SPECIAL REPORT NO. 21

• Visiting Medical Officer Arrangements

APRIL 1993

VICTORIA

Auditor-General
of Victoria

SPECIAL REPORT No. 21

VISITING MEDICAL OFFICER ARRANGEMENTS

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AUDIT
VICTORIA

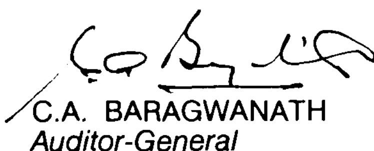
April 1993

The Honourable the Speaker
Legislative Assembly
Parliament House
Melbourne, Vic. 3002

Sir

Under the provisions of section 48A of the *Audit Act* 1958, I transmit the Auditor-General's Special Report No. 21 on Visiting Medical Officer Arrangements.

Yours faithfully



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PART 1

Executive Summary

1.1 FOREWORD

1.1.1 In 1989, I was appointed as auditor of the State's 140 public hospitals.

1.1.2 A recurring theme arising from the audits of individual hospitals since that time has been the inadequacy of the controls exercised over expenditure on Visiting Medical Officers (VMOs) engaged by public hospitals to provide medical services to public patients.

1.1.3 Deficiencies in the accountability of VMOs and the potential for substantial cost savings were identified by the Parliament's Economic and Budget Review Committee as far back as 1985. However, in light of the findings of my officers since 1989, it was evident to audit that appropriate measures to remedy the accountability deficiencies or to pursue cost savings had not been implemented and were still required.

1.1.4 Given that public hospitals annually spend in excess of $120 million on the engagement of VMOs, a detailed review of VMO arrangements within the Victorian public hospital system was undertaken and the results of the review are set out in this Report.

1.2 OVERALL AUDIT CONCLUSIONS

1.2.1 Visiting Medical Officer (VMO) services are an integral part of the Victorian public hospital system. These services are provided by private medical practitioners, granted visiting rights by individual public hospitals, and involve annual expenditure in excess of $120 million by these hospitals.

1.2.2 Over many years, the Department of Health and Community Services and public hospitals have been aware of significant deficiencies in the accountability and monitoring of VMO services. Such deficiencies were clearly highlighted in the Parliament's Economic and Budget Review Committee 1985 Report, which strongly recommended that the Department immediately address these deficiencies. To date, minimal action has been taken by the Department. Even when individual hospitals attempted to introduce enhanced arrangements, support was not forthcoming from the Department.

1.2.3 The adverse impact on the public hospital system of the Department's inaction is reflected in the continuing inefficient and uneconomic VMO practices in public hospitals which result in significant wastage of taxpayers' funds. While the dedication and expertise provided by VMOs was not questioned, nevertheless, the audit review found:

- payments for VMO services which were not supported by documentary evidence that such services had been provided;
- *prima facie* evidence of over-servicing of patients;
- private patients requiring surgery were treated during publicly-funded theatre sessions;
- *prima facie* evidence of VMOs working privately while on paid sick leave;
- evidence suggesting a bias by certain public hospitals against the admission of public patients for elective surgery, in favour of private patients, contributing to increased public patient waiting list numbers; and
- significant potential to further reduce public health costs through the greater use of sessional VMO arrangements in medium-sized hospitals, as opposed to the existing fee-for-service arrangements.

1.2.4 A further disturbing element was the improper shifting of State health costs to the Commonwealth by public hospitals and the emergence of *prima facie* evidence of irregularities in Medicare payments to VMOs.

1.2.5 It is crucial that both State and Commonwealth Governments co-operate to investigate the *prima facie* evidence of irregular payments outlined in this Special Report. Implementation of procedures which will prevent or, at least, detect any future irregularities will assist in ensuring that scarce taxpayer funds are able to be applied to areas of most need and equitable access to the public hospital system is achieved.

1.3 OVERALL RESPONSE BY SECRETARY TO THE DEPARTMENT

1.3.1 I commend the Auditor-General and his staff on the completion of this substantial report.

1.3.2 The general thrust of the recommendations, which:

- seek to bring to the notice of the relevant authorities the specific *prima facie* cases of fraud and over-servicing for appropriate action, and
- recommend the Department accept responsibility for strong leadership in the review and development of systems which will provide for the future identification of potentially fraudulent claims, and *prima facie* evidence of over-servicing, where the necessary data must be collected from across the hospital system, or through co-operation with the Commonwealth Government,

is supported.

1.3.3 The Government is now in the process of defining new relationships between the Department and public hospitals, through the introduction of casemix funding arrangements. These arrangements will further distance the Department from day-to-day operational decisions within hospitals, and will alter the balance of financial incentives facing hospitals.

1.3.4 A number of the problems identified by audit will, we anticipate, be resolved by hospitals as a result of these reforms, and will not require the more direct intervention by the Department in individual hospital affairs occasionally suggested by the Auditor-General.

1.4 SUMMARY OF MAJOR AUDIT FINDINGS

SESSIONAL ARRANGEMENTS — Page 27

- Hospitals had not established appropriate monitoring mechanisms for sessional VMOs to ensure that all paid VMO services were, in fact, provided.

  Paras 4.6 to 4.25

- Hospitals had not undertaken cost-benefit analyses to confirm that their existing out-of-hours remuneration arrangements were cost-effective.

  Paras 4.20 to 4.21

- The practice of sessional VMOs treating large numbers of private patients during publicly-funded theatre sessions represents a form of double payment for the same service, with reimbursement from both private patients and the hospital.

  Paras 4.26 to 4.36

- There was *prima facie* evidence to suggest that a number of sessional VMOs, while on paid sick leave from sessional hospitals, engaged in private practice.

  Paras 4.41 to 4.46

- Despite the potential for double payment of superannuation to sessional VMOs being brought to the attention of the Department in 1985, no action was taken to address this issue.

  Paras 4.47 to 4.53

FEE-FOR-SERVICE ARRANGEMENTS

Page 39

- The failure of individual fee-for-service hospitals to establish adequate VMO claim monitoring and accountability processes, together with the Department's lack of direction on this matter, have resulted in such hospitals having inadequate control over VMO payments.

  Paras. 5.3 to 5.9

- There is *prima facie* evidence of over-servicing of public patients in certain fee-for-service hospitals.

  Paras 5.10 to 5.15

- The divergent practices and differing accountability requirements within public hospitals, together with a strong resistance by certain VMOs to change, rendered the fee-for-service system vulnerable to manipulation and inefficiency.

  Paras 5.21 to 5.30

MEDICARE PAYMENTS FOR PUBLIC PATIENTS

Page 51

- No action has been taken by the Department to develop suitable arrangements with the Commonwealth to curtail the potential for VMOs to receive reimbursement from both Medicare and public hospitals for the provision of the same medical service.

  Paras 6.1 to 6.7

- There is *prima facie* evidence to suggest that certain VMOs and other medical practitioners are taking financial advantage of the absence of a suitable cross-checking mechanism, for their own personal gain.

  Paras 6.13 to 6.19

- The absence of an established Commonwealth/State monitoring mechanism enabled public hospitals to shift substantial costs to the Commonwealth, in contravention of the Medicare Agreement.

  Paras 6.20 to 6.26

RESTRICTIONS ON PUBLIC PATIENT ADMISSIONS

Page 59

- Restrictive admission practices by certain public hospitals, primarily for budgetary purposes, which give a higher priority to private patients, effectively inhibit the ability of the Government to achieve reductions in the numbers of public patients on hospital waiting lists.

  Paras 7.4 to 7.21

COST COMPARISON, FEE-FOR-SERVICE AND SESSIONAL ARRANGEMENTS

Page 65

- Annual cost savings in the order of $8 million were available if medium-sized public hospitals abandon inefficient fee-for-service VMO arrangements.

  Paras 8.12 to 8.15

- Since 1986, the State has forgone aggregate cost savings in excess of $50 million as a result of the Department of Health and Community Services' failure to undertake a systematic evaluation of VMO arrangements in all medium-sized public hospitals. These savings are predicated on the immediate acceptance by VMOs of sessional arrangements.

  Para. 8.16

GOVERNMENT RESPONSE TO EBRC RECOMMENDATIONS

Page 71

- The Department had failed to honour its commitment, given to the Parliament some 5 years ago, to address the significant deficiencies relating to the operation of VMO arrangements throughout the public hospital system.

  Paras 9.1 to 9.6

PART 2

Background to Visiting Medical Officer Arrangements

INTRODUCTION

2.1 Apart from approximately 2 000 effective full-time (EFT) medical officers within the Victorian public hospital system, medical services are also provided by private practitioners engaged as Visiting Medical Officers (VMOs), either:

- on the **fee-for-service** system (in excess of 2 500 individual practitioners); or
- on the **sessional** system (equivalent to approximately 500 EFT practitioners).

2.2 This arrangement was introduced into the Victorian public hospital system in 1975 following the establishment of Medibank, now known as Medicare, by the Commonwealth Government. Prior to this time, part-time medical staff were primarily engaged by hospitals on an honorary basis to treat public patients without charge to either the patient or the hospital.

2.3 At 30 June 1992, 122 Victorian hospitals engaged VMOs predominantly on the fee-for-service basis, whereas 18 hospitals used the sessional system.

2.4 Under the **fee-for-service** system, VMOs are paid by public hospitals for each medical service provided to public patients. This method of payment is similar to the system used by medical practitioners to directly bulk bill Medicare for services provided outside the public hospital network. Except for the Geelong, Ballarat and Bendigo Hospitals, where sessional arrangements apply, fee-for-service arrangements operate in all non-metropolitan public hospitals. Small and medium-sized metropolitan public hospitals also use the fee-for-service system. In the case of small hospitals, fee-for-service arrangements are more cost-effective than sessional arrangements, due to the lower levels of patient throughput.

2.5 Under the **sessional** system, which is effectively a time-based system, hospitals employ VMOs to attend public patients for specified periods, usually of 3.5 hours, between 8 a.m. and 6 p.m., Monday to Friday inclusive (known as in-hours sessions). The provision of medical care outside agreed sessional hours (including public holidays) is generally covered by the allocation of additional sessions on an on-call basis (referred to as out-of-hours sessions).

2.6 Unlike VMOs engaged on a fee-for-service basis, sessional VMOs, under State Award conditions, are also entitled to payments by public hospitals for:

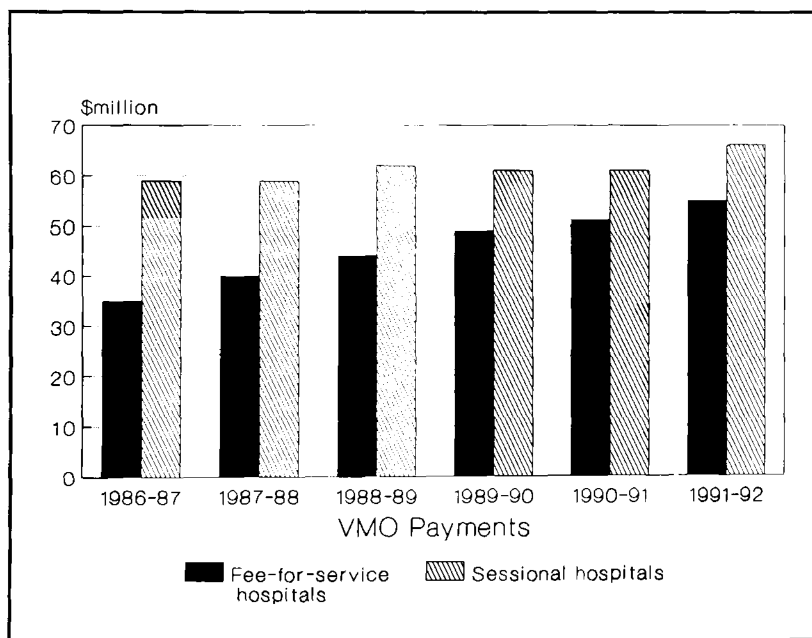
- 4 weeks annual leave and 2 weeks conference leave;
- public holidays;
- 28 days cumulative sick leave a year;
- 6 months long service leave after 15 years of continuous service; and
- 6 months sabbatical leave after 6 years service.

