PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

FIFTH REPORT TO PARLIAMENT

VICTORIAN PUBLIC HOSPITALS - ARRANGEMENTS WITH CONTRACTED DOCTORS

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In April 1993, the Auditor-General released a special report entitled 'Visiting Medical Officer Arrangements.' In his report, the Auditor-General identified deficiencies in the controls exercised over expenditure on visiting medical officer (VMO) services in public hospitals. Many of these deficiencies had been highlighted by the former Economic and Budget Review Committee in a 1985 report. Given the ongoing nature of the problems, the amount of money spent by Victorian public hospitals on the engagement of VMOs (in excess of $120 million per annum) and the fact that hospitals derive the majority of their funds from the public purse, the Committee believed that an Inquiry into visiting medical officer arrangements in public hospitals could provide substantial potential benefits.

The Auditor-General found that some hospitals had attempted to improve VMO accountability and had been unsuccessful due to resistance encountered from certain VMOs. The Committee believed that many of the deficiencies identified by the Auditor-General would not, therefore, be resolved without the co-operation of the Australian Medical Association. The Victorian Hospitals' Association and the Victorian branch of the Australian Medical Association were therefore requested to work together to develop a VMO accountability framework that would resolve the Auditor-General's concerns. This report provides details of the protocol which was developed by the two associations. It also outlines the Committee's recommendations on those matters which have either not been satisfactorily addressed in the agreed protocol or which are more appropriately addressed at the Departmental level. It is disappointing to note that the AMA failed to support or endorse the agreed protocol when issuing copies of the protocol to its members.
The Auditor-General, during his review, found that VMOs do not always update patient medical records to reflect the provision of direct patient care, and that some hospitals, in attempting to rectify this situation, had encountered strong resistance from certain VMOs. Given the potential ramifications in the event of litigation against a public hospital as well as the accountability implications, this is considered to be a significant problem. The Committee has therefore recommended that Departmental conditions of hospital funding should require all public hospitals to ensure that their VMOs update the medical record on each occasion a patient is attended.

I thank the Members of the Committee for their contributions to this Inquiry and on behalf of the Members, I thank the organisations and individuals who contributed through their oral and written presentations. I also thank the Committee's staff for drafting the report, briefing the Committee and for providing administrative support.

Hon. G. Graeme Weideman, MP, JP
Chairman
Overview (pp. 17 - 24)

- The Auditor-General, in his report on visiting medical officer (VMO) arrangements, found that some public hospitals had failed to introduce adequate accountability and monitoring processes to control expenditure on VMO services.

- The Victorian Hospitals' Association (VHA) and the Victorian branch of the Australian Medical Association (AMA), agreed to work together to develop an accountability framework or 'protocol', which would substantially address the deficiencies identified by the Auditor-General in respect of VMO accountability. The agreed protocol addresses some of the deficiencies and if implemented, will improve accountability. It fails, however to address the following key issues:

◊ all VMO services involving direct patient care should be recorded in patient medical records; and

◊ VMO invoices should be checked, by hospital staff, to patient records.

- The AMA, in advising its members of the protocol, has failed to endorse or recommend its implementation.
EXECUTIVE SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

Mixed Theatre Lists - Sessional Hospitals (pp. 35 - 40)

- Mixed theatre lists may contribute to overall efficiency. Where private patients are treated during publicly funded sessions, however, the internal auditor and/or the Medical Director should analyse theatre usage to identify VMOs who are allocating a significant number of private patients to public lists and not providing additional theatre time to compensate for this. Such cases should be followed up to ascertain if time has been delivered in the provision of alternative services. Where problems are identified, ongoing monitoring and verification procedures should be implemented to prevent and detect inappropriate VMO practices.

Fee-for-Service Billing Systems (pp. 47 - 48)

- The hospital claim sheet is the superior billing option in fee-for-service hospitals because it provides better control over hospital cash flows, enhances management information on VMO costs per patient and enables improved monitoring and verification of VMO claims.
EXECUTIVE SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

Verification and Monitoring of Fee-for-Service Claims (pp. 49 - 52)

- The Auditor-General found that resistance was encountered, from certain VMOs, in response to attempts by a number of hospitals to require them to update patient medical records on each occasion they provided direct patient care. Given the failure of the AMA and the VHA to resolve this problem in developing their agreed protocol, the potential exposure to public hospitals in the event of litigation and the accountability implications, it is recommended that Departmental conditions of hospital funding require all public hospitals to ensure that their VMOs update the medical records on each occasion a patient is attended.

- Where VMOs remit invoices to the hospital, details should be checked against patient medical records to ensure that services have actually been provided.

- The protocol developed by the AMA and the VHA recognises the need for clinical justification of medical services. In large public hospitals, it may not be practical to verify the clinical necessity of all VMO services, prior to paying for these services. The Medical Director should therefore perform systematic audits of VMO servicing patterns in order to prevent and detect over-servicing.

Guidance from the Department (pp. 52 - 55)

- The Department of Health and Community Services should provide its full support to those hospitals that face problems in negotiating with their VMOs to improve VMO accountability measures.
EXECUTIVE SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

Absence of a State/Commonwealth Cross-Checking Mechanism (pp. 57 - 62)

- The existing absence of a cross-checking mechanism between the states and the Commonwealth means that any inappropriate practices by medical practitioners, such as duplicate billing and over-servicing, are not likely to be detected. The Victorian Minister for Health should, in the public interest, accept the Department's recommendation to authorise the release of hospital data to the Commonwealth to enable the implementation of a cross-checking mechanism. It is preferable that the checking mechanism apply on a national basis so that participating states and territories are not financially disadvantaged.

The Shifting of Costs to the Commonwealth by Public Hospitals (pp. 63 - 67)

- Those public hospitals that are shifting a portion of their costs to the Commonwealth have a financial advantage over hospitals that do not employ such practices. Where this occurs, the Department cannot ensure that the more efficient hospitals are receiving more funding under casemix or that the public is receiving value for money in acquiring hospital services.

- In developing a cross-checking mechanism to detect fraud and over-servicing, the various state/territory governments together with the Federal Government, should utilise the opportunity to establish the extent of cost-shifting, by public hospitals, so that the impact of this practice on the efficient and effective utilisation of scarce health care resources can be assessed. Should the results of the assessment indicate that the problem is not significant, periodic rather than ongoing reviews should be conducted to ensure that inappropriate practices are identified.
EXECUTIVE SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

Restrictive Admission Practices (pp. 67 - 72)

- The Department should utilise statistical data analyses to identify any irregularities in the mix of private and public patients within individual hospitals and to undertake comparisons between hospitals. Hospital managers should also ensure that procedures are in place to prevent and detect inappropriate admission practices.
FINDINGS AND RECOMMENDATIONS

Finding 3.1 (page 24)

The Australian Medical Association (Victorian Branch) has a responsibility to its members to participate in the development of a VMO accountability framework and to fully support the implementation of such a mechanism. This will reduce the possibility of future adverse audit reports as well as the possibility of adverse media coverage resulting from such reports.

Finding 3.2 (page 25)

The agreed accountability protocol, developed by the Australian Medical Association (Victorian Branch) and the Victorian Hospitals’ Association, addresses some of the deficiencies identified by the Auditor-General in respect of VMO accountability, however it fails to address the following key issues:

• the need for VMOs to notate medical records on each occasion a patient is attended; and

• checking, by hospital staff, of VMO invoices against patient records.

Further, the AMA in advising its members of the agreed protocol, has failed to endorse or recommend its implementation.

Finding 3.3 (page 25)

The Auditor-General has given an undertaking to follow up the matters raised in his report on visiting medical officer arrangements. Should the Auditor-General identify residual or ongoing problems, each of the hospitals concerned will be invited by this Committee, to public hearing, to explain why they have failed to implement adequate accountability processes and how they intend to resolve outstanding matters.
Finding 3.4 (page 28)

The absence of accountability requirements in VMO contracts means that hospital managers may experience difficulties in ensuring that VMOs accept and comply with the procedures that have been put in place to enable hospitals to adequately control expenditure on VMO services.

Recommendation 3.1 (page 28)

Hospitals should incorporate accountability requirements into VMO contracts. All contracts should require VMOs to notate the medical record on each occasion a patient is attended and should also require compliance with any audit, peer review and quality assurance functions that have been implemented by the hospital to improve VMO accountability.

Finding 3.5 (page 30)

In accordance with the protocol developed by the AMA and the VHA, each sessional VMO should be required to complete and sign a record of attendance as evidence that ward and other sessions have been delivered. Time devoted to the treatment of private patients should not be included on this record.

