausted at work whilst over half (52%) are 'always' or 'usually' exhausted. Perhaps even more alarming is that junior doctors are never *NOT* exhausted (Table 9).

Table 9. Feelings of exhaustion by job role, per cent

	How often do you feel exhausted at work?					Total
	Always	Usually	Sometimes	Rarely	Never	
Junior Doctors	12.3	56.1	31.6			100.0
Staff Specialists/CMOs	9.4	36.8	48.8	4.9	.1	100.0
VMOs	8.7	24.6	47.8	15.9	2.9	100.0
Enrolled Nurses	36.0	32.4	23.4	6.3	1.8	100.0
Registered nurses/midwifes - Yrs 1-7	29.6	34.7	28.6	6.1	1.0	100.0
Registered nurses/midwifes - Yr 8	21.0	39.0	37.0	3.0		100.0
Senior Nurse roles	23.2	35.7	36.6	3.6	.9	100.0
Other doctors	13.5	32.7	46.2	5.8	1.9	100.0
Other nurses	25.6	20.9	41.9	9.3	2.3	100.0
Total	15.8	36.1	42.3	5.2	.6	100.0

Population: All respondents

5. Work Environment

This section explores the NSW public hospital doctors and nurses views about their experiences at work. The data reveals serious impending issues of possibly the worst combination; staff intentions to quit the public hospital system are high, there are multiple and substantial resource shortages across the system, and the workforce is exhausted.

Staff retention crisis

Almost two-thirds (62.4%) of all public hospital medical staff and nurses have seriously considered leaving the public system in the last 12 months (see Table 10). Whilst there is some variation by different staffing groups concerning the extent to which leaving has

been considered, the severity of this problem cannot be understated. Even amongst those least likely to state that they had seriously considered leaving – junior doctors – half have contemplated leaving the public system in the last 12 months. This is of particular concern given that these doctors are reliant on the public health system and any consideration of leaving is tantamount to reconsidering their careers. Most troubling of all is the category with the weakest association to their workplace and the best reported working conditions – VMOs - are the group that has considered leaving more often than any other sub-group.

Table 10: Has seriously considered leaving the NSW public health system in the last 12 months, per cent

	Have you seriously considered leaving the NSW public health system in the last 12 months?	
	Yes	No
Junior Doctors	50.9	49.1
Staff Specialists/CMOs	64.6	35.4
VMOs	69.6	30.4
Enrolled Nurses	56.8	43.2
Registered nurses/midwifes - Yrs 1-7	64.3	35.7
Registered nurses/midwifes - Yr 8	59.7	40.3
Senior Nurse roles	63.4	36.6
Other doctors	53.8	46.2
Other nurses	55.8	44.2
Total	62.4	37.6

Population: All respondents

Retaining staff

In order to combat the desire for medical staff to leave the public hospital system, a detailed understanding of the factors that may cause them to reconsider leaving is required. Doctors and nurses were both given a list from which they could choose up to three factors that would encourage them to remain in the public hospital system. The number one motivation for nurses is improved pay (61%), followed by greater recognition or respect for their work by management, Table 11.

Table 11. Nurses: Factors that would encourage you to remain in the public hospital System, per cent

	Percent
Improved Pay	60.9
Greater recognition/respect for the work I do from management	52.1
Reduced workload	41.7
Improved penalty rates/compensation for unsocial hours	34.3
More access/time for professional development	26.3
Improved work/life balance	26.3
More clinical support from senior/specialist nurses	18.3
More clinical support from other health professionals	16.0

Population: All nurses

Unlike nurses, who share similar motivations regardless of job roles, doctors views are dependent on their position. While staff specialists/CMOs, VMOs and other doctors share similar motivations to remain in the public hospital system, junior doctors have quite different views. This is indicative of the different work experiences of junior doctors, who, as we saw in the section on hours, work excessive hours and spend most of their unpaid work time on patient care. Other doctors are more likely to spend their unpaid work time on clinical-related administration.