2.7 Sessional arrangements operate in all teaching hospitals and other larger metropolitan public hospitals, such as the Preston and Northcote Community Hospital and the Western, Box Hill and Maroondah Hospitals.

2.8 The major difference between the sessional and fee-for-service systems is that, under the sessional system, VMOs are paid for the time spent attending public patients whereas, under the fee-for-service system, they are paid for each individual clinical procedure provided to public patients. Appendix A illustrates the differences that can occur in medical costs borne by hospitals, due to the use of the 2 methods of VMO remuneration.

2.9 In the past 6 years, public hospitals have spent over $580 million on VMO services. Chart 2A illustrates the annual VMO expenditure by public hospitals over this period, expressed in constant 1991-92 prices.

CHART 2A. EXPENDITURE ON VMOs BY PUBLIC HOSPITALS
(In constant 1991-92 prices)



2.10 The chart also indicates that, over the past 6 years, in constant 1991-92 prices, annual VMO payments by fee-for-service hospitals have increased by 57 per cent, from $35 million in 1986-87 to $55 million in 1991-92, whereas annual VMO payments by sessional hospitals have increased by only 12 per cent, from $59 million to $66 million over the same period. The increase in sessional expenditure principally occurred in 1991-92, as a consequence of specialist medical practitioners (including full-time medical officers and sessional VMOs) receiving an award increase of 6 per cent, effective from September 1991.

MEDICAL OFFICER PAYMENTS COMPARISON

2.11 An audit analysis utilising data provided by respective State Health Departments, to derive indicative estimates of medical officer payments per public in-patient equivalent across Australian States, showed that the average payments made by Victorian public hospitals in respect of medical officers are among the highest of all mainland States. Table 2B provides an interstate comparison of average medical officer payments per public in-patient equivalent for 1990-91 (the latest available data), which comprise all payments made to non-salaried medical officers (VMOs) and all payments to salaried medical officers, discounted for the proportion of services they provide to private patients.

TABLE 2B. MEDICAL OFFICER PAYMENTS PER PUBLIC IN-PATIENT EQUIVALENT, 1990-91 *(a)(b)*
($)

State	*Teaching (non-specialist) hospitals*	*Metropolitan (non-teaching) hospitals*	*Non-metropolitan hospitals*
Victoria	**460**	**342**	**298**
Western Australia	458	302	242
New South Wales	452	360	322
South Australia	451	358	289
Queensland	394	219	192

(a) Public in-patient equivalent comprises public in-patient admissions and out-patient occasions of service adjusted to in-patient equivalent.

(b) All States, other than Queensland, engage VMOs on the basis of both sessional and fee-for-service arrangements. In Queensland, public hospitals use sessional arrangements almost exclusively.

ACCOUNTABILITY RELATIONSHIP BETWEEN PUBLIC HOSPITALS, THE DEPARTMENT AND THE MINISTER FOR HEALTH

2.12 Under the *Health Services Act* 1988, public hospitals are given the status of autonomous corporate bodies. However, despite this autonomy, hospitals are required to manage their activities in accordance with broad policy directives provided by the Government.

2.13 Approximately 75 per cent of public hospital revenues are provided from government sources. Given this substantial government subsidisation, and that public hospitals are State-owned entities, except for certain denominational hospitals designated as public hospitals, there is a need for full accountability by these hospitals to taxpayers and the Parliament.

2.14 A key responsibility of the Government is to ensure the operation of a strong accountability framework for all public sector entities, including public hospitals. Under this framework, the Department of Health and Community Services, on behalf of the Minister for Health, is entrusted to:

- provide both sector-wide and individual directions and guidelines to public hospitals; and
- monitor the implementation of those directions.

2.15 Monitoring of hospital operations by the Department should also assist in the identification of any emerging sector-wide service delivery problems and the initiation of any appropriate corrective actions.

2.16 The Department, itself, has acknowledged the importance of accountability in the public hospital system. As part of its 1992-94 Strategic Directions publication entitled *Achieving Better Health and Health Services*, the Department stated that it would:

- reform the structure and management of health services to achieve greater effectiveness, efficiency and accountability; and
- achieve greater equity in health access and health outcomes.

PREVIOUS PARLIAMENTARY INQUIRIES

2.17 In 1985, the former Economic and Budget Review Committee (EBRC) of the Victorian Parliament examined the method of remuneration for VMOs at public hospitals.

2.18 Key findings of the EBRC contained in its report entitled *Report of the Inquiry into the method of Remuneration for visiting medical staff at Public Hospitals*, included:

- while both the fee-for-service and sessional systems were suitable methods of VMO remuneration, their suitability to individual public hospitals depended on applicable circumstances;
- significant cost savings were available to the Frankston Community Hospital and medium-sized fee-for-service hospitals from the introduction of sessional VMO arrangements;
- a need for action to limit the possibility of fraud and over-servicing in fee-for-service hospitals; and
- the absence of a Commonwealth/State cross-checking mechanism enabled double payment to VMOs from public hospitals and Medicare, for the provision of the same service.

2.19 The New South Wales Public Accounts Committee, in 1989, also inquired into public hospital payments to VMOs in that State. Key findings of the review, contained in its report entitled *Report on Payments to Visiting Medical Officers*, included:

- payments to VMOs had significantly increased, primarily due to a 1985 arbitration decision on sessional remuneration rates which caused the New South Wales sessional hourly rate to become substantially higher than rates paid in other States;
- while VMOs aimed to remain independent contractors they often sought the additional benefits associated with employee status;
- some members of the medical profession were reluctant to recognise that the expenditure of significant public funds, in the form of VMO payments, required a high degree of accountability;
- the system of payment for sessional VMOs was "doctor driven", as doctors claimed payments retrospectively for hours worked, rather than hospitals determining in advance the number of hours or services to be provided by VMOs;
- proper substantiation and accountability for payments to VMOs was not possible as hospital administrators generally could neither predict the total outlay on VMOs nor verify individual claims for payment; and
- the lack of timely, specific and comprehensive advice to hospitals from the New South Wales Department of Health, on matters of VMO management and accountability, had considerably exacerbated the deficiencies in accountability for VMO payments.

PART 3

Audit Objectives and Scope

INITIAL OBJECTIVES AND SCOPE

3.1 The initial objectives of the audit review of VMO arrangements were to assess whether:

- the administration of these arrangements by public hospitals was consistent with government policies and guidelines, including any award and legislative requirements;
- policies, practices and procedures covering the operation of VMOs had resulted in the economic and efficient provision of medical services by public hospitals;
- central management procedures established by the Department to monitor the economic and efficient provision of medical services by public hospitals were adequate; and
- appropriate action had been taken by the Department to implement the recommendations included in the EBRC's 1985 Report.

3.2 As part of the planning process for this review, audit developed a questionnaire for distribution to all major public hospitals, seeking information concerning the controls and practices applying to VMO arrangements. Prior to the release of the questionnaire, comments and suggestions were sought from the Victorian Hospitals' Association Ltd (VHA), the industry body representing all Victorian public hospitals, and the Victorian Branch of the Australian Medical Association (AMA). The responses provided by these organisations were incorporated into the questionnaire, which was then sent to all large and medium-sized public hospitals.

3.3 After analysing the responses received from hospitals, and taking into account further suggestions made by the VHA and the AMA, audit determined to examine the VMO arrangements applying at 37 public hospitals, listed in Appendix D.

3.4 The review focused on an examination of:

- the cost to public hospitals of services provided by VMOs;
- the adequacy of departmental and hospital VMO management information systems;
- actions taken by the Department and/or hospitals to maximise service delivery using VMO resources;
- accountability and financial controls over payments made to VMOs for services provided in public hospitals;
- arrangements for payments to VMOs for services provided outside normal working hours; and
- actions taken by the Department to implement the 1985 recommendations of the EBRC.

EXPANSION OF OBJECTIVES

3.5 During the course of the review, the lack of a Commonwealth/ State monitoring mechanism to identify instances of over-servicing and fraud was referred to by the senior management of several hospitals, who expressed concern to audit that the fee-for-service arrangement remained vulnerable to over-servicing and other irregularities. Therefore, the objectives of the review were expanded to determine:

- whether the services provided by VMOs were medically necessary; and
- whether Victorian taxpayers were paying for medical services provided to public patients for which VMOs were also reimbursed by the Commonwealth's Medicare system.

3.6 In order to assess the necessity of individual medical services provided by VMOs to public patients, medical experts from Deloitte Touche Tohmatsu's Health Consulting Division were engaged to undertake this aspect of the review.

3.7 Furthermore, it was essential that the review had access to Medicare payments data in order to determine whether VMOs were receiving reimbursement from Medicare for services provided to public patients in public hospitals, which had already been paid by individual hospitals. Therefore, the co-operation and assistance of the Commonwealth Health Insurance Commission (HIC) was sought.

3.8 In accordance with the requirements of the Commonwealth *Health Insurance Act* 1973, I formally requested, and was granted, the required access to Medicare data relating to payments made for medical services provided to public patients during specified periods. This data enabled a comparison to be made with payment information held by public hospitals.

3.9 A specific condition imposed by the HIC, as part of the access process, was the observance by audit of secrecy provisions contained within the Commonwealth legislation. Therefore, **as part of this review, it was not possible for the findings relating to specific VMOs to be confirmed with the individuals concerned or to be disclosed to the relevant hospitals and the Department. For the same reason, it was not possible for specific details relating to HIC data to be disclosed in this Report.**

3.10 In granting access, the HIC indicated that *"... if cases can be identified where this* [irregularities] *is occurring it would be of great interest to the Commission given its legislative responsibilities in dealing with fraud and excessive servicing. The Commission will conduct an investigation into any information you can provide and you will be informed of the results of the investigation".* Further comment on this matter is contained in Part 6 of this Report.

PART 4

Sessional Arrangements

BACKGROUND

4.1 Sessional VMOs are remunerated in accordance with the Victorian Sessional Medical Officers Determination. Under the Determination, sessional rates payable to VMOs are based on rates applicable to specialist full-time medical officers, and include a 37.5 per cent loading to cover travelling time, self-funded superannuation and other related expenses. Where VMOs work in excess of 6 sessions a week (i.e. normally more than 21 hours per week), the 37.5 per cent loading is not payable. However, from March 1993, the *Employee Relations Act* 1992 provides for all existing Victorian Awards and Determinations to be re-negotiated.

4.2 As previously mentioned in Part 2 of this Report, under the sessional system, VMOs may perform their duties during normal hours (i.e. in-hours) by attending either:

- a **standard session**, where they work for a continuous period of not more than 3.5 hours treating public patients; or
- a **composite session**, which enables VMOs to treat both public and private patients concurrently and deliver their contracted hours in a manner which is flexible and suits individual practitioners.

4.3 VMOs can be rostered by a hospital to perform 3 different types of in-hours sessions involving the provision of medical care to public patients, namely:

- operating theatre;
- ward (rounds); and
- out-patient clinic.