Recommendation 3.2 (page 34)

Hospitals should ensure that they have adequate systems in place to accumulate reliable on-call/recall data. This data should be utilised to evaluate clinical practices, such as frequency and urgency of recall, so that the most cost-effective out-of-hours remuneration methods may be implemented.
Recommendation 3.3 (page 34)

Hospitals should ensure that they have adequate procedures in place to control payments to VMOs for out-of-hours work. In accordance with the protocol developed by the AMA and the VHA, it is recommended that where a VMO is recalled to the hospital, the name of the person requesting the recall, should be recorded in the patient's medical record. In addition, recall claim sheets should include the date, patient's name and the VMO's arrival and departure times and should be checked to patient records, by the Medical Director, prior to payment, to ensure that recalls were necessary. On-call and recall claims should also be checked to rosters for appropriateness.

Finding 3.6 (page 39)

Mixed theatre lists may contribute to overall efficiency by reducing or eliminating unused theatre time. The use of mixed theatre lists in public hospitals, however, means that VMOs may have an opportunity and financial incentive to treat their private patients during publicly funded sessions.

Finding 3.7 (page 39)

Where private patients are treated during publicly funded sessions, hospital managers have a responsibility to ensure that VMOs compensate for this by providing an equivalent amount of their own time in performing additional services within the hospital.

Recommendation 3.4 (page 40)

The internal auditor and/or the Medical Director should analyse theatre usage to identify VMOs who are allocating a significant number of private patients to public lists and not providing additional theatre time to compensate for this. Such cases should be followed up to ascertain if time has been delivered in the provision of alternative services. Where problems
are identified, ongoing monitoring and verification procedures should be implemented to prevent and detect inappropriate VMO practices. Otherwise, periodic and systematic reviews should be utilised to ensure that future problems do not arise.

Finding 3.8 (page 44)

Sessional VMOs have the potential to engage in private practice while on paid sick leave from public hospitals.

Finding 3.9 (page 45)

VMOs, on average, do not take a lot of paid sick leave. The costs associated with the implementation of a Commonwealth/State cross-checking mechanism, to detect VMOs who bill Medicare while on paid sick leave from public hospitals, may outweigh the benefits.

Recommendation 3.5 (page 45)

Hospitals should review their sick leave payments to VMOs. Where it is believed that benefits can be derived, consideration should be given to re-negotiating such entitlements with VMOs.

Finding 3.10 (page 48)

The Committee finds that the hospital claim sheet is the superior billing option in fee-for-service hospitals because it:

- provides better control over cash flows;

- enhances management information on VMO cost per patient; and

- enables improved monitoring and verification of VMO claims because claim details are recorded at the time of service provision.
Recommendation 3.6 (page 51)

Where VMOs remit invoices to the hospital, details should be checked against patient medical records to ensure that the services have actually been provided.

Recommendation 3.7 (page 51)

Prior to payment, hospital claim sheets and VMO invoices should be checked, using available computerised information systems, for any apparent irregularities such as multiple visits to a patient on the same day. Verification procedures should also detect duplicate VMO claims and claims for compensable and private patients.

Recommendation 3.8 (page 51)

The protocol developed by the AMA and the VHA recognises the need for clinical justification of medical services. In large public hospitals, it may not be practical to verify that all VMO services are clinically necessary, prior to paying for these services. The Medical Director should therefore perform periodic and systematic audits of VMO servicing patterns in order to prevent and detect over-servicing.

Finding 3.11 (page 52)

The Auditor-General, in his report and at public hearing, expressed concern that the failure, by some VMOs, to notate the medical record on each occasion they attend a patient, may not be defensible in litigation against the hospital or the VMO. During his review, the Auditor-General found that a number of hospitals had attempted to rectify this problem and had experienced resistance from certain VMOs. The agreed protocol, which was developed jointly by the AMA and the VHA, does not adequately address the concerns expressed by the Auditor-General in this regard.
Recommendation 3.9 (page 52)

Departmental conditions of hospital funding should require all public hospitals to ensure that their VMOs update the medical record on each occasion a patient is attended.

Finding 3.12 (page 55)

Individual hospitals do not always have the capacity to obtain VMO acceptance to change.

Recommendation 3.10 (page 55)

The Department is likely to have more influence with the AMA and/or VMO groups than do individual hospitals. It is therefore recommended that the Department should provide its full support to those hospitals that face problems in negotiating with their VMOs to improve VMO accountability measures.

Finding 4.1 (page 62)

The existing absence of a cross-checking mechanism between the states and the Commonwealth means that any inappropriate practices by medical practitioners, such as duplicate billing and over-servicing, are not likely to be detected.

Finding 4.2 (page 62)

The costs associated with over-servicing and duplicate claims by medical practitioners are borne by all Australian taxpayers. The Commonwealth and the states each have a responsibility to actively contribute to the establishment of a Commonwealth/state cross-checking mechanism which is designed to prevent and detect such practices.
Finding 4.3 (page 62)

It is preferable that the checking mechanism apply on a national basis so that participating states and territories are not financially disadvantaged.

Recommendation 4.1 (page 62)

The Victorian Minister for Health should, in the public interest, accept the Department's recommendation to authorise the release of hospital data to the Commonwealth to enable the implementation of a cross-checking mechanism which will discourage and detect inappropriate billing and servicing practices by medical practitioners.

Finding 4.4 (page 65)

Under the Medicare agreement, the State is responsible for ensuring that costs are not shifted by public hospitals to the Commonwealth. The State, however, does not have access to Commonwealth data and would therefore experience significant difficulties in identifying such practices.

Finding 4.5 (page 66)

Those public hospitals that are shifting a portion of their costs to the Commonwealth have a financial advantage over hospitals that do not employ such practices. Accordingly, where this occurs and remains undetected, the Department cannot ensure that the more efficient hospitals are receiving more funding under casemix or that the public is receiving value for money in acquiring hospital services.
Finding 4.6 (page 66)

The introduction of a Commonwealth/State cross-checking mechanism to prevent and detect fraud and over-servicing will provide the Commonwealth with an opportunity to identify and prevent the shifting of certain health costs, by public hospitals, to the Commonwealth.

Finding 4.7 (page 66)

The extent of cost shifting by public hospitals is not known at the current time. Accordingly, it is also unknown as to whether the benefits associated with the identification and prevention of this practice will outweigh the costs. An assessment is required to identify the extent of cost shifting and to determine the cost-effectiveness of implementing ongoing procedures to minimise this practice.

Recommendation 4.2 (page 67)

In developing a cross-checking mechanism to detect fraud and over-servicing, the various state/territory governments together with the Federal Government, should utilise the opportunity to establish the extent of cost-shifting, by public hospitals, so that the impact of this practice on the efficient and effective utilisation of scarce health care resources can be assessed. Should the results of the assessment indicate that the problem is not significant, periodic rather than ongoing reviews should be conducted to ensure that inappropriate practices do not increase.

Finding 4.8 (page 71)

Visiting medical officers are often best qualified to establish clinical need. Given however, that visiting medical practitioners may have a financial incentive to place their private patients ahead of public patients on hospital waiting lists, hospital managers should ensure that procedures are in place to prevent and detect inappropriate admission practices.
Recommendation 4.3 (page 71)

Hospital waiting lists and elective surgery lists should be reviewed on a regular basis by the Medical Director as assisted by the internal auditor, where practicable, so that any significant biases, by visiting medical officers, in assigning their private patients to hospital waiting lists, can be identified and investigated.

Finding 4.9 (page 71)

The State, through the Department of Health and Community Services, has a legal obligation under the Medicare Agreement as well as a social responsibility to ensure that all persons are admitted to public hospitals on the basis of clinical need. The Department should therefore take a stronger role in ensuring that this occurs.

Recommendation 4.4 (page 72)

The Department should utilise statistical data analyses to identify any substantial changes in the mix of private and public patients within individual hospitals and also to undertake comparisons between hospitals. Any irregularities should be investigated. The Department will first need to ensure the completeness and accuracy of the data obtained from public hospitals.
FUNCTIONS OF THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

The Public Accounts and Estimates Committee is constituted under the *Parliamentary Committees Act* 1968, as amended. It presently consists of nine members of Parliament drawn from the Legislative Council and the Legislative Assembly.