Unsurprisingly, junior doctors are more likely than other doctors to rate a better work/life balance (62%), improved pay (52%), improved professional development (31%), and more clinical support from other health professionals (28%), as motivations to remain in the public hospital system, Table 12. Staff specialists/CMOs, VMOs and other doctors are most likely to rate receiving greater recognition by management (45%, 47% and 50%, respectively) and improved administrative support (44%, 43% and 46%, respectively) as encouragements to remain.

Table 12. Doctors: Factors that would encourage you to remain in the public hospital system by job role, percent

	Junior Doctors	Staff Specialists/ CMOs	VMOs	Other doctors
Improved pay	51.7	33.9	40.4	42.9
Time for research	6.9	16.7	2.1	21.4
Improved secretarial/administrative support	24.1	43.4	42.6	46.4
Improved accommodation (incl car parking)	6.9	11.8	10.6	10.7
Reduced bed occupancy rate	10.3	19.3	29.8	10.7
Time to supervise/teach other clinical staff	3.4	21.1	23.4	10.7
More clinical support from other health professionals	27.6	12.0	14.9	17.9
Improved professional development	31.0	19.1	17.0	14.3
Improved work life balance	62.1	29.3	27.7	25.0
Reduced workload	44.8	30.9	23.4	35.7
Greater recognition/respect for the work I do from management	17.2	45.4	46.8	50.0

Population: All doctors

Feeling Valued

The extent to which medical staff and nurses are considering leaving the public hospital system may be due to a number of factors. It is not possible to determine causal relationships through an attitudinal survey. Nevertheless, the perceptions respondents have about the extent to which they are valued, or not, by the people who they work for, and with, may go a long way to explaining their obvious dissatisfaction with the public hospital system. Table 13 presents the average responses from various respondent groups to questions asking them to rate from 1 (not at all) through to 10 (highly) the extent to which they feel valued by the different people, groups and departments with whom they come in contact through work. Public hospital staff clearly feel much more valued by patients, co-workers and other health professionals than they do by hospital or service management, area management or the Department of Health.

Table 13: Mean perception of respondents in different roles of feeling valued by different current people/groups with whom they interact*

Role	Patients	Co-workers	Other health prof	Hospital / service mgment	Area mgment	Dept Health
Junior Doctors	7.46	7.09	6.32	4.23	3.21	3.11
Staff Specialists/CMOs	7.90	7.97	6.95	4.64	3.59	2.96
VMOs	7.77	7.78	6.93	4.40	3.26	2.61
Enrolled Nurses	7.65	7.72	6.45	5.28	4.05	4.05
Registered nurses/midwifes - Yrs 1-7	7.93	7.48	6.58	5.23	4.18	3.91
Registered nurses/midwifes - Yr 8	7.75	7.63	6.54	5.17	4.06	3.67
Senior Nurse roles	8.10	7.90	6.81	5.70	4.23	3.64
Other doctors	7.93	8.02	7.48	4.94	4.04	3.61
Other nurses	7.29	7.81	7.02	6.90	5.68	5.03
Total	7.84	7.83	6.83	4.91	3.79	3.27

Population: All respondents
*10 = Feel very valued, 1 = Does not feel valued at all

Consultation and Work Intensification

A number of key workplace issues relating to level of consultation, trust and work intensification were able to be tested against a national benchmark survey of over 8,000 workers[2]. These measures provide an indication of the experiences at work of public hospital staff relative to the experiences of an 'average' Australian employee. Compared to the perceptions of non-managerial Australian workers, public hospital employees perceive that:

- managers within their hospital or service (workplace) are far less trustworthy;
- far less consultation is taking place on matters affecting staff; and,
- much more is expected of them for the same amount of pay.

Table 14 provides a breakdown of these measures for an average employee and for doctors and nurses within the public hospital system.

[2] The Australia@Work survey is a national longitudinal survey. The first wave of data was collected between March and July 2006.