4.4 Where VMOs are required to provide medical services outside normal hours, referred to as out-of-hours sessions, they are entitled to receive:

- **Exclusive on-call** payments, equivalent to one standard session, to be paid in situations where VMOs designate that they will only be available for out-of-hours consultations at one specific hospital; or
- **Consultative on-call** payments, equivalent to 25 per cent of the standard sessional rate, to be paid where VMOs are available to be consulted by more than one hospital but are not necessarily required to physically attend those hospitals; and
- **Re-call** payments, in the event that a VMO, who is rostered on-call, is actually required to return to duty to attend public patients. In this case, the VMO receives the applicable sessional on-call payment together with an additional allowance to cover time spent at the hospital and travelling time.

4.5 In situations where VMOs are re-called to duty when not rostered to do so, they are paid at fee-for-service rates.

INABILITY TO EFFECTIVELY SUBSTANTIATE SESSIONAL PAYMENTS

4.6 Any system established to pay accounts would be expected to incorporate procedures which provide for the verification that goods and services have been received, prior to payment being made. The significance of these procedures has been recognised and included in the New South Wales Public Hospitals (Visiting Medical Officers - Sessional Contracts) Determination, which requires VMOs to maintain a record of the date and time when each service was rendered. However, the Victorian Determination does not require sessional VMOs to maintain equivalent information. In addition, while the majority of sessional hospitals require their VMOs to sign a contract prior to engagement, these contracts do not generally specify accountability requirements to evidence the provision of services, such as those contained in the NSW Determination.

4.7 Without the necessary legislative or contractual authority, Hospital Boards of Management and executives have placed themselves in a position where it is difficult for them to enforce measures aimed at ensuring the accountability of VMOs.

4.8 By not establishing adequate mechanisms to substantiate that sessional VMOs have, in fact, provided the services for which they were engaged, hospitals are not in a position to monitor the accuracy and validity of claims submitted by VMOs.

4.9 The following paragraphs outline a number of deficiencies in the substantiation of sessional VMO claims by hospitals.

Substantiation of attendance at ward sessions

4.10 At most sessional hospitals, VMOs were not required to evidence their attendance at ward sessions and, even where such evidence was required, VMOs were not routinely recording evidence of attendance at such sessions. Accordingly, no management trail existed to verify the performance of ward sessions and to demonstrate that medical care had actually been provided.

4.11 Attempts by hospitals to substantiate that ward sessions were fully performed was further complicated in situations where the VMO was engaged to perform a composite ward session.

4.12 As indicated previously, a composite session enables the VMO to see both public and private patients concurrently and to deliver the contracted sessional hours in a manner which is flexible and suits the VMO. Therefore, a composite session can be spread over several days so long as the agreed total hours, usually 3.5 hours, are provided to public patients.

4.13 Composite ward sessions benefit hospitals by enhancing the continuity of patient care. The benefit to VMOs is that they can attend their private patients more or less simultaneously as they are treating public patients. As noted in the EBRC's 1985 Report *"... Composite sessions are based on the notion that the time spent on private patients is made up for at other times by attending to public patients"*.

4.14 While composite sessions benefit both patients and VMOs, **hospitals had not established appropriate recording and monitoring mechanisms to ensure that the hours paid for attendance at ward sessions had actually been delivered in the treatment of public patients.**

Monitoring out-of-hours work

4.15 The EBRC's 1985 Report stated that with sessional payments applying for in-hours work, and on-call/re-call allowances and fee-for-service fees payable for out-of-hours work, there was a considerable financial incentive for VMOs to delay consultations until "after hours". The Committee was of the view that all public hospitals should have in place a procedure for monitoring and controlling payments for out-of-hours work to ensure that the sessional system was not abused.

4.16 The Committee recommended that *"... the Department ensure that all public hospitals, using the sessional system of remunerating Visiting Medical Officers, routinely and effectively monitor the appropriateness of out-of-hours work conducted by Visiting Medical Officers".*

4.17 The Government's April 1988 response to this recommendation was to *"... ensure that all public hospitals which use the sessional system monitor the appropriateness of out-of-hours work conducted by visiting medical staff".*

4.18 The Auditor-General's *Special Report No. 12 - Alfred Hospital*, issued in May 1990, reported that, at the Alfred Hospital:

> *"A management information system disclosing the extent of on-call and re-call hours and associated payments to VMOs for each specialty had not been developed. As a consequence, management did not monitor and assess the cost-effectiveness of on-call payments".*

4.19 During the current audit review, audit determined that **the majority of sessional hospitals were yet to develop effective monitoring systems for out-of-hours work conducted by sessional VMOs, and the Department had not provided sessional hospitals with any guidance on the establishment of such monitoring mechanisms, as recommended by the EBRC.** Specifically, 13 of the 18 sessional hospitals within the State were unable to provide audit with details of on-call, re-call and associated payments to VMOs per specialty for the period July 1991 to June 1992. Most cited the lack of readily available management data as the reason for not being able to meet the request.

4.20 The review also disclosed significant differences between hospitals in VMO payment practices for out-of-hours work. Some hospitals remunerated their VMOs for out-of-hours work by making on-call and re-call payments while, at other hospitals, VMOs were typically paid on a fee-for-service basis. There was no logical basis for the varying payment methods adopted by any particular hospital, rather they appeared to be historically based without reference to the cost and benefits associated with alternate practices.

4.21 Until such time as sessional hospitals undertake cost-benefit analyses of alternate payment systems for out-of-hours work, hospital management will not be in a position to ensure that current practices are the most cost-efficient.

4.22 As previously reported, VMOs who are rostered on-call exclusively at one hospital are entitled to be paid at a rate equivalent to one standard session. However, the Department did not have in place a mechanism to ensure that no VMO could be exclusively on-call at more than one hospital at the same time.

4.23 There is a need for the Department to establish a process which ensures that individual VMOs do not receive exclusive on-call payments from more than one hospital at any one time.

4.24 In responding to the audit findings of poor control over sessional VMO payments, management at a number of sessional hospitals verbally advised audit that:

- they relied, in part, on nursing staff to inform them if VMOs were neglecting public patients; or
- they believed in the integrity of their VMOs, and to monitor their activities too closely could have a negative effect on staff morale; or
- certain VMOs worked many unpaid hours at the hospital and management did not wish to jeopardise this by imposing what they regarded as being unnecessary formal controls over work practices.

Overall comment

4.25 Irrespective of the above views, hospitals must be able to substantiate that sessional hours have actually been provided prior to making any payments to VMOs. Consequently, there is an urgent need for documentation and monitoring mechanisms to be enhanced to ensure that VMOs have actually provided services to public patients prior to payment.

- *RESPONSE provided by Secretary to the Department*

The Department agrees with audit that appropriate accountability arrangements should be in place. Payments to VMOs should be subject to the same standards of verification and accountability as other services purchased by hospitals. Audit' s claim that the Department should provide sessional hospitals with guidance on the establishment of monitoring mechanisms specifically for VMOs is, however, inappropriate. Hospitals have comprehensive management structures, and are independent corporate entities. They are fully equipped for monitoring sophisticated treatment events. They must also assume responsibility for accounting for salary expenditure and for ensuring adequate internal audit arrangements.

MIXED LISTS

4.26 At sessional hospitals, patients awaiting elective surgery are usually assigned by VMOs to hospital waiting lists and, once admission has been scheduled, are then assigned by either the hospital or the VMO to an operating theatre list, which typically corresponds to a surgeon's standard operating theatre session.

4.27 Operating theatre sessions are generally scheduled for 3.5 hour periods which correspond with VMO standard sessions. Sessional hospitals may utilise several operating theatres simultaneously during these periods.

4.28 Of the sessional hospitals, 8 provide private operating theatre sessions (or **private theatre lists**) to which private patients may be allocated, and public operating theatre sessions (or **public theatre lists**) to which public patients may be allocated. The remaining 10 sessional hospitals allocate both their public and private patients to one theatre list, known as a **mixed list**.

4.29 The type of operating theatre list assigned to VMOs by particular sessional hospitals has financial implications to VMOs, in that:

- with a **public theatre list**, the hospital will pay the VMO to conduct the operating theatre session and no fees will be charged by the VMO to the patient;
- in the case of the **private theatre list**, the VMO directly charges the patient; and
- with a **mixed list**, all VMO fees are met by the hospital under sessional arrangements and, in addition, the VMO can directly charge any private patient included on the theatre list.

4.30 The audit review disclosed that at certain sessional hospitals, where no private theatre lists were established, particular VMOs consistently allocated significant numbers of private patients to their public theatre lists. The VMOs compensated for this practice by performing a further unpaid theatre session (or part thereof), involving all or mostly public patients. However, at other sessional hospitals which provided private theatre lists, particular VMOs often allocated significant numbers of private patients to their public lists without a corresponding allocation of public patients to their private lists.

4.31 Specifically, audit established that, in 1991-92, for 10 of the 18 sessional hospitals, **at least 20 per cent of patients treated as part of a publicly paid theatre session were, in fact, private patients with no equivalent number of public patients being treated as part of a private theatre session. At one hospital, this proportion was almost 50 per cent.** In these situations, the VMO surgeon and the VMO anaesthetist can be paid twice, once by the public hospital for the scheduled theatre session and again by the private patient for the procedure. Given that VMOs often control the allocation of patients for elective surgery, there is a financial incentive to VMOs to give preference to private patients on mixed theatre lists.

4.32 Audit considers that the practice of sessional VMOs treating large numbers of private patients during publicly-funded theatre sessions represents a form of double payment, from private patients and the hospitals, for the same service.

4.33 The review found that one sessional hospital had recognised the discrimination against public patients inherent in mixed lists and had, therefore, never adopted this practice, believing that to do so would constitute double payment for the same service. The hospital advised audit that, as a result, it was having difficulty in attracting VMOs of a particular specialty. A local private practice group providing that service indicated that, in their opinion, they were being disadvantaged by comparison to specialists at other sessional hospitals which used the mixed list system. In a letter to the hospital, they advised that:

> *"The very basic requirement of the sessionalist at your hospital is that* [we] *be treated in a similar manner to the vast majority of visiting sessionalists in Victoria. This requires that each session whether public or private attended at the hospital attracts a sessional payment ...*
>
> *"If payment for all sessions were implemented it would require an increase in sessional allocations of 12 sessions per week which is a rise from the present 14 to a total of 26 ...*
>
> *"A cheaper alternative in the short-term for the hospital would be to accept mixed lists as policy for the present public lists therefore allowing private patients to be regularly booked on these lists and leaving the present private lists as they are".*

4.34 The hospital sought assistance from the Department to resolve the mixed list dilemma. According to the hospital, the Department did not consider it appropriate to become involved in the dispute.

4.35 The Department, despite being fully aware of the problems associated with mixed lists, had not attempted to identify the extent of the practice across the State and encourage hospitals to abandon this practice.

4.36 As a matter of urgency, the Department should review the use and manipulation of mixed lists in sessional hospitals, with a view to initiating appropriate action to eliminate opportunities for double payments to occur.

- *RESPONSE provided by Secretary to the Department*

  The Medicare Agreement provides for access by all Australians to public hospitals, irrespective of their insurance status. The decision as to whether a patient should be admitted is supposed to be based solely on clinical need. The Department will review and reverse any pattern of incentives which cause hospitals to admit private patients, at the expense of public patients. This issue will be addressed in the Department's casemix funding arrangements, to be introduced from July 1993.

COMPARISON OF SESSIONAL REMUNERATION RATES

4.37 As part of the current review, audit undertook a comparative analysis of sessional rates for both in-hours and out-of-hours work for a number of specialist classifications of VMOs engaged by public hospitals throughout Australia.

4.38 **The analysis disclosed that VMOs engaged on a sessional basis in Victorian public hospitals were, after allowing for (where applicable) on-costs such as leave and other entitlements, better remunerated than their interstate counterparts, with the exception of NSW.** For example, after taking into account on-costs, a Victorian specialist with 3 years experience earns approximately $99 per sessional hour compared with $127 for equivalent specialists in New South Wales and $84, $83 and $80 for equivalent specialists in South Australia, Western Australia and Queensland, respectively.