The Committee carries out investigations and reports to Parliament on matters associated with State financial management. Its functions under the Act are to inquire into, consider and report to the Parliament on -

a) any proposal, matter or thing connected with public administration or public sector finances;

b) the annual estimates or receipts and payments and other Budget papers and any supplementary estimates of receipts and payments presented to the Assembly and the Council;

if the Committee is required or permitted so to do by or under the Act.
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GLOSSARY OF TERMS

Casemix funding - introduced into Victoria from 1 July, 1993. Under this arrangement, hospitals will receive a fixed annual grant together with a payment per patient which is based on the weight assigned to the diagnosis related group (DRG) of the patients' treatment.

Compensable patient - a patient who is entitled, under law (other than Veterans' Affairs Legislation) to compensation for damages or other benefits in respect of the injury, illness or disease for which the hospital services are provided.

Composite session - enables a VMO to treat both private and public patients during a specified time period.

Consultative on-call - where a VMO is available to be consulted out-of-hours. A VMO may be on consultative on-call for more than one hospital but will not necessarily be required to physically attend those hospitals while on-call.

Diagnosis Related Groups (DRGs) - a classification system which categorises acute patients into groups which demonstrate similar levels of resource usage and similar clinical features.

DRG unit payment - this is a key component of the casemix formula. The purpose of the payment is to compensate hospitals for accommodation, nursing care and other costs (other than medical costs) associated with the provision of patient treatment. The amount which is payable to an individual hospital is calculated by multiplying the number of DRG weighted inpatients treated by a unit cost ($800 for 1993/94).

Exclusive on-call - where a VMO's availability for out-of-hours consultation is restricted to an individual hospital.

Fee-for-service - under this arrangement, VMOs are paid by public hospitals for individual medical services/procedures provided to public patients.
Inpatient - a patient who is admitted to hospital for the purpose of receiving treatment.

Mixed list - where public and private patients are allocated to the same theatre list.

On-call - where a VMO is available for out-of-hours consultations.

Outpatient - a person who receives treatment but is not admitted to the hospital.

Public medical payment - the amount payable to public hospitals under casemix, to cover the average cost of providing medical treatment to public inpatients. This is calculated by multiplying the number of DRG weighted public inpatients by the average cost ($300 in 1993/94).

Recall - Occurs when a VMO is rostered on-call and is actually required to return to duty to attend a public patient.

Sessional - time based system whereby VMOs are employed by hospitals to attend public patients during specified periods.

Visiting medical officer (VMO) - a doctor in private practice who also performs work for one or more hospitals on a contract basis.
ACRONYMS AND ABBREVIATIONS

ABS - Australian Bureau of Statistics

AHMAC - Australian Health Ministers' Advisory Council

AMA - Australian Medical Association (all references in this report apply to the Victorian branch of the Association only)

DRG - diagnosis related group

EBRC - Economic and Budget Review Committee

H & CS - Health and Community Services

VHA - Victorian Hospitals' Association

VMO - visiting medical officer
EXTRACTS FROM THE RECORDS OF PARLIAMENT

MINUTES OF THE PROCEEDINGS OF THE LEGISLATIVE COUNCIL

Tuesday 10 November 1992

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE - The Honourable R.I. Knowles moved, by leave, That, contingent upon the Royal Assent being given to the Parliamentary Committees (Amendment) Bill, the Honourables P.R. Hall, T.C. Theophanous and D.R. White be members of the Public Accounts and Estimates Committee.

Question - put and resolved in the affirmative.

VOTES AND PROCEEDINGS OF THE LEGISLATIVE ASSEMBLY

Friday 13 November 1992

JOINT INVESTIGATORY COMMITTEES - Motion made, by leave, and question - That contingent on the coming into operation of the Parliamentary Committees (Amendment) Act 1992 -

Mr Baker, Mr Hyams, Mr Plowman (Benambra), Mr Smith (Glen Waverley), Mr Thomson (Pascoe Vale) and Mr Weideman be members of the Public Accounts and Estimates Committee.

(Mr Gude) - put and agreed to.
CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

In October 1985, the former Economic and Budget Review Committee (EBRC), as a result of an Inquiry into visiting medical officer (VMO) arrangements in public hospitals, released a report entitled "Report of the Inquiry into the method of Remuneration for visiting medical staff at Public Hospitals." The report concluded that there were a number of deficiencies in respect of accountability and monitoring of VMO payments within public hospitals and recommended various actions to overcome these deficiencies. In 1988, the Minister for Health, in response to the EBRC report, gave an undertaking to act upon the Committee's findings and recommendations.

In April of 1993, the Victorian Auditor-General released Special Report No. 21 as a result of his performance audit on visiting medical officer arrangements in Victorian public hospitals. The Auditor-General's report identified significant deficiencies in the controls exercised over expenditure on VMO services. In addition, it was noted that the deficiencies highlighted by the former EBRC in 1985, have, as yet, to be adequately addressed. The Auditor-General stated that:

"... 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 foregone."

Given the on-going nature of the problems identified by the Auditor-General, the amount of money spent by Victorian public hospitals on the engagement of VMOs (in excess of $120 million per annum) and the fact

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1 The Victorian Auditor-General's Office, Special Report No. 21, Visiting Medical Officer Arrangements, L.V. North, Government Printer, Melbourne, 1993, p. 73.
that hospitals derive the majority of their funds from the public purse, the Public Accounts and Estimates Committee believed that an Inquiry into visiting medical officer arrangements could provide substantial potential benefits to the Victorian community.

The Members believed that many of the existing deficiencies would not be resolved unless co-operation was obtained from the major interest groups. Accordingly, the Committee asked the Australian Medical Association (Victorian Branch) and the Victorian Hospitals' Association to develop a VMO accountability framework that would be acceptable to both associations. Various public hospitals and other interested parties were also invited to provide submissions to the Committee with a view to resolving the issues identified by the Auditor-General.

1.2 THE COMMITTEE'S INQUIRY

1.2.1 Terms of Reference

In accordance with the Parliamentary Committees Act 1968, the Public Accounts and Estimates Committee conducted an Inquiry with the following terms of reference:

- to inquire into, consider and report to Parliament on the issues raised by the Auditor-General in his performance audit report - Visiting Medical Officer Arrangements (Special Report No. 21, April 1993), including

  : an examination of the adequacy of accountability and monitoring processes in relation to claims for payments by visiting medical officers in Victorian public hospitals;

  : the identification and analysis of any anomalies and/or inequities in existing VMO arrangements; and

  : an examination and assessment of the administrative policies, practices and procedures relating to VMO arrangements, in order to
INTRODUCTION

determine whether these ensure the economic, efficient and effective provision of medical services by public hospitals.

- to inquire into, consider and report on the action taken, and proposed, by the Australian Medical Association (Victorian Branch), the Victorian Hospitals' Association and the Department of Health and Community Services, as a result of the Auditor-General's findings and recommendations.

1.2.2 Method of Investigation

The Public Accounts and Estimates Committee inquired into the adequacy of accountability in respect of payments to visiting medical officers through:

- seeking oral and written submissions;

- an examination of submissions received from the Victorian branch of the Australian Medical Association, the Victorian Hospitals' Association, the Auditor-General, public hospitals and other relevant parties;

- consideration of issues at several public hearings; and

- an analysis of any recent trends and developments within the health industry that might have the capacity to impact upon the Auditor-General's findings and recommendations.

1.2.3 Legislative Requirements

Section 40(2) of the Parliamentary Committees Act 1968 provides that:

"Where a report to the Parliament of a Joint Investigatory Committee other than the Public Bodies Review Committee recommends that a particular action be taken by the Government with respect to a matter,
the appropriate responsible Minister of the Crown shall, within six months of the report of the Committee being laid before both Houses of the Parliament, report to the Parliament as to the action (if any) proposed to be taken by the Government with respect to the recommendation of the Committee."
CHAPTER TWO: OVERVIEW OF THE PUBLIC HOSPITAL SYSTEM IN VICTORIA

2.1 ADMINISTRATION

Under existing health care arrangements, the states are responsible for public hospitals and the Commonwealth is responsible for the majority of non-hospital services. State responsibilities include inpatient and outpatient services, hospital provided pharmaceutical services and care provided to the elderly within public hospitals.

There are approximately 150 public hospitals in Victoria and they employ about 50,000 people.¹ The Minister for Health and the Department of Health and Community Services have overall responsibility for funds expended by public hospitals in Victoria. Each hospital has a Board of Management which is responsible for overseeing and managing the operational aspects of the hospital.