Table 14: Occupation by various attitudinal questions, per cent

	Australian employees	Doctors	Nurses
Managers at my workplace consult employees about issues affecting staff			
Strongly agree	19.6	2.6	6.5
Agree	51.4	24.3	36.1
Neither agree nor disagree	6.5	11.2	7.2
Disagree	15.6	34.2	30.8
Strongly disagree	5.5	27.7	19.4
Managers at my workplace can be trusted to tell things the way they are			
Strongly agree	18.0	2.1	3.9
Agree	52.7	15.0	29.4
Neither agree nor disagree	7.9	14.3	10.3
Disagree	14.8	32.6	36.0
Strongly disagree	5.6	36.0	20.6
More and more is expected of me for the same amount of pay			
Strongly agree	15.8	53.5	65.6
Agree	35.9	27.4	29.1
Neither agree nor disagree	9.8	11.1	1.8
Disagree	33.2	4.9	2.7
Strongly disagree	4.9	3.2	0.9

Population: All respondents and all non-managerial employees from the Australia@Work survey

Inadequacy of Resources

Respondents were asked to comment on the adequacy of the resources available in their work area to provide quality health care. This section reports on doctors and nurses views about the adequacy of these in general. The problem of resources, is, however, not spread evenly throughout the system. We also report on the severity of the problem in regards to locations and particular functional areas in the system.

All Public Hospitals

Table 15 summarises the key issues rated by respondents as matters of particular concern regarding the level and quality of resources. With the exception of the ratio of 'permanent medical staff to locums' (of which a third think this is 'poor' or 'inadequate') between 5 and 8 out of 10 doctors feel that public hospitals are inadequately resourced in key functional areas. The vast majority of doctors (80%) report that the 'number of beds or services to meet patient demand' is either 'poor' or 'inadequate' whilst three quarters of all doctors (75%) feel that the 'provision of clinical support staff (eg. ward clerks, IT, admin, stores)' is substandard and more than two thirds (69%) agree there is 'not enough medical staff available to provide quality teaching and supervision of junior clinical staff and clinical students'.

Nurses are less scathing of the adequacy of resources in public hospitals than doctors; nevertheless, between 5 and 7 out of ten nurses feel resources aren't sufficient. For nurses, the issues of most concern is 'the supervision of junior nursing staff and students' with over two-thirds (68%) reporting that this is either 'poor' or 'inadequate'. Three out of five nurses (62%) also feel that the 'number of beds or services to meet patient demand' is not adequate and over half (56%) report that the there is 'poor' or 'inadequate' 'provision of clinical support staff (Table 15).

Table 15: Proportion of doctors and nurses who think resources are 'poor' or 'inadequate'

Resource	Doctors	Nurses
Ratio of permanent medical staff to locum/casual/agency staff	33.8	25.2
Provision of necessary clinical equipment	55.9	47.4
Number of staff available for quality supervision	68.8	67.9
Number of FTE medical staff	64.7	51.6
Number of beds/services to meet patient demand	79.6	61.8
Provision of clinical support staff	75.4	55.8
Skill mix of nursing staff	Not asked	39.7

Population: All respondents

Facility and Area Health Service

Despite the apparent insufficiencies in resources across all public hospitals there are, alarmingly, some that fare even worse than others with regard to staffing levels and supervisory capacity. In particular, doctors in regional hospitals are far more likely to report that the 'number of FTE medical staff', the 'number of medical staff available' for 'teaching and supervision' and the 'ratio of permanent medical staff to locum medical staff' are 'poor' or 'inadequate' compared to their counterparts in major teaching hospitals, metropolitan or urban hospitals or other facilities[3] (see Table 16).

Table 16: Proportion of regional doctors who think resources are 'poor' or 'inadequate' compared to doctors in other facilities.

Resource	Regional Doctors	All Doctors
Number of FTE medical staff	80.7	64.8
Number of staff available for quality supervision	84.7	68.9
Ratio of permanent medical staff to locum/casual/agency staff	60.2	33.8

Population: All doctors

Considering different area health services, doctors in the Northern Sydney and Central Coast area health service report that the 'ratio of permanent staff to locums' is more dire than amongst their counterparts (48.3% reporting that it's either 'poor' or 'inadequate' compared to 33.8% of doctors elsewhere). Similarly, doctors in Sydney West area health service report poorer 'numbers of beds or services to meet patient demand' compared to doctors elsewhere (86.6% versus 79.8%).