4.39 The New South Wales Public Accounts Committee's 1989 Report also commented that, based on 1988 data, sessional VMOs in NSW were better paid than their equivalent interstate colleagues, including Victoria. However, audit observed that the gap in sessional rates between NSW and Victoria had narrowed significantly since that Committee's review, principally because NSW sessionalists had not received any increase in remuneration since February 1988. Furthermore, in March 1993, the NSW Determination was revised, effective from July 1993, to significantly reduce sessional VMO remuneration rates in that State. As a result of this revision, specialist rates paid to NSW sessional VMOs will still exceed those paid in Victoria by between 2 and 8 per cent, compared with 28 per cent prior to the revision.

4.40 With the recent reduction in VMO rates in New South Wales, audit is of the view that Victorian sessional rates are now broadly consistent with equivalent rates in other States.

SICK LEAVE

4.41 Under the Sessional Medical Officers Determination, VMOs are entitled to various types of leave, including 28 days cumulative sick leave a year.

4.42 Audit undertook a review of sick leave taken by VMOs which, *inter alia*, involved determining whether VMOs on paid sick leave at sessional hospitals were working privately over the same period. The exercise, using Medicare payments data, involved establishing the number and type of medical services provided by VMOs for which there was a Medicare claim during the period of time the VMOs were on paid sick leave.

4.43 The results of this analysis, which are set out in Table 4A, show that, according to hospital and Medicare records, **77 per cent of the VMOs randomly selected by audit had worked privately while on paid sick leave from their respective hospitals.**

4.44 Audit recognises that, because these findings were not discussed with the individual VMOs due to the secrecy provisions contained in the Commonwealth *Health Insurance Act* 1973, there may have been instances where a VMO was legitimately unfit for duty during an allocated session but had suitably recovered to perform private duties later the same day.

TABLE 4A. VMOs WORKING PRIVATELY WHILE ON PAID SICK LEAVE FROM PUBLIC HOSPITALS

Number of VMOs in sample	31
Number of VMOs working privately while on sick leave	24
Sessional payments to VMOs for sick leave periods during which they worked privately	**$44 188**
Number of days VMOs on sick leave	641
Number of days VMOs worked privately while on sick leave	415
Number of services performed by VMOs over sick leave periods	4 281
Medicare refund associated with services performed	**$229 113**

4.45 Details of certain instances where VMOs performed services which attracted Medicare reimbursement, while on paid sick leave, are detailed in Appendix B. The cases cited, highlight that VMOs received paid sick leave which they utilised for the purpose of earning private income.

4.46 **There is a need for co-operative action by both State and Commonwealth authorities to investigate the above cases detected by audit. Such co-operation should extend to the implementation of procedures to detect and, ideally, prevent future irregular sick leave payments.**

- *RESPONSE provided by Secretary to the Department*

  The Department will explore with hospitals and Commonwealth authorities the development of monitoring systems to detect irregular payments such as those identified by audit. Where evidence of fraudulent claims exists, the Department fully supports criminal prosecution of the VMOs concerned.

DOUBLE PAYMENT OF SUPERANNUATION TO VMOs

4.47 As previously mentioned, a 37.5 per cent loading is included in sessional VMO rates.

4.48 The EBRC, in 1985, noted that, despite sessional rates including an allowance for superannuation, some sessional medical officers had joined the Hospitals Superannuation Fund. As VMOs engaged under sessional arrangements were being compensated for their ineligibility to join an employer-sponsored superannuation scheme, **the Committee believed that membership of the Hospitals Superannuation Fund by sessional medical officers was a form of double payment which should cease.**

4.49 The EBRC recommended that the Department *"... identify the occurrence of payments by public hospitals of employer contributions to superannuation schemes on behalf of sessional medical officers and that all such payments cease".*

4.50 The Government responded in April 1988 that it aimed to *"... eliminate double payments to VMOs by identifying and curtailing those instances where public hospitals are contributing to superannuation schemes on behalf of VMOs who receive a salary component of 7.5 per cent as a superannuation payment under the Sessional Medical Officers Determination".*

4.51 In 1989, the Hospitals Superannuation Board, which administers the Hospitals Superannuation Fund, extended superannuation coverage to part-time employees who worked at least 20 per cent of regular hours. In this situation, hospitals may have enrolled any VMO deemed to be an employee who worked at least 20 per cent of normal hours, in the Hospitals Superannuation Fund.

4.52 Audit established that the Department had made no attempt to determine the number of sessional VMOs for whom contributions were being made to the Hospitals Superannuation Fund by public hospitals and, as a consequence, had not taken action to eliminate the double payment of superannuation contributions.

4.53 Notwithstanding the EBRC's 1985 recommendation, and the Government's 1988 commitment to take action, the Department has not taken any action to make an appropriate adjustment to sessional rates to ensure that there is no double payment of superannuation to sessional VMOs.

- *RESPONSE provided by Secretary to the Department*

  The advent of the Employee Relations Act will enable hospitals to take the opportunities available to them to limit excessive superannuation payments.

PART 5

Fee-for-service Arrangements

BACKGROUND

5.1 Fee-for-service arrangements entitle a VMO to seek payment, in accordance with the Victorian Fee-for-Service Medical Officers Award, for every service provided to public patients treated in a public hospital to which the VMO has been granted visiting rights by the hospital's Board of Management.

5.2 Fee-for-service arrangements are used in the majority of Victoria's non-metropolitan hospitals and in small and medium-sized metropolitan hospitals.

POOR CLAIM MONITORING AND ACCOUNTABILITY

5.3 The EBRC's 1985 Report highlighted various concerns relating to the adequacy of control exercised by public hospitals over fee-for-service payments to VMOs and recommended that the Department and the VHA undertake discussions *"... with a view to the adoption of a uniform process for monitoring and reviewing the provision of medical services to public patients in public hospitals operating on a fee-for-service basis. Such a process should include:*

- *master claim sheets for each in-patient that are monitored by the Medical Director (or the Chief Executive Officer where there is no Medical Director) before payment is made to visiting medical officers; and ...*
- *the establishment of a peer group review process".*

5.4 The Government, in its April 1988 response to the Report, indicated that it aimed to *"... provide for audit and peer group review of the provision of medical services by undertaking discussions with the VHA and AMA for the adoption of a uniform process for monitoring and reviewing the provision of medical services to public patients in public hospitals that operate on a fee-for-service basis".* **Notwithstanding this undertaking, the audit review disclosed that no action had been taken by the Department.**

5.5 While it is appreciated that the responsibility for the verification and payment of fee-for-service claims rests with individual public hospitals, audit found that the Department had not issued any guidelines to hospitals on the adoption of a uniform process for monitoring and reviewing fee-for-service claims. In addition, the majority of hospitals had no formal input from their medical staff groups to assist in monitoring claims or in providing a peer review of the claims management process.

5.6 The audit review also revealed that deficiencies in hospital information systems did not enable hospital managers to undertake regular reviews of medical practices and VMO claim patterns. As a consequence, hospitals were collecting and reviewing only the most basic VMO data, such as total payments to each VMO on either a monthly or yearly basis, and undertaking the most rudimentary of checks, such as the confirmation of patient status, i.e. public or private/insured. Accordingly, hospitals were unable to ensure the optimum utilisation of VMO services.

5.7 Specifically, the following deficiencies were identified in the monitoring of fee-for-service arrangements by certain hospitals:

- Patient medical records were not updated and endorsed by VMOs to indicate evidence of service which would substantiate claims for consultations to hospital patients. Even where medical records were updated, there was no independent matching of VMO claims to patient medical records to ensure evidence of service performed;
- Checking of VMO claims, if conducted, was infrequent and superficial; and
- A lack of independent medical officer review of VMO claims prior to payment.

5.8 **The failure of individual fee-for-service hospitals to act upon the EBRC's specific recommendations in this area, together with the Department's failure to implement the actions proposed in its 1988 response, has resulted in such hospitals having inadequate control over VMO payments.**

5.9 Audit's findings confirmed that the EBRC's concerns relating to over-servicing and the need to improve accountability are still applicable. These matters are further discussed in the following paragraphs.

OVER-SERVICING BY VMOs

5.10 The EBRC's 1985 Report highlighted that, under the fee-for-service system, a financial incentive existed for VMOs to supply unnecessary services as the cost to the patient was zero, and the patient was unable to evaluate the need for the service. This practice is commonly referred to as "over-servicing".

5.11 An audit survey of the larger fee-for-service hospitals revealed that although some hospitals had reviewed their VMO payments for compliance with agreed verification procedures, **only one fee-for-service hospital had examined over-servicing** as an issue. In this instance, the hospital's Director of Medical Services found that there was no medical necessity for a significant number of VMO services performed at the hospital. In particular, the need for certain pre and post-operative consultations were questioned as were instances where general practitioners and specialists were attending patients simultaneously. The hospital responded to these findings by introducing improved guidelines for the provision of services by VMOs and establishing a medical review of claims and associated patient medical records, including the substantiation of the medical need for the service(s) provided.

5.12 Senior management at a number of hospitals, particularly smaller fee-for-service hospitals, advised audit that their current staff did not possess the necessary expertise to scrutinise VMO claims and, consequently, they relied on the integrity of their VMOs to ensure that services provided were medically necessary.

5.13 Given the above considerations, audit engaged medical experts from the Health Consulting Division of Deloitte Touche Tohmatsu to assess the extent of any over-servicing by VMOs.

5.14 The review of patient records and VMO claims, relating to 740 public patient admissions at 4 major fee-for-service hospitals, by audit's medical experts, disclosed *prima facie* evidence of over-servicing. The medical experts found that, in their opinion:

- in excess of 25 per cent of claims for assistance at surgery were in respect of non-complex procedures where assistance was not required;
- in excess of 40 per cent of claims for pre-operative visits by surgeons were not medically necessary;
- patients admitted by general practitioners (GPs) were visited by those GPs on a daily basis and, given the less acute nature of these cases, the frequency of attendances could be regarded as over-servicing; and
- with the exception of one hospital, patients under the care of consultant physicians were visited by the physician on a daily basis even when not medically necessary.

5.15 Given the deficiencies in the monitoring of VMOs, the apparent inability of hospital management to address these deficiencies, and the prima facie evidence of public patient over-servicing, audit agrees with the EBRC's recommendation that there is scope for the establishment of a departmental peer group review, comprising medical experts, to periodically assess the provision of medical services across the public hospital system. Hospitals will also need to involve their Directors of Medical Services in monitoring the provision of medical services against agreed standards so as to eliminate the potential for over-servicing.

- *RESPONSE provided by Secretary to the Department*

  As with sessional payments the Department supports the implementation of appropriate accountability measures within the hospitals but no longer consider it appropriate to recommend uniform processes for verification of claims.

  Hospitals have comprehensive management structures, and are independent corporate entities. They must assume responsibility for determining the need for medical services and accounting for payments.

Use of comparative data

5.16 In 1985, the EBRC recommended that the Department, as part of its role of monitoring the provision of medical services in fee-for-service hospitals, develop the use of *"... comparative statistics on medical services provided by visiting medical officers".*

5.17 Despite the potentially significant wastage of taxpayer funds arising from medical over-servicing, the Department had not taken any action to specifically utilise comparative data relating to services provided to public patients by VMOs, or to examine medical servicing patterns across the State, for the purposes of identifying the nature and extent of this practice.