The Health Services Act 1988 provides the authority for the Minister and the Department of Health and Community Services to ensure that hospitals are adequately accountable for funds allocated to them. The Department has issued a document entitled "Hospital Conditions of Funding 1993/94" which sets out the criteria that public hospitals are required to meet in order to receive government funding. Among other things, hospitals are required to:

• operate within the framework of the Medicare Agreement between Victoria and the Commonwealth;

• provide access to services on the basis of clinical need;


² Health and Community Services, Hospital Conditions of Funding 1993/94, Health Policy and Programs Division, 1993, pp. 2-12.
• obtain the Department’s approval for capital projects in excess of pre-determined amounts;

• raise fees in accordance with the Department’s fees manual;

• provide various statistical and financial data which is required by the Department; and

• ensure that the accounts and records of the hospital are audited in accordance with the Health Services Act 1988.

Traditionally, the Department has regulated many aspects of public hospital operations. In accordance with the current Government’s policy, there has been a move to reduce Departmental controls over public hospitals in order to give hospital managers responsibility for ensuring that hospitals operate at an efficient level and within the confines of their budgets.

2.2 VISITING MEDICAL OFFICER ARRANGEMENTS

Visiting medical officers (VMOs) are private medical practitioners who provide services to public hospitals on a contract basis. Hospitals utilise the services of VMOs for a variety of reasons. It might allow them, for example, to enhance the quality of services offered or broaden their range of services. Other factors which influence the mix of salaried and contracted practitioners include the availability of appropriately qualified and experienced practitioners and the willingness of specialist practitioners to work as salaried staff. The availability of practitioners will, in turn, be influenced by such factors as the geographic location of the hospital. Table 2.1 provides details of the numbers of visiting and salaried medical practitioners engaged by public hospitals in Victoria.
### Table 2.1

<table>
<thead>
<tr>
<th>Medical Practitioner Details: Victoria's Public Hospitals</th>
<th>Approx.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital employed practitioners</strong></td>
<td></td>
</tr>
<tr>
<td>No. of effective full-time medical officers</td>
<td>2,000</td>
</tr>
</tbody>
</table>

| **Visiting (contracted) medical officers**                |        |
| No. of individual fee-for-service VMOs                    | 2,500  |
| No. of effective full-time sessional VMOs                 | 500    |

| Annual amount expended by public hospitals on              | $120 million |
| fee-for-service and sessional VMOs                         |        |

Source: Data extracted from the Auditor-General's Special Report No. 21 - Visiting Medical Officer Arrangements, April 1993, pp. 3 & 17.

Visiting medical officers may be engaged on either a fee-for-service or sessional basis. Under the fee-for-service system, VMOs are paid by public hospitals for each medical service provided to a public patient. This arrangement is prevalent in small Victorian hospitals because it is more cost-effective than the sessional system when hospitals have low levels of patient throughput.

The sessional system is time-based with hospitals employing VMOs to attend public patients for specified periods (or sessions). This arrangement is more cost-effective in medium to large public hospitals which have high levels of patient throughput.
Prior to March 1993, VMOs were remunerated in accordance with either the Victorian Sessional Medical Officers Determination or the Victorian Fee-For-Service Medical Officers Award. These awards have ceased to exist with the Employee Relations Act 1992 providing for the re-negotiation of all Victorian Awards and Determinations from 1 March, 1993. Each hospital is now required to negotiate, with its VMOs, the terms and conditions associated with acquiring VMO services.

2.3 FUNDING

2.3.1 Availability of funds

There are limited funds available for expenditure on public hospital based services and the overall demand for services is almost always higher than supply. Accordingly, hospital based services are rationed in virtually all developed countries. In Australia, as in many other countries, care is provided on the basis of clinical need and the excess of demand over supply is reflected, theoretically at least, in hospital waiting lists.

2.3.2 Sources of Revenue

Public hospitals are primarily funded by government grants although funds are also derived by way of fees received from private and compensable patients, interest on investments, donations, charges to private practitioners who utilise hospital facilities and other sources.

Fees are charged where a person elects to be treated as a private, rather than a public patient. The fee is normally met by the patient's private health insurance fund although private patients who are uninsured or under-insured are required to meet some or all of the costs themselves. Fees for compensable patients are met by authorities such as the Victorian WorkCover Authority and the Transport Accident Commission.
User fees do not reduce the total cost of health care but do reduce the cost to the public purse. Accordingly, any reductions in private health cover place a greater strain on the public health system.

Immediately following the introduction of Medicare in 1984, there was a marked decline in private health coverage. The extent of private health insurance coverage in 1983, for instance, was approximately 70 percent of the Australian population. By 1985 this figure had declined to around 53 percent. Since then, private health insurance coverage has further declined, at a more gradual rate, to a reported existing level of a little under 40 percent. Figure 2.1 provides an indication of recent trends in private health coverage.
Figure 2.1
Percentage of Australian population with private health insurance


2.3.3 Commonwealth and State Responsibilities

Commonwealth Grants

The funding of Victoria's public hospitals is shared by the Commonwealth and the State governments.

In Australia, the states (and territories) receive financial assistance grants as part of the general financing arrangements which are negotiated between the state and federal governments. The grants are distributed to the states in
accordance with the recommendations of the Commonwealth Grants Commission and are determined by reviewing overall state financial needs, that is, taking account of the differences in revenue raised by the states from comparable taxes, and differences in the per capita costs of providing services of a similar standard. Funds are allocated between budget areas (e.g., health, education, police) at each state's discretion.

Under the Commonwealth/State Medicare Agreement relating to public hospitals, each state receives a base hospital funding grant from the Commonwealth. These grants are distributed to the states on the basis of population, adjusted by age and sex, to take account of the above average use of hospital services by women and the elderly. In addition to the base grants, bonus and incentive payments are also available to the states. These are designed to encourage improved public access to hospitals and also to promote certain reforms in the hospital system. In Victoria, the amount received from the Commonwealth under the Hospitals/Medicare Agreement is equivalent to approximately half of net State expenditure on public hospitals.

**Medicare Arrangements**

The Medicare arrangements between the Federal and state/territory governments are incorporated into formal bilateral Medicare Agreements. The previous agreements were signed in 1988 and expired on 30 June, 1993. New agreements have now been signed and are applicable until 30 June, 1998.

Medicare has two major components. These are the Federal/State Hospital/Medicare agreements and the medical benefit arrangements.

Under the Federal/State agreements relating to public hospitals, the states (and territories) have agreed to provide treatment in public hospitals, without charge, to all permanent Australian residents and eligible temporary residents.
The medical benefit arrangements specify the maximum amounts the Federal Government will pay towards the cost of individual medical services. Under Medicare, the Federal Government assists patients to meet the cost of medical services in three ways:

- **out-of-hospital services - 85% of the schedule fee** is paid by Medicare;

- **private medical services provided to hospital inpatients - 75% of the schedule fee** is paid; and

- **practitioners may direct bill and accept the Medicare benefit as full payment for the service provided** (commonly referred to as bulk billing).

### 2.3.4 Allocation of Funds to Public Hospitals

Resources are allocated to public hospitals through the Department of Health and Community Services. Prior to 1986, hospitals were funded on an historical basis irrespective of their activity levels. Recurrent expenditure funding was generally based on the previous year's expenditure adjusted for inflation. From 1986 and onwards, the former Health Department of Victoria, aimed to relate funding to hospital output through the phasing in of Health Service Agreements.

Those Health Service Agreements specified the level and range of services to be provided by a hospital in return for the funds provided to them. The agreements were formulated through negotiations between the hospitals and the Department and, until recently, were the principle mechanism through which accountability, to the Department of Health and Community Services was achieved.

The Economic and Budget Review Committee's 1992 Inquiry "Hospital Services in Victoria" concluded that Health Service Agreements, at that time, did not provide an explicit link between output and funding and provided no reward for improved efficiency or for being more efficient than
other service providers.\textsuperscript{3} The Committee found that the Agreements had not achieved a significant move away from historical patterns of funding\textsuperscript{4} and recommended that Agreements for group A and B hospitals should incorporate incentives for efficiency through the introduction of casemix funding for inpatient services.\textsuperscript{5} Health Service Agreements for the 1993/94 financial year are directly linked to the new casemix funding formula.

From 1 July 1993, casemix funding was introduced into the majority of Victorian public hospitals. Casemix is based on a classification and weighting system that categorises patient conditions into clinically meaningful groups with similar costs (diagnosis related groups or DRGs).