Nurses feel they have poorer access to appropriate equipment in regional hospitals compared to other facilities (57% report 'poor' or 'inadequate' equipment in regional hospitals compared to 47% of nurses in other facilities). On the other hand, nurses in major teaching hospitals are far more likely to report that skill mix is a problem (50%) compared to nurses from other facilities (40%). Nurses generally reported similar perceptions of area health services. The exceptions to these are slightly better (relatively) access to or provision of:

- clinical support in Northern Sydney and Central area (45% of nurses in this AHS felt this was 'poor' or 'inadequate' compared to 56% of all nurses);
- equipment in Northern Sydney and Central area (41% of nurses in this AHS felt this was 'poor' or 'inadequate' compared to 48% of all nurses); and,

[3] Due to relatively small number of respondent doctors from rural hospitals, community services, ambulance services and justice health these findings cannot be reliably reported individually.

- full-time effective nursing numbers (40% of nurses in this AHS felt this was 'poor' or 'inadequate' compared to 52% of all nurses).

Department or Unit

Both doctors and nurses working in public hospital emergency departments are straining under serious inadequacies in resources. These doctors and nurses are far more likely than the average to report that the number of beds available (92% of doctors and 79% of nurses) and the number of senior staff available to appropriately supervise junior staff (89% of doctors and 83% of nurses) are 'poor' or 'inadequate'. In addition, doctors in emergency departments are also far more likely to report that the 'ratio of permanent staff to locums and casual' (57% of emergency doctor staff compared to 34% of doctors in other departments) and the 'number of FTE medical staff' (78% compared to 65%) are serious problems.

Nurses in surgical wards and operating theatres or peri-operative wards are faced with more significant resource shortages with regard to an 'appropriate skill mix' (58% and 51% respectively compared to an average of 40%) and 'the provision of equipment to undertake the necessary clinical work' (58% and 70% respectively compared to 48% on average). In addition, more than 7 our of 10 nurses working in operating theatres or peri-operative wards report 'poor' or 'inadequate' 'clinical administrative support' compared to 56 per cent of nurses in all departments. (Due to the size and number of these tables, they are presented in Appendix A, rather than in the report.)

Perceptions of immediate problems

While this report has detailed staff perceptions of problems within the public health service in general, a series of direct questions were asked at the end of the survey to gauge definitive views on what were held to be immediate problems for respondents themselves and/or their departments. The responses are presented in Table 17, below. Both doctors and nurses appear to have strong perceptions that recruiting and retaining staff, high bed occupancy rates, and fostering a culture of excellence in the NSW health system are direct and immediate problems, with around two thirds of nurses and three quarters of doctors agreeing.

Table 17. Perceptions of problems in the public health system that relate directly to respondents

Problem	Nurses			Doctors		
	Yes	No	Don't know	Yes	No	Don't know
Supervision of junior clinical staff	59.7	37.1	3.3	49.4	48.0	2.7
Communication between health professionals	46.0	52.2	1.8	43.5	55.1	1.4
Clinical note-taking and record keeping	45.2	52.6	2.2	46.6	51.4	1.9
Recruiting and retaining staff	66.0	30.2	3.8	77.3	19.8	2.9
Involvement of clinical staff in management decisions	52.8	40.1	7.1	63.1	31.1	5.9
High bed occupancy rates/patient through-put	64.8	28.1	7.1	74.7	20.7	4.6
Constraints in fostering a culture of excellence within the NSW public health system	64.1	28.1	7.8	76.2	17.0	6.8

Population: All respondents

It should be noted, that while the table above does not display disaggregations by any particular group, there are particular trends in perceptions of problems dependent on the role, position, department and even length of time a respondent has been employed. For example, junior doctors are far less likely to agree that clinical note taking is a problem, compared to more senior doctors (approximately one quarter of junior doctors agree, compared to slightly less than half of senior doctors). There is a similar trend with enrolled nurses compared to registered nurses, midwives and senior nurses.