5.18 In order to determine the usefulness of departmental data for comparative purposes, audit examined 1991-92 departmental data for public patients in public hospitals, excluding specialist hospitals, and concluded that such data could be used to identify areas requiring management attention. The usefulness of this data was illustrated in a comparison of the incidence of a common obstetrical procedure per birth, where a VMO was paid a specific fee, with the number of incidences per birth, where no fee was payable. The comparison showed that VMOs in fee-for-service hospitals who were able to charge a specific fee conducted 15 per cent more of these procedures per birth compared with VMOs in sessional hospitals who were unable to charge such fees. In addition, the incidence of this particular procedure at selected hospitals where fee-for-service arrangements applied was up to 2.5 times higher than at certain sessional hospitals.

5.19 Although audit is not questioning the medical necessity for this particular procedure, the review highlights the usefulness of comparative medical service analyses in identifying areas which may require further attention by the Department.

5.20 Because of the comparability of currently held system-wide data, the Department should make greater use of such information to identify areas warranting further management attention.

- *RESPONSE provided by Secretary to the Department*

  The Department will investigate the continuing use of system-wide statistical data to alert hospitals to prima facie evidence of over-servicing.

OPPOSITION BY VMOs TO IMPROVED ACCOUNTABILITY

5.21 A number of hospitals have attempted to change existing procedures associated with fee-for-service arrangements to enhance VMO accountability requirements. However, as illustrated below, such attempts have often met with strong resistance from VMOs within each hospital. In fact, 10 of the State's 16 largest fee-for-service hospitals advised audit that they have experienced opposition from their VMOs in response to particular initiatives to improve accountability. This reaction was more prevalent in non-metropolitan hospitals where specialist medical practitioners were often in short supply, resulting in the VMOs being in a stronger position to influence hospital Boards of Management.

5.22 While most VMO opposition related to one or more aspects of particular VMO arrangements, one base hospital advised audit that *"... there is resistance to any service reduction or restriction, any policing, any extraneous reviews, and any review of clinical activities".*

Proposed introduction of billing systems

5.23 Of the 16 major fee-for-service hospitals, 7 advised audit that revised VMO payment arrangements were not implemented because of strong VMO opposition. In the case of one large base hospital, a billing sheet was introduced for completion by fee-for-service VMOs on each occasion a service was provided to public patients within the hospital. This system was expected to replace the practice of VMOs preparing and submitting their own accounts to the hospital. The hospital billing sheet was designed to accurately capture all relevant information relating to services provided by VMOs which was often not available in the accounts previously submitted by VMOs. The subsequent opposition and non co-operation of the VMOs resulted in the hospital abandoning the initiative and returning to past practices.

5.24 Audit established that this hospital currently detects incorrect VMO claims of up to $5 000 a month as a result of incorrect billing by VMOs, e.g. duplicate invoices, which imposes a substantial and unnecessary administrative cost on the hospital, including the employment of a full-time VMO clerk.

Proposed notation of medical records

5.25 Strong resistance was encountered from certain VMOs in response to attempts by a number of hospitals to require them to notate medical records on each occasion they attend patients. Hospital management advised audit that individual VMOs maintain that, unless there is a specific change in a patient's condition or a change in treatment is required, there is no necessity for a notation to be made in the medical record.

5.26 The following correspondence illustrates these concerns:

"A dispute has arisen at the Hospital in regard to the Hospital's right to audit and verify claims for payment made by Visiting Medical Officers for the treatment of public in-patients.

"The particular Visiting Medical Officer in question believes that the Hospital should accept and pay his claim for payment as presented, without the necessity to verify whether or not he had actually afforded the treatment for which a claim was being made.

"It is the Board of Management's firm belief that this is totally inappropriate and in fact on occasions I have refused payment for claims which could not be verified".

5.27 The Directors of Medical Services at a number of hospitals also expressed concern to audit that the absence of a notation in the medical record, apart from being against best medical practice, may not be defensible in litigation against the hospital or the VMO.

Proposed performance measures

5.28 A number of hospitals have encountered resistance in attempting to introduce both formal appointment contracts and performance indicators for VMOs. An audit survey of the State's 16 largest fee-for-service hospitals disclosed that:

- only 6 hospitals required their VMOs to sign formal contracts upon appointment; and
- management had introduced criteria to assess the performance of VMOs at only 4 hospitals.

5.29 Audit considers that VMO performance measurement should be an integral part of the duties of a Director of Medical Service, and be subject to a peer review initiated by the Department.

Overall comment on accountability

5.30 The divergent practices and differing accountability requirements within public hospitals, together with strong resistance by certain VMOs to change, has rendered the fee-for-service system vulnerable to manipulation and inefficiency. This unsatisfactory situation has been compounded by the lack of guidance and support to hospitals from the Department. Audit reiterates its previous comment that action needs to be taken by the Department to address the significant accountability deficiencies that currently exist.

- *RESPONSE provided by Secretary to the Department*

As stated previously, the Department strongly supports the implementation of appropriate accountability measures within hospitals, but considers that this is the responsibility of individual hospitals.

The casemix funding system, to be introduced from July 1993 will ensure that hospitals are paid by the State on a consistent basis for medical services performed. This will provide hospitals with a strong incentive to adopt accountable cost-effective practices.

THE VICTORIAN FEE-FOR-SERVICE AWARD

5.31 Victorian public hospitals engaging VMOs on a fee-for-service basis are required to comply with the Victorian Fee-for-Service Medical Officers Award. Other States have adopted the Commonwealth Medicare Benefits Schedule (CMBS) as part of their fee-for-service arrangements rather than introduce their own award.

5.32 While most fees under the Victorian Award are similar to those contained in the CMBS, there are significant differences in respect of fees payable for a number of services. The most significant differences relate to certain opthalmology services, e.g. lens extraction and artificial lens insertion. The CMBS fees for these procedures are $550 and $305, respectively, while the Victorian Award equivalent is $836 and $444. Audit considers that these and other differentials should be reviewed as part of any re-negotiation of fee-for-service remuneration arrangements.

5.33 The Victorian Award, introduced in 1987, was sharply criticised by all hospital managers and senior departmental officers contacted by audit. In addition, in 1992, the Association of Medical Directors of Victorian Hospitals prepared a paper critical of many aspects of the Award. Several specific audit criticisms detailed below are also referred to in the Association's paper.

Added administrative cost

5.34 An audit review of claims submitted by VMOs to fee-for-service hospitals revealed that a number of VMOs ignored the Victorian Award and quoted CMBS item numbers when billing public hospitals. Consequently, hospitals were required to translate the CMBS item numbers into their Victorian equivalents, necessitating significant additional clerical resources. Audit found that one major hospital ignored the Victorian Award and paid its VMOs using the Commonwealth Schedule.

5.35 **Ambiguities arising from the application of the Victorian Fee-for-Service Medical Officers Award and the added administrative burden experienced by hospitals in using the Award result in unnecessary costs being imposed on public hospitals. The Department should re-assess the desirability of maintaining the conditions contained in the Award, given that Victorian industrial awards are currently subject to re-negotiation.**

Lack of explanatory notes

5.36 Unlike the Commonwealth Schedule, the Victorian Award does not include explanatory notes to assist public hospital administrators in its interpretation and application. While the explanatory notes in the Commonwealth Schedule are generally accepted within the public hospital industry as applying to the Victorian Award, the Award does not specifically refer to the Commonwealth Schedule. Hospital managers and the Association expressed concern to audit that if the practice of interpreting the Victorian Award in the context of the Commonwealth Schedule was legally challenged, it may be found to be invalid.

Potential cost to the Government

5.37 The CMBS explanatory notes provide the following formula to be used to determine fees payable to surgical VMOs in respect of multiple procedures performed in a single operation:

- 100 per cent for the item with the greatest Schedule fee; plus
- 50 per cent for the item with the next greatest Schedule fee; plus
- 25 per cent of the Schedule fee for each other item.

5.38 The July 1992 issue of the *AMA Victorian Branch Newsletter* contained the following reference to the Victorian Award:

> *"Did you know that under the Fee-for-Service Medical Officers Award there are no rules and preceding notes as in the Commonwealth Medicare Benefits Schedule.*
>
> *"Practitioners should be aware of this, particularly with regard to billing for multiple operations. There is no multiple operation rule and therefore 100 per cent of the Fee-for-Service fee should be billed for each item ...*
>
> *"Practitioners are advised to submit all current accounts in full and where this has not been done in the past, a 12 month back pay rule can be invoked. Practitioners should find records for the past 12 months and where any unilateral discounting has been applied by the hospital, or the full fees were not been billed by the practitioner, submit amended past accounts to the hospital".*

5.39 As a result of the Newsletter, a number of VMOs submitted back-dated claims for 12 months to public hospitals, based on 100 per cent item billing for all services provided. The claims were forwarded to fee-for-service hospitals, accompanied by a covering letter which expressed similar sentiments to the following example:

> *"We are instructed by the AMA that some patients in the last twelve months have been incorrectly billed ... In accordance with this directive from the AMA, this amended account is submitted".*

5.40 Audit found that fee-for-service hospitals were advised by the Department to continue to apply the CMBS multiple procedures discounting formula and that hospitals have complied with the Department's direction. In a letter to the AMA, in August 1992, the Department advised that *"... the Award needs to be read in line with the CMBS procedures as it has always been regarded as the underpinning basis of the Fee-for-Service Medical Officers Award".*

5.41 To date, hospitals have resisted demands for payment, although the matter is yet to be resolved. Based on advice from senior hospital management, **audit estimated that the non-application of the multiple procedure rule would add around 25 per cent, or $14 million annually, to VMO costs in fee-for-service public hospitals**.

- *RESPONSE provided by Secretary to the Department*

  The Victorian Fee-for-Service Medical Officers Award was made by the Hospital Remuneration Tribunal (HRT) on 27 September 1988 but was deemed to have come into effect on 1 November 1987. From 22 July 1987, however, following an industrial dispute involving the AMA threatening the withdrawal of medical services in rural hospitals, there had been an agreement between the AMA and the Government over the payment arrangements for fee-for-service VMOs. This interim fee agreement formed the operational basis of the subsequent award, and was appended to the final Award document. It is this list of fees which has been subject to enduring criticism for its variation from the Commonwealth Medical Benefits Schedule (CMBS) and for the lack of explanatory notes.

  Prior to 22 July 1987, the Industrial Relations Division of the Department advised that fee agreements should be linked to the CMBS but that no award should be struck because fee-for-service VMOs were independent contractors. The negotiation of the Award was led by the then Minister for Health and his staff. Key documents and negotiating positions were signed and endorsed by the Minister, against clear departmental advice.

  The Department has consistently held that the basis for the Award was the CMBS and that the CMBS rules apply, save where specific differences have been agreed. This view has been supported by the HRT. The AMA does not accept this nexus and, as identified by audit, has been prepared to use the Award as a tool in industrial disputes.

PART 6

Medicare Payments for Public Patients

BACKGROUND

6.1 As previously mentioned, VMOs are remunerated by public hospitals for services provided to public patients, either on a sessional or fee-for-service basis. In contrast, for services provided to private patients, VMOs (and other providers of medical services) are paid by Medicare, either directly by bulk billing, or indirectly, by billing the patient who subsequently claims reimbursement (up to a set percentage of the scheduled fee) from Medicare.

6.2 While the Commonwealth's Health Insurance Commission (HIC) monitors the claims made by medical practitioners under Medicare, the HIC surveillance system cannot monitor payments made to VMOs by public hospitals due to confidentiality provisions contained in the Victorian *Health Services Act* 1988.

6.3 Under the Victorian legislation, the HIC does not have an automatic right of access to public hospital records, including patient medical records and VMO payments. However, the Victorian legislation does provide the Minister for Health with a discretion to grant access to otherwise confidential information if, in the Minister's opinion, it is in the public interest.