Under the new arrangements, hospitals will receive fixed annual grants together with case payments which are based on the weight assigned to the DRG of the hospitals base (specified target) number of patients treated. Any throughput above the base number of weighted inpatients is credited to a State additional throughput pool. Hospitals receive a payment from the pool which is equal to their proportionate share of the funds which are available in the pool (with minimum and maximum amounts applying to each DRG unit). Where a hospital fails to meet its quarterly throughput target, the hospital's total case payment is adjusted, and amounts allocated to the hospital in the following quarter are reduced accordingly.

The purpose of the unit DRG payment is to compensate hospitals for accommodation, nursing care, prosthesis and any other variable costs (except for medical costs) associated with the provision of treatment. The unit payment in 1993/94 is $800 per weighted inpatient. According to the Department, this approximates the marginal cost of hospital care.\textsuperscript{6}

\begin{itemize}
\item\textsuperscript{3} Economic and Budget Review Committee, Parliament of Victoria, \textit{Hospital Services in Victoria: Efficiency and Effectiveness of Health Service Agreements, The Impact of the Mix of Public and Private Patients on the Funding of the Public Hospital System}. L.V. North, Government Printer, Melbourne, 1992, p. 17.
\item\textsuperscript{4} Ibid., p. 13.
\item\textsuperscript{5} Ibid., pp. 17 & 20.
\item\textsuperscript{6} Department of Health and Community Services, \textit{Casemix Funding for Public Hospitals Victoria's Policy}. Acute Health Services Division, 1993, p. 11.
\end{itemize}
In addition to the unit DRG payment, hospitals also receive a public medical payment of $300 per weighted public inpatient. The purpose of the public medical payment is to compensate hospitals for the medical costs associated with treating public patients. For private patients, medical costs are met by Medicare (75% of the scheduled fee) and by the patient's private health insurance fund and/or the patient. The public medical payment is not capped and therefore not subject to additional throughput pool arrangements.

Fixed grants are payable to hospitals to assist them in meeting the costs associated with training and development, treatment of outpatients, fixed overheads and for other specified purposes.

The fixed overhead grant, which comprises approximately twenty seven percent of total hospital funding under casemix,\(^7\) is based on the number of weighted inpatients treated during the 1992 calendar year. Where a hospital is deemed to be inefficient in relation to other hospitals, this grant will not be sufficient to cover the actual overhead costs incurred by the hospital.

The fixed grants are pre-determined and will not alter during the 1993/94 financial year regardless of the throughput levels achieved by individual hospitals during the period. For the 1993/94 financial year, approximately thirty four percent of each hospital's total budget will comprise variable case payments and the remainder of the budget allocated on a fixed grant basis.\(^8\) Appendix E provides an overview of all components of the casemix funding formula.

During the transitional period, hospitals receive compensating grants. These are essentially the difference between the funding under the historical system and the new casemix system. Compensating grants have been introduced to allow less efficient hospitals time to improve practices.

\(^7\) Ibid., p. 23.

\(^8\) Ibid.
The Minister for Health has advised the Committee that these grants will be phased out over a two year period (1 July 1993 - 30 June 1995).\(^9\)

According to the Department, the "new system is designed to reward hospitals which have higher levels of throughput, treat more patients and perform more complex or lengthy procedures."\(^10\) It is believed that this will encourage hospital managers to assess their hospital's performance and "...should improve both efficiency and access to hospital services...".\(^11\)

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\(^10\) Department of Health and Community Services, *Casemix Funding for Public Hospitals Victoria's Policy*, op. cit. p. 5.

\(^11\) Ibid., p. 6.
CHAPTER THREE: HOSPITAL CONTROLS OVER VISITING MEDICAL OFFICER PAYMENTS

3.1 AN OVERVIEW OF THE AUDITOR-GENERAL'S FINDINGS

The Auditor-General, in his report, found that some public hospitals had failed to introduce accountability and monitoring processes which would enable management to adequately control expenditure on VMO services. Further, it was noted that some hospitals had experienced significant resistance from certain VMOs when management had attempted to introduce processes which would improve accountability.\(^1\) The Auditor-General also stressed that minimal action had been taken by the Department even though it had been aware of the deficiencies for many years.\(^2\)

Specific deficiencies identified by the Auditor-General along with his recommendations for addressing these are examined in sections 3.4 to 3.6 of this report.

3.2 THE NEED FOR ADEQUATE ACCOUNTABILITY

The community, in recent times, has increasingly expected a high standard of accountability for the expenditure of public funds. There is a greater need for accountability in the public sector than in the private sector because taxpayers, unlike shareholders, cannot withdraw their funds. Citizens have a right to the assurance that funds raised by way of taxes and charges are spent for the purposes intended, and that services purchased by government, reflect value for money.

Given that public hospitals provide an essential community service and are, in the main, publicly owned and funded, the Committee believes that

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\(^1\) Victorian Auditor-General's Office, Special Report No. 21, *Visiting Medical Officer Arrangements*, L.V. North, Government Printer, Melbourne, April 1993, pp. 9 & 11.

\(^2\) Ibid., p. 5.
hospitals should be adequately accountable to the Parliament through the Department and the Minister. Such accountability is required because the Parliament is the community's representative and the ultimate authority for the provision of public funds to hospitals.

There is no reason that public hospitals should not require and receive adequate accountability from VMOs. Other professional groups have recognised and accepted the requirement that they substantiate claims for payment in respect of services provided. Doctors should also be subject to appropriate levels of scrutiny and inevitably, the medical profession will need to accept this. The New South Wales Public Accounts Committee, in its 1989 Report on "Payments to Visiting Medical Officers" stated that:

"While doctors may see such accountability as intrusive or as an erosion of their authority, there is a need to understand the requirement for Parliament and the public to be assured that public funds are being expended in the most efficient, effective and accountable way. No other industry would tolerate the expenditure of such sums without management control and accountability." 3

There are costs, however, to the hospitals, associated with substantiating VMO claims. These include the costs relating to the time taken by VMOs and/or hospital staff to complete documentation as well as the time required by hospital staff to check claims. There is obviously a point where the costs associated with improved accountability will be higher than the benefits realised. The objective, therefore, is to achieve a level of accountability which reduces the risk of overpayment to an acceptable level. An attempt to eliminate the majority or all of the risks would not be economically feasible.

3.3 AN AGREED ACCOUNTABILITY FRAMEWORK

In July of 1993, the Department of Health and Community Services, issued an updated Finance and Accounting Manual for Public Hospitals. The manual included guidelines on the checking and verification of VMO claims in public hospitals. The Secretary to the Department has since stressed that the manual is intended to provide guidance only and is in no way an instruction to hospitals. The Secretary pointed out that if instructions were issued on how hospitals should deal with VMOs, this would conflict with the Department's policy to distance itself from the day to day operational decisions of hospitals.4

Members of the Victorian branch of the Australian Medical Association (AMA), at public hearing on 14 July 1993, expressed the view that accountability and monitoring is fundamentally the responsibility of hospital management and is not the responsibility of the VMOs. The Executive Director of the AMA stated:

"We state categorically that it is the responsibility of the medical profession to deliver the best medical care. It is the responsibility of management to ensure there is appropriate auditing of payment for patient care. It is not the responsibility of the medical profession. I can compare it with the delivery of goods: obviously, it is up to the customer to ensure that the goods have been received."5

While the Committee recognises that management has a key responsibility in ensuring the adequacy of accountability, the views expressed by the AMA fail to recognise that the Auditor-General concluded that some hospital managers had been unable to improve accountability because of strong resistance from VMOs. During the public hearing on 14 July 1993 with the AMA, it was pointed out by a Committee Member that hospital

4 Secretary to the Department of Health and Community Services, Letter of 6 October, 1993.

5 Australian Medical Association (Victorian Branch), Minutes of Evidence, 14 July, 1993, p. 6.
management would not succeed in improving accountability without the co-operation of VMOs.  

The Committee believes that the AMA has a responsibility to its members to participate in the development of a VMO accountability framework and to support the implementation of such a mechanism. This will reduce the possibility of future adverse audit reports as well as the possibility of adverse media coverage resulting from such reports. The AMA had complained at public hearing about the adverse publicity which the medical profession had received as a result of the Auditor-General's report on VMOs.  

Following the 14 July public hearing with the AMA, the Committee asked the Auditor-General to provide a list of the minimum processes that would be required, within a public hospital, to adequately control claims for payment by VMOs. The document prepared by the Audit Office, entitled 'Hospital Controls Over the Remuneration of VMOs' provided the basis for the eventual development of a VMO accountability framework. A copy of this document is attached at appendix A of this report. The Committee provided copies of the document to both the AMA and the Victorian Hospitals' Association (VHA) in order to obtain their views on it at later public hearings.  