While around two thirds of all nurses are likely to envisage a problem with recruiting and retaining staff, regardless of their role, only 40 per cent of junior doctors compared with 81 per cent of staff specialist doctors and 70 per cent of VMOs, agree. This is also true for the involvement of clinical staff in management decisions. While only 41 per cent of junior doctors agree there is a problem, 64 per cent of staff specialists and 80 per cent of VMOs agree that there is.

6. Conclusions

Considered in isolation, each challenge currently faced by the NSW public health system is alarming. However, and unfortunately, these challenges do not occur in isolation. Rather they combine to reveal a system that must be at breaking point. Recent media publicity surrounding tragic events that have occurred within the system seem to confirm that this is exactly the case. NSW public hospital doctors and nurses are working in appalling conditions; they are understaffed – whether through a sheer shortage of professionals on the wards, or through insufficiently skilled professionals, they are feeling under-valued, over-worked and exhausted. It is no wonder that such a large proportion of these workers are seriously considering leaving the public system. The multiple challenges suffered by staff within the system are not sustainable. Devising and implementing both short-term and long-term solutions is imperative. Our results show that benchmarked against some key measures of workplace relations, the public hospital system in NSW is lagging much further behind other workplaces with regard to work intensity and employee consultation and trust between managers and employees. These challenges appear to be logical places

to start. The vision of the NSW Department of Health is to "achieve healthy people – now and in the future'[4]. The public hospital workforce is a good place to start with health and well-being improvements.

7. References

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[4] Source: http://www.health.nsw.gov.au/aboutus/index.asp

8. Appendix A

The level of clinical support staff (e.g. ward clerks, IT, admin, stores)

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	75.1%	24.9%	100.0%
	Metropolitan/ urban hospital	70.5%	29.5%	100.0%
	Regional hospital	83.3%	16.7%	100.0%
	Rural hospital	77.8%	22.2%	100.0%
	Community services	72.7%	27.3%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	83.3%	16.7%	100.0%
	Other	72.2%	27.8%	100.0%
	Total	75.4%	24.6%	100.0%
Nurses	Major teaching hospital	51.2%	48.8%	100.0%
	Metropolitan/ urban hospital	52.9%	47.1%	100.0%
	Regional hospital	57.1%	42.9%	100.0%
	Rural hospital	61.9%	38.1%	100.0%
	Community services	58.6%	41.4%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	50.0%	50.0%	100.0%
	Other	57.9%	42.1%	100.0%
	Total	55.8%	44.2%	100.0%

The ratio of permanent medical staff to locum/casual medical staff

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	29.7%	70.3%	100.0%
	Metropolitan/ urban hospital	38.5%	61.5%	100.0%
	Regional hospital	60.2%	39.8%	100.0%
	Rural hospital	50.0%	50.0%	100.0%
	Community services	30.0%	70.0%	100.0%
	Ambulance Service		100.0%	100.0%
	Justice Health'	25.0%	75.0%	100.0%
	Other	22.2%	77.8%	100.0%
	Total	33.8%	66.2%	100.0%
Nurses	Major teaching hospital	27.5%	72.5%	100.0%
	Metropolitan/ urban hospital	21.4%	78.6%	100.0%
	Regional hospital	23.7%	76.3%	100.0%
	Rural hospital	28.4%	71.6%	100.0%
	Community services	15.7%	84.3%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	25.0%	75.0%	100.0%
	Other	50.0%	50.0%	100.0%
	Total	25.2%	74.8%	100.0%

The number of medical staff available to provide quality teaching and supervision of junior clinical staff and clinical students