6.4 Similar confidentiality restrictions apply under the Commonwealth *Health Insurance Act* 1973 which prevent the disclosure of Medicare data to external bodies, including State Health Departments and individual public hospitals. The Commonwealth Minister for Health also has the prerogative to provide access to restricted data.

6.5 Both the EBRC, in 1985, and the New South Wales Public Accounts Committee, in its 1989 Report, identified the need for a cross-checking mechanism to be established between State and Commonwealth Governments to prevent and detect VMOs who, having been fully remunerated by public hospitals for services provided to public patients, are also paid by Medicare for the same services.

6.6 In particular, the EBRC was concerned with the potential for VMOs to receive dual payment for aftercare (i.e. post-operative care) services and recommended that *"... the Victorian Government initiate discussions with the Commonwealth with a view to establishing a mechanism for monitoring fee-for-service payments to doctors for the provision of aftercare to public patients".*

6.7 **To date, the Department has still not taken any action to develop suitable arrangements with the Commonwealth to address the potential for VMOs to receive reimbursement from both Medicare and public hospitals for the provision of the same medical service.**

- *RESPONSE provided by Secretary to the Department*

Neither the Department nor hospitals have access to identifying information from the HIC Medicare data base. The confidentiality provisions of the Victorian Health Services Act allow for information to be provided at ministerial discretion, when provision of information is deemed to be in the public interest. The Department believes that this power should be used more aggressively than in the past. The Department has never been requested by the Commonwealth to provide routine information on VMO billing for monitoring purposes. Following the report by audit, it would clearly be appropriate for the Commonwealth and State Governments to consider legislative amendment to allow systematic monitoring.

REVIEW OF MEDICARE/HOSPITAL PAYMENTS TO VMOs

6.8 In view of the concerns raised by the 2 parliamentary committees regarding the absence of an established Commonwealth/State cross-checking mechanism and the Department's lack of action to establish such a mechanism, audit undertook a review to determine whether there had been instances of VMOs receiving payment from both Medicare and any Victorian public hospital for the provision of the same medical service to a public patient.

6.9 Audit reviewed a large selection of VMO payments relating to public patient admissions in 23 public hospitals across Victoria and compared relevant details with Medicare payments data.

6.10 The review revealed a number of *prima facie* irregular payments made to VMOs and other medical service providers for services provided to public patients in public hospitals. Specifically, **11 per cent of public patient admissions** examined by audit, **involving payments to 49 medical practitioners, had at least one payment considered to be irregular.** In addition, the review highlighted that in respect of **a further 7 per cent of public patient admissions** examined by audit **certain costs, which were the responsibility of the State, were effectively transferred to the Commonwealth by public hospitals**.

6.11 As previously mentioned in Part 3 of this Report, due to the secrecy provisions of the Commonwealth *Health Insurance Act* 1973 and the Victorian *Health Services Act* 1988, **it was not possible for these findings to be confirmed with the relevant VMOs and public hospitals.**

6.12 The *prima facie* irregularities identified by audit are discussed, in detail, in the following paragraphs.

PRIMA FACIE IRREGULAR PAYMENTS TO VMOs AND OTHER MEDICAL PRACTITIONERS

6.13 The Medicare surveillance system should detect and reject duplicate medical practitioner claims, such as 2 initial visits relating to the same series of specialist consultations, or consultation charges for consequential aftercare visits customarily provided after surgery or confinement for which the medical practitioner has already been paid by Medicare. However, if, in respect of a public patient, a medical practitioner who is also a VMO seeks reimbursement for these services from the public hospital and from the patient (by either directly billing Medicare or billing the patient who would seek reimbursement from Medicare), the absence of a cross-checking mechanism will allow both claims to be paid without detection.

6.14 The audit review disclosed *prima facie* evidence of instances where VMOs and other medical practitioners, such as general practitioners without visiting rights, had received payment from both public hospitals and Medicare for the provision of the same service and, due to the lack of a cross-checking mechanism, these duplicate payments had gone undetected. Table 6A provides a summary of these, and other irregular payments.

TABLE 6A. PRIMA FACIE IRREGULAR PAYMENTS TO VMOs AND OTHER MEDICAL PRACTITIONERS

Type of irregularity	*No. of admissions*	*No. of irregular payments made*	*No. of VMOs and other medical practitioners involved*
Aftercare consultations paid by both Medicare and hospital	44	47	29
Initial specialist consultations paid by both Medicare and hospital	6	6	6
Postnatal and antenatal consultations paid by both Medicare and hospital	5	7	5
GPs with no visiting rights, or VMOs not the treating doctor, paid by Medicare for hospital patient consultations with no evidence of service	4	9	4
Anaesthetists paid by Medicare for pre-operative examinations with no evidence of service	3	3	2
VMOs paid by both hospital and Medicare for the same service	4	10	5
Hospital full-time medical officer charging public patient	1	1	1
Sub total	67	83	52
Less medical practitioners involved in more than one type of irregularity	-	-	3
Total	**67**	**83**	*(a)* 49

(a) Includes 45 VMOs.

6.15 Specifically, the audit examination disclosed:

- 47 Medicare payments involving 44 patients (23 per cent of relevant patients in the audit sample) where surgeons claimed for post-operative consultations subsequent to the patient's discharge after payment had been made by the fee-for-service hospital for the surgery *and* aftercare. As the aftercare component represents typically between 25 and 33 per cent of the surgical fee, VMOs at these hospitals who charge patients for post-operative consultations are effectively paid twice for providing the same service;
- Consultant physicians and surgeons charging the patient an *initial* consultation fee prior to admission and claiming from the hospital another *initial* consultation fee when the patient was admitted as a public in-patient, instead of charging a *subsequent* consultation fee, which is substantially lower. The difference between an *initial* and *subsequent* consultation fee charged by a VMO is up to $55 in each instance;
- VMOs charging hospitals for antenatal visits even though a claim had been made against Medicare for the maximum prescribed number of consultations, which covered all antenatal care; and
- VMOs inappropriately charging the patient (after discharge) for postnatal consultations even though the hospital had paid the VMO an "all-inclusive" fee to cover confinement *and* postnatal care.

6.16 Examples of these, and other alleged irregular payments, have been detailed in Appendix C.

6.17 The failure of the Department to establish a monitoring mechanism for medical practitioner payments has created the potential for VMOs to take financial advantage of the separate Commonwealth/State systems and allow duplicate and other irregular payments to be made without detection, which would add to the overall health costs borne by taxpayers.

6.18 As a minimum, there is a need for a release of relevant information between Commonwealth and State authorities, which would provide an appropriate framework for the detection of irregular payments.

6.19 Once this Report has been tabled in the Parliament, **subject to the approval of the Victorian Minister for Health, in accordance with the provisions of the Health Services Act 1988, relevant hospital data, including patient details, will be released to the HIC so that these apparent irregularities can be fully investigated.**

- *RESPONSE provided by Secretary to the Department*

  The Department supports the approach being taken by the Auditor-General.

  Illegal or fraudulent billing practices are regarded by the Department as totally unacceptable. Any medical practitioners identified as deliberately involved in such practices should be subjected to dismissal and criminal prosecution.

COST SHIFTING FROM STATE TO COMMONWEALTH

6.20 The Commonwealth *Health Insurance Act* 1973 states that a Medicare benefit is not payable in respect of a professional service if *"... the medical expenses in respect of that service have been paid, or are payable, to a recognised hospital".* In addition, *"... a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:*

- *the Commonwealth; or*
- *the State".*

6.21 The Medicare Agreement also states that care and treatment *"... will include the provision of* [public] *in-patient, out-patient, casualty and emergency, and day patient services in metropolitan and rural areas ... consistent with acceptable medical and health practices in the State ..."* and *"... the State will ensure that ... aftercare services for public patients ... do not attract claims for Medicare benefits".*

6.22 Therefore, no individual admitted to a public hospital as a public patient may be charged for any treatment or medical service received in a public hospital and the Commonwealth cannot be charged through Medicare for such services. These costs are the responsibility of the State and are funded through a combination of Commonwealth grants and State revenues.

6.23 The review disclosed 76 instances, involving 9 public hospitals, where **the cost of providing medical services to public in-patients had been shifted by the hospitals from the State to the Commonwealth.** Table 6B provides a summary of these findings.

TABLE 6B. INSTANCES OF COST SHIFTING TO THE COMMONWEALTH FOR SERVICES PROVIDED BY PUBLIC HOSPITALS TO PUBLIC IN-PATIENTS

Type of service	*No. of admissions*	*No. of irregular payments made*	*No. of public hospitals*
Pathology services	22	39	6
Radiology services	8	12	4
VMO consultations and surgical procedures paid by Medicare, not hospital	15	25	8
Sub-total	45	76	18
Less hospitals involved in more than one type of irregularity	-	-	9
Total	**45**	**76**	**9**

6.24 The majority of instances, included in the above table, involved the cost of providing medical services, such as pathology and radiology, to public in-patients being inappropriately billed to Medicare rather than to the hospital. Audit could not determine whether such cost shifting was encouraged by the hospitals or the Department.

6.25 As a consequence of these practices, which are contrary to the Medicare Agreement and the Commonwealth *Health Insurance Act* 1973, hospitals have been able to recover from the Commonwealth part or all of the costs associated with the provision of certain public in-patient services while maintaining the existing level of public hospital grants.

6.26 An audit review of public hospital records in respect of 330 private patients indicated no instances where VMO costs were met by public hospitals. This indicated that **public hospitals carefully scrutinised VMO claims to ensure that private patient costs were not inadvertently met from the public purse. It is ironic that such diligence was not applied to claims in respect of public patients.**

PART 7

Restrictions on Public Patient Admissions

BACKGROUND

7.1 The Medicare Agreement between the Commonwealth and the State stipulates that any person who elects, on admission as an in-patient to a public hospital, to be a public patient shall receive care and treatment at no cost to the patient. The Agreement also provides that *"The State will ensure that a person's health insurance or financial status or intention in respect of an election* [to be a public patient] *will not be a determinant in the priority for receiving care and treatment".*

7.2 In recent years, the percentage of Australians covered by private health insurance has declined. This trend was highlighted in a recent Private Health Insurance Administration Council publication which revealed that the percentage of Australians covered by private health insurance had decreased from 47 per cent in 1988 to below 41 per cent in 1992.

7.3 The Victorian situation was referred to in a December 1992 submission by the State Government to the Senate Standing Committee on Community Affairs examining the Medicare Agreements Bill 1992. The submission noted that *"... since 1988 the proportion of persons with private health insurance has been declining at a rate of about one per cent per annum"* and, in the past year, *"... the rate of decline has increased to around 3 per cent".*

INCENTIVES FOR HOSPITALS TO TREAT PRIVATE PATIENTS

7.4 As a consequence of the community progressively withdrawing from private health insurance schemes, public hospitals have experienced an increase in the number of persons electing to be treated as public patients.

7.5 The review established that problems associated with mixed theatre lists at sessional hospitals, as outlined in Part 4 of this Report, provide a financial incentive for VMOs to give preference to private patients. In addition, because of current public hospital funding arrangements, a similar incentive exists for public hospitals as the net costs of private patients to public hospitals are substantially lower than for public patients. This is due to certain costs, such as VMO payments, being borne by external sources.

7.6 The net saving to hospitals from the admission of private patients in preference to public patients was clearly illustrated in the 1990-91 Annual Report of a fee-for-service hospital. The report stated that:

> *"Hospitals like ours pay doctors on a basis known as fee-for-service. Each doctor is paid a separate fee for each service provided on the hospital's behalf* [to] *each public patient, whether it is an operation for a surgical patient or a consultation for a medical patient.*
>
> *"Private patients pay their doctor for their operation or for visits while they are in hospital, and they pay a daily fee to the hospital for accommodation and nursing care ...*

"Public patients pay nothing to the hospital for accommodation and nursing care. More importantly, our hospital pays their doctor for their operation, or for visits while they are in hospital.