At separate public hearings on 10 September 1993, the AMA and VHA agreed to work together with a view to developing an accountability framework which would substantially address the deficiencies identified by the Auditor-General. Both organisations indicated that they had previously decided to work together to develop appropriate accountability/monitoring guidelines. Members of the AMA, however, demonstrated a great deal of  

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6 Ibid., p. 19.
7 Ibid., p. 6.
reluctance to specify when this would be achieved. Their comments included:

"This protocol took a decade to hammer out, but we will do better than that."\(^{10}\)

"I do not want to beat around the bush, but it would be totally unreasonable for us to be put in a position of saying when the VHA will agree with what we want or when we will agree with what the VHA wants; we do not actually know what the terms will be."\(^{11}\)

The AMA and the VHA were asked to provide the Committee with copies of their VMO accountability 'protocol' by the end of October 1993. Both organisations complied with this request.

The Auditor-General reviewed the documents which had been prepared by the AMA and VHA and concluded "that substantial agreement has been reached on the protocols for VMOs which will lead to major improvements in overall accountability."\(^{12}\) It was suggested by the Auditor-General, however, that the following matters would need to be agreed upon and incorporated into the protocol:\(^{13}\)

- VMO contracts should include all terms and conditions of engagement. The contract for sessional VMOs should include an annual attachment which details the times when sessional services will be provided;

- The option proposed by the VHA for account raising and payment (recording of account details on a sheet in the patient record) has worked in several hospitals and is satisfactory for audit purposes as it complements the patient's medical record rather than replacing that

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\(^{10}\) Australian Medical Association (Victorian Branch), Minutes of Evidence, 10 September, 1993, p. 19.

\(^{11}\) Ibid., p. 21.

\(^{12}\) Victorian Auditor-General's Office, Letter to the Public Accounts and Estimates Committee concerning the VMO protocol, 18 November, 1993.

\(^{13}\) Ibid
record. The AMA's objection to this option is therefore not supported by practical experience;

- Directors of Medical Services have a responsibility to examine both pre and post-operative visits and not only pre-operative visits as proposed by the AMA; and

- The peer review process should involve practitioners who are not part of the hospital's VMO group. In addition, where there are instances of habitual over-billing and/or over-servicing the relevant VMO contract should be terminated by the hospital.

The Committee wrote to the VHA and the AMA seeking clarification of the following matters:

- The agreed extent of accountability requirements to be incorporated into VMO contracts;

- The AMA's position on the recording of all VMO services (date and time, details of service provided) in the patient's medical record;

- The extent of checking, by hospital staff, of VMO invoices against patient records and agreed rates;

- The establishment of peer review processes for purposes other than dispute resolution; and

- The checking of post-operative visits/services by the Director of Medical Services.

In particular the Committee wanted to know whether the AMA and VHA had reached agreement on these matters and whether they intended to modify the previously submitted VMO protocol to address these issues.

The VHA in a subsequent letter to the Committee explained their position on the matters raised but gave no indication as to whether their protocol would be updated to clarify or incorporate those matters. The Committee's
staff were advised by the Executive Director of the AMA on 21 December 1993 that the AMA did not believe that any adjustments to the protocol were required.

In December 1993, the VHA issued a memorandum, along with a copy of the agreed AMA/VHA protocol, to its members. A copy of this document is attached at appendix B of this report.

The AMA subsequently informed the Committee that a memorandum, along with a copy of the agreed protocol, had been issued in February 1994, to the Chairmen of Senior Medical Staff at all Victorian public hospitals. A copy of this document is attached at appendix C of this report. The memorandum issued by the AMA does not, unfortunately, provide full support to the agreed protocol. It states:

"In the absence of a centralised process for establishment of terms and conditions for VMOs, the AMA is unable to directly determine implementation of this protocol. It should therefore be seen as a guide for VMOs undertaking negotiations at any individual hospital. In such negotiations, members should ensure that audit arrangements are acceptable to themselves."

In March 1993, the AMA in its monthly magazine "Branch News", announced the circulation of the agreed protocol to the Chairmen of the Senior Medical Staff at all Victorian public hospitals, and advised that a copy of the protocol could be obtained from either the AMA or the VHA.

While the agreed VMO accountability protocol has ensured some progress in resolving the deficiencies identified by the Auditor-General, it has become apparent that the AMA is not prepared to fully address all matters. Two of the key issues raised in the Auditor-General's report concerned the failure, by certain VMOs, to record all services in the patient medical record and resistance, by some VMOs, to improved accountability. The protocol does not require VMOs to notate the medical record on each occasion they attend a patient. Nor does it incorporate adequate checking procedures in relation to VMO claims. These and other issues are discussed in detail later in this report.
The AMA has also failed to give its full support to the protocol. This is not unexpected given the AMA's initial reluctance to specify a time frame for the development of an agreed protocol. Any unresolved problems will now need to be addressed within the individual hospitals.

Given the AMA's reluctance to fully co-operate in resolving the deficiencies identified by the Auditor-General, it is important that the Auditor-General and his staff follow up the matters raised in the VMO report within the near future. The Auditor-General provided an undertaking to do this at a meeting with the Committee on 2 March, 1994.

Finding 3.1

The Australian Medical Association (Victorian Branch) has a responsibility to its members to participate in the development of a VMO accountability framework and to fully support the implementation of such a mechanism. This will reduce the possibility of future adverse audit reports as well as the possibility of adverse media coverage resulting from such reports.
Finding 3.2

The agreed accountability protocol, developed by the Australian Medical Association (Victorian Branch) and the Victorian Hospitals' Association, addresses some of the deficiencies identified by the Auditor-General in respect of VMO accountability, however it fails to address the following key issues:

• the need for VMOs to notate medical records on each occasion a patient is attended; and

• checking, by hospital staff, of VMO invoices against patient records.

Further, the AMA in advising its members of the agreed protocol, has failed to endorse or recommend its implementation.

Finding 3.3

The Auditor-General has given an undertaking to follow up the matters raised in his report on visiting medical officer arrangements. Should the Auditor-General identify residual or ongoing problems, each of the hospitals concerned will be invited by this Committee, to public hearing, to explain why they have failed to implement adequate accountability processes and how they intend to resolve outstanding matters.
3.4 SECTORIAL HOSPITALS

3.4.1 Contractual Arrangements

The Auditor-General, during his review, found that while the majority of sessional hospitals require their VMOs to sign a contract prior to engagement, these contracts do not generally specify accountability requirements. Audit concluded that without the necessary 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.14

With the abolition of the Sessional Medical Officers Determination in March 1993, hospitals are now responsible for negotiating contracts with their VMO groups and/or with individual VMOs. Deregulation has the potential to offer hospitals increased flexibility because it provides them with a greater opportunity to tailor contracts to their specific needs. On the other hand, deregulation also means that some hospitals may experience problems in dealing with VMO requests for increased levels of remuneration.

The VMO accountability protocol which has been developed by the AMA and the VHA does not mention the inclusion of accountability requirements in VMO contracts. When questioned about this omission, the VHA stated:

"The Government has encouraged individual hospitals to negotiate with their medical staff, rather than having a central negotiation arrangement."15

The absence of a centralised negotiating process does not preclude or hinder the incorporation of accountability requirements into VMO contracts. Nor should it in any way prevent the AMA and the VHA from endorsing a

15 Victorian Hospitals' Association, Response of 8 December 1993 to the Committee's letter regarding the agreed protocol.
broad set of guidelines which would assist hospital management and visiting medical officers to address the Auditor-General’s concerns. The Government's policy does not, in fact preclude the AMA and VHA from listing, in their agreed protocol, a number of the factors to be incorporated into VMO contracts, and does not, therefore, explain the failure of the two organisations to address the accountability issue.

Accountability requirements are likely to vary between the various hospitals depending on the accounting and auditing systems that individual hospitals have in place. At a minimum, however, VMO contracts should require VMOs to ensure that the medical record is notated on each occasion a patient is attended. Compliance with auditing, peer review and quality assurance functions relating to VMO services should also be required.