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	66.0%	34.0%	100.0%
	Metropolitan/ urban hospital	71.2%	28.8%	100.0%
	Regional hospital	84.7%	15.3%	100.0%
	Rural hospital	78.6%	21.4%	100.0%
	Community services	59.1%	40.9%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	75.0%	25.0%	100.0%
	Other	76.5%	23.5%	100.0%
	Total	68.9%	31.1%	100.0%
Nurses	Major teaching hospital	67.2%	32.8%	100.0%
	Metropolitan/ urban hospital	69.2%	30.8%	100.0%
	Regional hospital	67.4%	32.6%	100.0%
	Rural hospital	73.5%	26.5%	100.0%
	Community services	61.5%	38.5%	100.0%
	Ambulance Service		100.0%	100.0%
	Justice Health'	62.5%	37.5%	100.0%
	Other	56.3%	43.8%	100.0%
	Total	67.9%	32.1%	100.0%

The number (FTE) of medical staff

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	61.8%	38.2%	100.0%
	Metropolitan/ urban hospital	65.5%	34.5%	100.0%
	Regional hospital	80.7%	19.3%	100.0%
	Rural hospital	81.5%	18.5%	100.0%
	Community services	65.2%	34.8%	100.0%
	Ambulance Service		100.0%	100.0%
	Justice Health'	75.0%	25.0%	100.0%
	Other	66.7%	33.3%	100.0%
	Total	64.8%	35.2%	100.0%
Nurses	Major teaching hospital	44.1%	55.9%	100.0%
	Metropolitan/ urban hospital	44.8%	55.2%	100.0%
	Regional hospital	51.0%	49.0%	100.0%
	Rural hospital	62.9%	37.1%	100.0%
	Community services	61.4%	38.6%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	62.5%	37.5%	100.0%
	Other	60.0%	40.0%	100.0%
	Total	51.8%	48.2%	100.0%

Provision of equipment to undertake the necessary clinical work

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	57.6%	42.4%	100.0%
	Metropolitan/ urban hospital	48.6%	51.4%	100.0%
	Regional hospital	56.1%	43.9%	100.0%
	Rural hospital	48.1%	51.9%	100.0%
	Community services	61.9%	38.1%	100.0%
	Ambulance Service		100.0%	100.0%
	Justice Health'	66.7%	33.3%	100.0%
	Other	38.9%	61.1%	100.0%
	Total	55.9%	44.1%	100.0%
Nurses	Major teaching hospital	48.8%	51.2%	100.0%
	Metropolitan/ urban hospital	47.4%	52.6%	100.0%
	Regional hospital	56.7%	43.3%	100.0%
	Rural hospital	38.7%	61.3%	100.0%
	Community services	46.6%	53.4%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	25.0%	75.0%	100.0%
	Other	50.0%	50.0%	100.0%
	Total	47.4%	52.6%	100.0%

The number of beds/services to meet patient demand

		Poor / Inadequate	Satisfactory / Good	Total
Doctors	Major teaching hospital	82.0%	18.0%	100.0%
	Metropolitan/ urban hospital	68.5%	31.5%	100.0%
	Regional hospital	84.3%	15.7%	100.0%
	Rural hospital	64.0%	36.0%	100.0%
	Community services	81.0%	19.0%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	66.7%	33.3%	100.0%
	Other	66.7%	33.3%	100.0%
	Total	79.6%	20.4%	100.0%
Nurses	Major teaching hospital	65.6%	34.4%	100.0%
	Metropolitan/ urban hospital	60.8%	39.2%	100.0%
	Regional hospital	64.5%	35.5%	100.0%
	Rural hospital	51.9%	48.1%	100.0%
	Community services	63.5%	36.5%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	62.5%	37.5%	100.0%
	Other	78.9%	21.1%	100.0%
	Total	61.8%	38.2%	100.0%

The skill mix of nursing staff in your unit (i.e. the proportion of RNs to other nurses) (Nurses only)

		Poor / Inadequate	Satisfactory / Good	Total
Nurses	Major teaching hospital	49.6%	50.4%	100.0%
	Metropolitan/ urban hospital	40.3%	59.7%	100.0%
	Regional hospital	44.2%	55.8%	100.0%
	Rural hospital	38.1%	61.9%	100.0%
	Community services	14.3%	85.7%	100.0%
	Ambulance Service	100.0%		100.0%
	Justice Health'	25.0%	75.0%	100.0%
	Other	45.0%	55.0%	100.0%
Total		40.1%	59.9%	100.0%