"There has been criticism of public hospitals giving preferential access to private patients because there are financial benefits in treating private patients. It seems paradoxical and unfair that because our hospital is faithful to its role as a public hospital, it does not share in those financial benefits and is at the same time financially penalised because of the shift to public [patients] *over which it has no control".*

Fee-for-service hospitals

7.7 The majority of fee-for-service hospitals restrict total patient admissions by allocating an annual patient quota to each VMO. The quota may limit the number of total admissions or restrict specific (usually expensive) medical procedures, e.g. joint replacements. However, the audit review disclosed that, in an apparent attempt to limit the growth in public patient numbers, certain of these hospitals had, in recent years, established VMO public patient quotas, with no corresponding limit placed on private patient admissions.

7.8 Of the 13 major fee-for-service hospitals covered by audit on this issue, 4 confirmed that they had imposed public patient quotas for VMOs with no corresponding limit imposed for private patients. Another hospital advised audit that during the 8 weeks of the year generally regarded by the industry as *holiday periods*, e.g. Christmas and other school holiday periods, their operating theatre was closed to public elective patients but open for emergency and private elective patients. The impact of this decision was that the hospital could increase its private patient admission numbers.

7.9 One of the 4 hospitals, which included public patient limits in its VMO quotas, commented on the effect of this policy in its 1990-91 Annual Report. The hospital reported that:

"In the last edition of this Report, the ratio of public/private acute in-patients was 80/20 which was one of the highest levels of public patient classifications in Victoria. Concerted efforts were made to increase the number of private patients towards a target of 70/30 public/private patients in 1990-91. At the end of June 1991, the ratio of public/private acute in-patients was 67/33. This vastly improved performance can be attributed to a more effective admissions procedure and an offer of enhanced benefits to patients who elect to be admitted privately.

"The decrease in the number of public patients has meant a reduction in VMO costs and provided a stimulus to our cash flow from increased revenue. The increase in private patients also has a flow-on effect to pathology and radiology receipts".

7.10 The hospital concerned advised audit that the waiting time of public patients for elective surgery had increased, as a result of this practice.

7.11 The negative impact of this practice on public patients assigned to hospital waiting lists was highlighted by a VMO's advice to hospital management when such restrictions were first imposed on his services:

"I am writing to clarify advice given to me by your staff recently, concerning the Orthopaedic Service at [your] *Hospital. To be precise, I was told that there would be no further Joint Replacements, other than on privately insured patients, after Christmas 1991 ...*

"I had patients booked for Total Joint Replacement up until April 1992. Many of these patients are severely disabled and have no possible chance of being treated elsewhere within an appropriate period of time.

"As you may well know, the waiting time for such cases is up to 3 years at Monash [Medical Centre] *and 18 months to 2 years at Frankston* [Hospital]*".*

7.12 The imposition of restrictive public patient admission practices in certain fee-for-service hospitals, primarily for budgetary purposes, together with the increased public patient demand for elective surgery, adversely impacts on the ability of the Government to reduce public patient waiting list numbers.

- *RESPONSE provided by Secretary to the Department*

  The Department will review any pattern of incentives which causes hospitals to increase private patients at the expense of public patients. The issue will be addressed in the Department's casemix funding arrangements to be introduced from July 1993.

Sessional hospitals

7.13 Audit examined the admission practices at 9 of the 18 sessional hospitals and determined that:

- public patient quotas for elective surgery were not imposed, although it was found that one hospital offered a fertility program primarily to private patients; and
- VMO specialists effectively administered waiting lists and/or allocated waiting list patients for surgery, in 6 of the 9 hospitals.

7.14 The review found that, despite the effect of a decline in private health insurance coverage in recent years, resulting in an increase in public patient demand for elective surgery, there had been negligible change in the mix of private and public operating theatre times at sessional hospitals to reflect the increased demand imposed by public patients. Instead, the increased demand had been reflected in increased public patient waiting lists.

7.15 Management at a number of these hospitals advised audit that, while they did not support or encourage this situation, it was substantially beyond their control as current funding prohibited the allocation of additional operating theatre sessions for public patients at their respective hospitals.

7.16 In addition, as a consequence of the use of mixed theatre lists, which was discussed in Part 4 of this Report, VMOs at the majority of sessional hospitals are potentially paid twice when treating private patients on publicly-funded lists, thereby providing a financial incentive for VMOs to give preference to private patients. At sessional hospitals where VMOs effectively administer elective surgery waiting lists and/or the process of allocating patients to operating theatre lists, management at these hospitals, which includes the Director of Medical Services, were not in a position to ensure the admission of all patients on a clinical needs basis.

ARE PRIVATE PATIENTS GIVEN PREFERENTIAL TREATMENT?

7.17 Audit attempted to quantify the impact of the previously discussed restrictions and incentives relating to hospital admission practices by analysing monthly *elective surgery activity returns* submitted by hospitals to the Department. However, in February 1993, the Department responded to audit indicating that:

"This data has never been analysed since collection first began about 1 year ago. It has become clear that the data collected is at best inconsistent, and that some hospitals either do not provide the relevant data or else the data is without doubt incorrect ...

"As a consequence of the data being incomplete and inconsistent, I am reluctant to release it, as any reference drawn from it would be questionable".

7.18 This response illustrates **the Department's lack of attention to analysing the reasons underlying the increase in public patient waiting list numbers, a matter of considerable concern to the public.**

7.19 Audit reviewed the June 1992 *elective surgery activity returns* for 10 sessional hospitals (representing 34 per cent of the State's patient treatment capacity) which had attempted to accurately complete the returns, i.e. by including details of the health insurance status of waiting list patients. The analysis revealed that 2 per cent of waiting or delayed elective surgery patients at 30 June 1992 were classified as insured. In contrast, private patients undergoing elective surgery during June 1992 represented 32 per cent of total elective surgery admissions at those hospitals.

7.20 While audit did not test the validity of the data included in the returns, management at certain sessional hospitals advised that insured waiting list patients that were not allocated to an operating theatre list were negligible while uninsured patients often waited up to 2 to 3 years for a confirmed operating theatre booking.

7.21 Contrary to the Medicare Agreement and the clinical need of patients, evidence suggests that private patients are given a higher priority for elective surgery than public patients as a consequence of restrictive admission practices adopted by certain public hospitals.

- *RESPONSE provided by Secretary to the Department*

  The Department is confident that the introduction of casemix funding will dramatically change the nature of public hospital service provision in Victoria and that inappropriate practices by hospitals will not continue.

PART 8

Cost Comparison, Fee-for-service and Sessional Arrangements

MORNINGTON PENINSULA HOSPITAL

8.1 In 1975, when sessional arrangements were introduced into Victorian public hospitals, the Department considered that VMO sessional arrangements were cost-effective at hospitals that had a capacity of more than 100 beds. However, the Frankston Community Hospital, which at that time had 163 beds, adopted the fee-for-service arrangement for the engagement of its VMOs. In February 1992, the Frankston Community Hospital and the Southern Memorial Hospital, located at Rosebud, were amalgamated to form the Mornington Peninsula Hospital.

8.2 Between 1978 and 1984, the Hospital and the Department made several attempts to change to sessional VMO arrangements. However, as stated in the EBRC's 1985 Report, no change occurred *"... due to staunch opposition from the Hospital's Medical Staff Association and the Victorian Branch of the AMA"*.

8.3 By 1985, when the EBRC inquired into the methods of remuneration applying to VMOs at Victorian public hospitals, the Frankston Community Hospital had grown from 163 beds to 195 beds. The EBRC's mandate was to:

> *"... inquire into, report and recommend on the method of remuneration for visiting medical staff at public hospitals having particular regard to the Frankston Community Hospital".*

Mornington Peninsula Hospital - Frankston Campus, 1992.

8.4 To assist in its inquiry, the EBRC engaged medical experts to compare the fee-for-service arrangement operating at the Hospital with a hypothetical sessional system.

8.5 Based on the analysis provided by its medical experts, the EBRC concluded that significant cost savings relating to VMO services could be achieved from the introduction of in-hours sessional arrangements at the Hospital. Therefore, the EBRC recommended that the Hospital *"... begin negotiations with* [its] *Visiting Medical Officers with a view to the early introduction of a (partial) sessional payment system of remuneration".*

8.6 In April 1988, the Minister for Health, in responding to the 1985 EBRC Report, indicated that the Hospital would need to review its VMO arrangements as the *"... current building program will increase bed numbers to 300 and will result in the hospital assuming a more complex role".* However, **no steps were taken by the Department to implement the EBRC recommendation to reconsider VMO arrangements at the Hospital.**

8.7 In 1991, the Chief Executive Officer of the Hospital initiated discussions with the Medical Staff Association culminating in an internal review of existing VMO arrangements.

8.8 Following the review, the Hospital put forward a number of proposals for revised arrangements, which were rejected by the Medical Staff Association. In January 1992, a medical consulting firm was engaged by the Hospital to undertake an independent assessment of payment methods and to make recommendations for the remuneration of VMOs at the Hospital.

8.9 The consultant's report, which was submitted to the Hospital's Board of Management in September 1992, **identified annual savings of approximately $2 million** if sessional arrangements were introduced for its VMOs.

8.10 From March 1993, the Hospital, with the agreement of its Medical Staff Association, commenced using a system of sessional payments for its VMOs.

8.11 Based on the 1992 consultant's analysis of VMO costs incurred by the Hospital, audit estimated that the delayed introduction of sessional VMO arrangements had resulted in the Hospital, and taxpayers, incurring additional VMO costs of around $8 million since 1986.

- *RESPONSE provided by Secretary to the Department*

  Audit should recognise that the Department led initiatives to change from fee-for-service to sessional arrangements at Frankston Hospital during the early to mid 1980s. The failure of these initiatives relates to the will and strategy directions of the then Government, not its executive arm. The matter was taken up again by the Department and the Board and Executive of the newly amalgamated Mornington Peninsula Hospital in 1991 and working closely together, the 2 parties were able to overcome strong opposition by the AMA and the Hospital's medical practitioners to introduce sessional arrangements appropriate to the expanded role of the Hospital.

COST SAVINGS FROM THE WIDER INTRODUCTION OF SESSIONAL ARRANGEMENTS

8.12 In its 1985 Report, the EBRC concluded that medium-sized fee-for-service hospitals with increasing patient throughput could reduce their VMO costs by introducing sessional arrangements. The Report stated that:

> *"... the Department should undertake a systematic evaluation of the relative economies of fee-for-service and sessional remuneration in all medium-sized public hospitals currently using fee-for-service arrangements. The hospitals involved should then commence discussions with appropriate representatives of the visiting medical staff with a view to introducing at least a partial sessional system of remuneration where it would be the most economical method of providing medical services".*

8.13 The audit revealed that, despite significant increases in patient throughput at a number of fee-for-service hospitals since 1985, the Department had not acted on the EBRC's recommendation to review the relative cost-efficiencies of introducing sessional arrangements in all medium-sized public hospitals.

8.14 Using a benchmark of a minimum of 3 000 annual public in-patients treated to denote a medium-sized public hospital, which is broadly consistent with the 1975 benchmark of 100 beds used by the Department to initially determine hospitals where sessional arrangements would be cost-effective, audit identified that **15 fee-for-service hospitals were of a size that would support sessional arrangements.**

8.15 By comparing 1991-92 departmental data on average medical officer costs per public in-patient for medium-sized fee-for-service hospitals and sessional hospitals, audit determined that potential **aggregate annual cost savings in the order of $8 million were available to these hospitals** (excluding Frankston Community Hospital) if VMOs were engaged on a sessional basis.