The submission received from the Wodonga District Hospital stated:

"... 'That for a Hospital to provide cost efficient health care the VMOs must be treated as part of the Hospital's team and so be given access to the reasons decisions are made, allowed to participate/influence the process of change and regarded as honest workers subject to the same checks as others.' ... Unfortunately at many sites in Victoria confrontation is being sought with VMOs on the basis of their perceived greed (or from the VMO viewpoint jealousy) and change is being dictated to the VMOs.'"16

Some of the views expressed in the Wodonga Hospital submission have merit. Clearly, VMOs are more likely to be receptive to change if they are given an opportunity to participate in the decision-making process. The Committee has not, however, received any evidence to suggest that VMOs are excluded from this process. Resistance to improved accountability from individual VMOs is also less likely to be a problem if agreement is reached with the VMO group as a whole. The ability of VMOs to influence decision-making should not, in the Committee's view, extend to a point where VMO accountability is undermined.

16 Wodonga District Hospital, Submission to the Public Accounts and Estimates Committee, 6 January, 1994.
Some hospitals, in their submissions to the Committee, indicated that they have taken measures to incorporate accountability requirements into VMO contracts. This is a positive response to the Auditor-General's report and indicates that some hospital managers have given thought to this matter and have taken action accordingly.

Finding 3.4

The absence of accountability requirements in VMO contracts means that hospital managers may experience difficulties in ensuring that VMOs accept and comply with the procedures that have been put in place to enable hospitals to adequately control expenditure on VMO services.

Recommendation 3.1

Hospitals should incorporate accountability requirements into VMO contracts. All contracts should require VMOs to notate the medical record on each occasion a patient is attended and should also require compliance with any audit, peer review and quality assurance functions that have been implemented by the hospital to improve VMO accountability.

3.4.2 Recording of Services and Monitoring of Claims

3.4.2.1 Ward Sessions

The Auditor-General noted that at most sessional hospitals, no management trail existed to demonstrate that VMOs had performed ward
sessions or had provided medical care. Further, where composite ward sessions were utilised, hospitals had not established appropriate recording and monitoring mechanisms to ensure that hours paid had actually been delivered in the treatment of public rather than private patients.\textsuperscript{17}

It was suggested that there is an urgent need for hospitals to enhance their documentation and monitoring mechanisms in order to ensure that VMOs have actually provided services to public patients prior to hospitals paying for those services.\textsuperscript{18}

Some hospital managers pointed out that they have flexible arrangements with their VMOs. These arrangements require VMOs to deliver a specific number of sessions per week but do not require that a full session be delivered in one block. Rather, the hours worked are spread over the week to suit both the hospital and the VMO. Managers expressed the view that these arrangements best ensure efficiency of operations. The Bendigo Hospital provides a good example of this. Their submission stated:

"The length of time required for ward based inpatient care will vary according to speciality and the patient load. ... Ward rounds are often composite in nature particularly where resident staff are involved in the care of private patients or for teaching purposes. For example in the orthopaedic unit both private and hospital patients are seen every day by the consultant. This provides for excellent supervision of resident staff and continuity of care for the patients. Only one session per week is allocated for ward rounds. Patient care is enhanced by frequent consultant involvement. This may not be best achieved by simply attending for three hours on a specified day once per week."\textsuperscript{19}

Management at the Royal Melbourne Hospital, when visited by the Committee, made similar observations. It was also pointed out that the allocation of sessions at the Hospital is not sufficient to cover the actual work performed by medical staff. Further, the pursuit of a rigid time-

\textsuperscript{17} Victorian Auditor-General's Office, Special Report No. 21, op. cit., pp. 30 & 31.
\textsuperscript{18} Ibid., p. 32.
\textsuperscript{19} The Bendigo Hospital, Submission to the Public Accounts and Estimates Committee, 24 December, 1993.
recording system might result in VMOs claiming for all time spent in delivering services to public patients. If this occurred, VMO costs would increase. These views are understandable given the following comments which were made by the Victorian branch of the AMA in a submission to this Committee:

"Submission of a record of attendances infers payment according to this record. The AMA would be pleased to advise members to be meticulous in providing this information. Additional funds will be required, however, to reimburse VMOs for hours worked."\(^{20}\)

Those who work additional (unpaid) hours in other professions do not, as a consequence, refuse to submit an attendance record. The comments made by the AMA are therefore not considered to be persuasive.

VMOs like other hospital staff should complete and sign a record of attendance. This should state that the VMO has delivered a specified number of sessions and that these have been delivered in the treatment of public patients. The protocol developed by the AMA and the VHA supports the utilisation of attendance records for VMOs.

Finding 3.5

In accordance with the protocol developed by the AMA and the VHA, each sessional VMO should be required to complete and sign a record of attendance as evidence that ward and other sessions have been delivered. Time devoted to the treatment of private patients should not be included on this record.

\(^{20}\) Australian Medical Association (Victorian Branch), *Response of 10 September, 1993 to the Auditor-General's Submission to the Public Accounts and Estimates Committee on "Hospital Controls Over the Remuneration of VMOs"*, p. 5.
3.4.2.2 Out-of-Hours Work

Cost Benefit Analyses of Alternative Payment Arrangements

During his review, the Auditor-General determined that the majority of sessional hospitals had yet to develop effective monitoring mechanisms for out-of-hours work conducted by VMOs. The majority of hospitals were unable to provide details of on-call, recall and associated payments per speciality for the 1991/92 financial year due to a lack of readily available management data. Also, the remuneration methods adopted were varied and appeared to be historically based and without reference to the costs and benefits associated with alternative practices. The Auditor-General recommended that hospitals should undertake cost-benefit analyses of alternative payment systems to ensure that the methods utilised to remunerate VMOs for out-of-hours work are the most cost-efficient.

The Committee supports the Auditor-General's findings. Each hospital should ensure that they have adequate systems in place to accumulate reliable on-call/recall data. This data should be utilised to evaluate the various out-of-hours remuneration methods so that the most efficient arrangements can be implemented.

The Monash Medical Centre submission provided an excellent overview of the way in which they remunerate their VMOs for out-of-hours work. The hospital conducted a major review, a few years ago, to assess the cost-effectiveness of the various available remuneration methods. According to the Hospital's submission, exclusive on-call arrangements are now confined to general surgery, obstetrics and anaesthesia because these units have a high proportion of urgent or frequent recall. Non-exclusive on-call arrangements are utilised in other units except where fee-for-service arrangements are less costly due to low incidences of recall.

21 Victorian Auditor-General's Office, Special Report No. 21, op. cit., p. 31.
22 Ibid., p. 32.
23 Monash Medical Centre, Submission to the Public Accounts and Estimates Committee, 6 December, 1993.
The Monash Medical Centre submission indicated that there was widespread objection to the changes that they implemented in relation to out-of-hours VMO remuneration.\textsuperscript{24} It is presumed that the objections came from the VMOs.

The implementation of more efficient arrangements will result in reductions in VMO remuneration levels and might therefore encounter resistance from either individual VMOs or the VMO group within each public hospital. Should this occur, the Department has a responsibility to fully support the hospital's actions. It is clear from the Auditor-General's report that individual hospitals do not always have the capacity to gain VMO acceptance to change.

The Auditor-General recommended that the Department should establish a process to ensure that individual VMOs do not receive exclusive on-call payments from more than one hospital at any one time.\textsuperscript{25} The Auditor-General, in his report, did not identify any instances of VMOs receiving exclusive on-call payments from more than one hospital and the Committee is not convinced that the potential benefits, of Departmental verification procedures, will outweigh the associated costs. If hospitals are successful in implementing on-call/recall arrangements which best meet their specific needs, then exclusive on-call should not be utilised excessively. Further, if a VMO has given an undertaking to be exclusively available to a specific hospital and is unavailable when notified by that hospital, it should become apparent to hospital management that there may be an underlying problem which requires investigation. Presumably, exclusive on-call arrangements would not continue if the VMO's availability could not be relied upon as this would not be in the interest of either the hospital or its patients.

\textsuperscript{24} Ibid.

\textsuperscript{25} Victorian Auditor-General's Office, Special Report No. 21, op. cit., p. 32.
Documentation and Monitoring Mechanisms

The Auditor-General noted that hospitals do not have adequate procedures in place to monitor and control payments for out-of-hours work. Further, although the Economic and Budget Review Committee, in 1985, recognised that VMOs have a considerable financial incentive to delay consultations until after hours, the Department had not provided hospitals with any guidance on the establishment of mechanisms to monitor out-of-hours work. It was recommended that hospitals should enhance their documentation and monitoring systems so as to ensure that VMOs have actually provided services to public patients prior to being paid for such out-of-hours services.