8.16 Based on the above calculations, the failure of the Department to act on the EBRC's recommendation to introduce sessional VMO arrangements at the Frankston Community Hospital and 15 other hospitals has resulted in the State forgoing savings in excess of $50 million since 1986. These savings are predicated on the immediate acceptance by VMOs of sessional arrangements.

- *RESPONSE provided by Secretary to the Department*

  Formal responsibility for administering payment mechanisms belongs with each hospital board. The Department recognises that sessional payments may well provide significant cost advantages over fee-for-service arrangements in many hospitals where the latter system presently predominates. The recently released discussion paper on casemix funding provides a uniform level of reimbursement for the medical costs of public patients, based on sessional rates, regardless of whether hospitals adopt fee-for-service or sessional arrangements. It thus provides an incentive to the hospitals to adopt the most cost-effective way of obtaining medical services.

PART 9

Government Response to EBRC Recommendations

LACK OF ACTION BY THE DEPARTMENT

9.1 In August 1985, the Governor-in-Council, in accordance with the provisions of the *Parliamentary Committees Act* 1968, requested the EBRC to *"... inquire into, report and recommend on the method of remuneration for visiting medical staff at public hospitals having particular regard to the Frankston Community Hospital"*.

9.2 In October 1985, the EBRC presented its findings to the Parliament through its Report entitled *Report of the Inquiry into the method of Remuneration for visiting medical staff at Public Hospitals*.

9.3 The *Parliamentary Committees Act* 1968, requires that, where a committee recommends in a report to the Parliament that the Government undertakes particular actions, the responsible Minister is required, within 6 months of the report being tabled, to provide a response to the Parliament indicating what action, if any, is proposed to be taken in respect of the committee's recommendations.

9.4 Notwithstanding the above legislative requirement, in the case of the EBRC's 1985 Report, the Minister for Health did not provide a response to the Parliament until April 1988, some 2 years after the legislated deadline for such a response had expired.

9.5 In addition, a recurring theme of this audit review has been that, despite the commitment for action given in the 1988 response, the Department has failed to implement any substantial action to overcome the significant weaknesses in VMO arrangements identified by the EBRC. As a consequence, significant opportunities to achieve identified cost savings have been forgone.

9.6 In order to ensure that commitments made by the Government in response to parliamentary reports are honoured, consideration could be given to reviewing the legislative provisions relating to parliamentary committee operations with a view to requiring committees to ascertain, within specified timeframes, whether their recommendations have been subsequently addressed.

Appendix A

Comparison of costs for elective surgery at fee-for-service and sessional hospitals

INTRODUCTION

Advice provided by audit's medical experts, illustrates the differences that can occur in VMO costs borne by public hospitals, which are detailed below, under sessional and fee-for-service systems.

The VMO costs associated with 4 public hospital admissions, involving elective general surgery, are compared for sessional and fee-for-service hospitals. These examples, comprising major and minor procedures, which could typically be undertaken during one standard (3.5 hour) operating theatre session, are:

- 2 repairs of femoral or inguinal hernias (major procedures); and
- 2 gastroscopies (minor procedures).

ASSUMPTIONS APPLICABLE TO THE EXAMPLE

Remuneration rates

- Sessional rates are in accordance with the Victorian Sessional Medical Officers Determination for specialists with 3 years experience, including on-costs.
- Fee-for-service rates are in accordance with the Victorian Fee-for-Service Medical Officers Award.

Assumptions - Based on advice provided by audit's medical experts

- For hernia repairs, assume 3 post-operative visits by surgeon: 2 as an in-patient and one as an out-patient.
- For gastroscopy cases, assume one out-patient post-operative visit only.
- For hernia repairs, assume intravenous infusion of fluids required during operation.
- For pre-operative initial visits, assume both surgeon and anaesthetist consult 12 patients per session. For post-operative visits, assume the surgeon consults 16 patients per ward session and 12 patients per out-patients session.
- For pre-operative initial visits by surgeon, assume these occurred subsequent to the patient's admission to the hospital.

	Rate ($)	*($) Rounded*
COST AT FEE-FOR-SERVICE HOSPITAL		
Pre-operative initial visits -		
Surgeon	4 x 60.60	242
Anaesthetist	4 x 30.50	122
		364
Operating theatre -		
Surgeon -		
Hernia repair	2 x 328.20	656
Gastroscopy	2 x 160.10	320
Anaesthetist -		
Hernia repair(Units)	2 x 8 units x 12.05	193
Hernia repair (IV)	2 x 25.45	51
Gastroscopy (Units)	2 x 6 units x 12.05	145
		1 365
Post-operative care -		
Included as a component of surgical fee		-
Total VMO costs		**1 729**
COST AT SESSIONAL HOSPITAL		
Pre-operative initial visits -		
Surgeon -		
Composite ward session, 12 patients per session	$336 x 0.083 x 4	112
Anaesthetist -		
Composite ward session, 12 patients per session	$336 x 0.083 x 4	112
		224
Operating theatre -		
Surgeon - one session		336
Anaesthetist - one session		336
		672
Post-operative care -		
Surgeon -		
Composite ward session, (Hernia patients only) 16 patients per session	$336 x 0.0625 x 2 x 2	84
Out-patients session, 12 patients per session	$336 x 0.083 x 4	112
		196
Total VMO costs		**1 092**
SAVINGS TO HOSPITALS UNDER SESSIONAL ARRANGEMENTS		**637**

Appendix B

VMOs working privately while on sick leave

The following examples relate to Medicare payments received by sessional VMOs, who were recorded as being on paid sick leave from their respective public hospitals at the time the private services were provided.

Case No. 1

A surgeon, while on paid sick leave for a continuous period of 7 months, performed 490 individual private services, including 63 major surgical procedures, e.g. knee reconstruction and arthroscopic surgery. Patients were charged fees totalling $43 915 in respect of these services. In addition, the VMO received $18 280 in sick leave payments from a public hospital.

Case No. 2

An obstetrician/gynaecologist, whose medical certificate stated that he was *"unfit to continue working as a visiting medical officer in obstetrics"*, performed 30 separate procedures over a period of several months, involving the delivery of babies while on paid sick leave from a public hospital.

Case No. 3

An anaesthetist, who provided a medical certificate for 12 days and was paid sick leave totalling $1 370, performed 35 private medical services, including the administration of an anaesthetic in respect of 17 separate operations, over the same period. Patients were charged fees totalling $2 265.

Case No. 4

A specialist, over a 4 day period, while on paid sick leave from a public hospital, performed 87 private medical services, charging fees totalling $3 833 over the period.

Case No. 5

A consultant physician, over a 12 day period, while on paid sick leave from a public hospital, performed 131 private medical services over the same period, charging fees totalling $11 905.

Case No. 6

A specialist, on a day's paid sick leave from a public hospital (one rostered session on that day), performed 33 private medical services in respect of 15 patients and charged a total of $899, on the same day.

Case No. 7

A psychiatrist, on a day's paid sick leave from a hospital (for which he had been rostered for one session), consulted 14 patients separately on the same day, charging fees of $1 263.

Appendix C

Alleged irregularities by VMOs

VMOs PAID BY HOSPITAL AND MEDICARE FOR THE SAME SERVICE

Case No. 1

Two VMOs working in the same private medical practice were legitimately paid by a non-metropolitan hospital for a total of 7 consultations to a public in-patient, an 84 year old woman, over a 5 day period. However, the VMOs were also paid by Medicare in respect of the same consultations.

Case No. 2

A specialist VMO consulted a 71 year old public in-patient at a medium-sized metropolitan hospital. The specialist was legitimately paid by the hospital for an initial specialist consultation. However, the VMO was also paid by Medicare for the same initial consultation.

Case No. 3

A specialist VMO consulted a 45 year old public in-patient at a base hospital. The VMO was paid by the hospital for an initial consultation. However, the VMO also was paid by Medicare for a consultation on that day. It transpired that Medicare had also been charged by the VMO for an initial consultation some 5 days earlier.

GPs WITH NO VISITING RIGHTS

Case No. 4

A GP, with no visiting rights to a particular metropolitan hospital, bulk billed Medicare for 4 separate consultations in respect of a 70 year old woman who was a public in-patient at that hospital over the period the consultations supposedly took place. There was no evidence in the hospital's patient medical record that the GP had visited the patient at any time over this period.

The HIC advised audit that the GP, not the patient, had signed each claim form with the notation:

> *"Patient too ill to sign"*; or
>
> *"Signed on behalf of patient who is unable to"*.

In addition, the Medicare number and other patient details were handwritten on each claim form, i.e., the patient's Medicare card was not used.

Case No. 5

A GP, with no visiting rights to a particular major teaching hospital, bulk billed Medicare for 3 separate consultations in respect of a 51 year old woman who was a public in-patient at the hospital over the period that the consultations supposedly took place. There was no evidence in the hospital's patient medical record that the GP had visited the patient at any time over this period.

Case No. 6

A GP, with no visiting rights to a certain metropolitan hospital, bulk billed Medicare for one "home visit" in respect of a 39 year old man, who was a public in-patient at the hospital at the time that the consultation supposedly took place. There was no evidence in the hospital's patient medical record that the GP had visited the patient at any time over this period.

VMO NOT THE TREATING DOCTOR

Case No. 7

A VMO, with visiting rights to a particular large non-metropolitan hospital, bulk billed Medicare for a specialist consultation in respect of a 68 year old woman who was a public in-patient at the time the consultation supposedly took place. In this instance, the VMO was not the treating doctor for this patient. Also, there was no evidence in the hospital's patient medical record that the VMO had visited the patient at any time over this period.

ANAESTHETISTS - NO EVIDENCE OF SERVICE

Case Nos. 8, 9 and 10

Three "low risk" patients, i.e. patients with medical conditions requiring types of surgery which were considered by the hospital to be low risk, underwent same-day surgery at a base hospital, with the anaesthetist conducting pre-operative examinations of the patients in the operating theatre immediately prior to surgery. The anaesthetist did not charge the hospital for these pre-operative examinations, although he did (legitimately) charge the hospital for administration of the anaesthetic and insertion of intravenous fluids in respect of each patient's operation. However, other anaesthetists, who were hospital VMOs, charged each patient for pre-operative anaesthetic examinations which supposedly took place between one and 3 days prior to the patients' admission to hospital.

Appendix D

Hospitals included in the audit review

SESSIONAL

The Alfred Group of Hospitals
Austin Hospital
Ballarat Base Hospital
The Bendigo Hospital
Box Hill Hospital
Dandenong Hospital
The Geelong Hospital
Maroondah Hospital
Mercy Hospital for Women Inc.
Monash Medical Centre
Peter MacCallum Cancer Institute
Preston and Northcote Community Hospital
Royal Children's Hospital
The Royal Melbourne Hospital
The Royal Victorian Eye and Ear Hospital
The Royal Women's Hospital
St Vincent's Hospital (Melbourne) Ltd
Western Hospital

FEE-FOR-SERVICE

The Angliss Hospital
Ararat and District Hospital
Casterton Memorial Hospital
Daylesford District Hospital
Gippsland Base Hospital
Goulburn Valley Base Hospital
Hamilton Base Hospital
Latrobe Regional Hospital
Mildura Base Hospital
Mordialloc-Cheltenham Community Hospital
Mornington Peninsula Hospital
Sandringham and District Memorial Hospital
St George's Hospital and Inner Eastern Geriatric Service
Wangaratta District Base Hospital
The Warrnambool and District Base Hospital
West Gippsland Hospital
The Williamstown Hospital
Wimmera Base Hospital
Wodonga District Hospital