The protocol developed by the AMA and the VHA sets out certain requirements for out-of-hours (on-call/recall) arrangements. These are as follows:

- Rosters should specify the type of on-call arrangements;
- Where a VMO is recalled to the hospital, the name of the person requesting the recall should be recorded in the patient's medical record; and
- The maximum number of recall hours in an on-call period should not exceed the number of total on-call hours.

On-call details may be recorded on the VMO's attendance record. Pro-forma claim sheets are normally utilised to record details of recalls. At a minimum, claim sheets should include the date, the name of the person who initiated the recall, the patient's name and the VMO's arrival and departure times.

In addition to the procedures outlined in the agreed protocol, it is suggested that on-call and recall claims be checked to rosters to ensure that claims are

26 Ibid., p. 31.
27 Ibid., p. 32.
appropriate. Recall claims should also be checked to the patient's medical record, by the Medical Director, to ensure that the recall was necessary and did not relate to a private or compensable patient. Alternatively, depending on the volume of claims, these checks may be performed on a periodic and systematic basis. Attendance records and recall claim sheets should be authorised by the Medical Director prior to being forwarded to payroll.

Recommendation 3.2

Hospitals should ensure that they have adequate systems in place to accumulate reliable on-call/recall data. This data should be utilised to evaluate clinical practices, such as frequency and urgency of recall, so that the most cost-effective out-of-hours remuneration methods may be implemented.

Recommendation 3.3

Hospitals should ensure that they have adequate procedures in place to control payments to VMOs for out-of-hours work. In accordance with the protocol developed by the AMA and the VHA, it is recommended that where a VMO is recalled to the hospital, the name of the person requesting the recall, should be recorded in the patient's medical record. In addition, recall claim sheets should include the date, patient's name and the VMO's arrival and departure times and should be checked to patient records, by the Medical Director, prior to payment, to ensure that recalls were necessary. On-call and recall claims should also be checked to rosters for appropriateness.
3.4.3 Composite Theatre Sessions

In Victoria, a public hospital theatre list may comprise:

• private patients only;

• public patients only; or

• a mixture of both private and public patients (commonly referred to as a mixed list or composite session).

The utilisation of mixed theatre lists, within public hospitals, is a common practice.

The Auditor-General's review disclosed that at certain sessional hospitals, where no private theatre lists were established, particular VMOs 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.\textsuperscript{28} Audit concluded that the treatment of large numbers of private patients during publicly funded sessions, represents a form of double payment, as VMOs are remunerated by both the private patient and the hospital for the same service.\textsuperscript{29}

It was recommended by the Auditor-General that the Department, as a matter of urgency, review the use and manipulation of mixed lists in sessional hospitals, with a view to initiating appropriate action to eliminate any opportunities for duplicate payments.\textsuperscript{30}

\textsuperscript{28} Ibid., p.33.
\textsuperscript{29} Ibid., p. 34.
\textsuperscript{30} Ibid.
The Secretary to the Department, in response to the report, stated that this issue would be addressed in the Department's casemix funding arrangements to be introduced from July 1993.\textsuperscript{31} While it is recognised that casemix may provide hospitals with an incentive to adopt cost-effective practices in obtaining medical services, it does not, however, reduce the financial incentive for VMOs to allocate their private patients to publicly funded theatre lists.

A number of hospitals, in their submissions to the Committee, made comments on the use of mixed lists. Evidence received by the Committee indicates that mixed theatre lists may contribute to overall efficiency by reducing or eliminating unused theatre time. The Bendigo Hospital submission provides a good example of this. It states:

"It has not been the practice in this hospital to have composite procedural sessions. This had led to inefficiencies in the use of operating Theatres with unutilised blocks of time in both private and public lists. Composite sessions that fully utilise available time should be encouraged. Time is a resource like any other and is under casemix better attached to productivity targets rather than being viewed simply as remunerated hours."\textsuperscript{32}

The Dandenong Hospital submission stated:

"We are endeavouring to eliminate composite sessions where possible but some disciplines are still best remunerated on this basis."\textsuperscript{33}

Unused theatre time has a cost because the VMO is paid for a full session whether such time is fully utilised or not. It is therefore more efficient for the VMO to treat private patients during that unallocated time and to compensate for this by providing unpaid services to public patients at other

\textsuperscript{31} Ibid.

\textsuperscript{32} The Bendigo Hospital, Submission to the Public Accounts and Estimates Committee, 24 December, 1993.

\textsuperscript{33} Dandenong Hospital, Submission to the Public Accounts and Estimates Committee, 21 December, 1993.
times. A VMO may perform many functions within a public hospital. These might include teaching, quality review and clinical research as well as the provision of direct care to public patients in theatres, wards and outpatients. Given these varied functions, a VMO may perform any of a number of alternative duties to compensate for having treated private patients on publicly funded lists. The Monash Medical Centre submission stated:

"As long as a clinical needs basis is adopted management believes that 'private in public' patients should be able to access 'mixed' public lists. Any double payment for that particular patient on that particular list is, we believe, counter-balanced by overall services provided to public patients at other times. It is recommended, however, that the Internal Auditor make enquiries into the number of private patients on public lists and more particularly as to whether access is gained over public patients against the criteria of clinical need."

It is recognised that mixed theatre lists may provide advantages to both public hospitals and to VMOs. Where private patients are treated in publicly funded sessions, however, hospital managers need to ensure that VMOs compensate for this by providing an equivalent amount of their own time in performing alternative services within the hospital.

The Monash Medical Centre's suggestion that the internal auditor should review mixed theatre lists is considered to be a good one. It is suggested that the internal auditor and/or the Medical Director analyse theatre usage to identify VMOs who are allocating a significant number of private patients to public lists and not providing additional theatre time to compensate for this. Such cases should be followed up to ascertain if time has been delivered in the provision of other services and what, if any, corrective action may be necessary.

The Auditor-General has suggested that rosters should specify the type, classification and number of sessions to be worked and that the Director of Medical Services should ensure that the number of private patients treated

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34 Monash Medical Centre, Submission to the Public Accounts and Estimates Committee, 6 December, 1993.
by each VMO during publicly funded sessions is in accordance with the VMO's contract of engagement and hospital policy.\textsuperscript{35}

Given the volume of patients in some sessional hospitals it may not be feasible for verification and monitoring procedures to be performed prior to payment. In addition, the volume and frequency of required checking mechanisms will depend on the extent of inappropriate VMO practices. It is suggested therefore, that each hospital implement procedures to enable it to assess the extent, if any, of manipulation of theatre lists. If there is a problem, ongoing monitoring and verification procedures should be implemented to prevent and detect inappropriate VMO practices. If the hospital does not have a problem, it is believed that periodic reviews should still be conducted to ensure that future problems do not arise. These reviews should be implemented on a systematic basis so that the practices employed by each VMO are examined over a specified period.

There are those who advocate that the lower sessional VMO remuneration rates in Victoria reflect the fact that VMOs treat some of their private patients in publicly funded sessions.

The AMA stated:

"The rates of pay for sessional medical officers have been built upon the fact that there was always a public/private split in sessions and this is one of the reasons why Victoria's rates are significantly lower than other states."\textsuperscript{36}

The Austin Hospital submission stated:

"I understand that the Hospital Remuneration Tribunal, when setting the medical specialist sessional rate, has specifically taken into account the fact that some private patients would be treated in hospital paid

\textsuperscript{35} Victorian Auditor-General's Office, \textit{Hospital Controls Over the Remuneration of VMOs}, document tabled at public hearing on 1 September, 1993.

\textsuperscript{36} Australian Medical Association (Victorian Branch), Response of 3 June, 1993 to the Auditor-General's Report, p. 3.
sessional time. This situation accounts at least in part for the considerably lower remuneration rate in Victoria than applies in New South Wales. 

While it is recognised that VMOs in the Australian Capital Territory and New South Wales, for example, receive higher sessional rates of remuneration than their Victorian counterparts, the suggestion that Victorian public hospitals should compensate for this by allowing VMOs to treat their private patients in publicly funded sessions is unacceptable. Such a system does not allow hospital managers to exercise adequate control over VMO expenditure as no limits have been placed on the number of private patients to be treated in publicly funded sessions. The system is also inequitable as it disadvantages those practitioners that do not assign their private patients to public lists.

Finding 3.6

Mixed theatre lists may contribute to overall efficiency by reducing or eliminating unused theatre time. The use of mixed theatre lists in public hospitals, however, means that VMOs may have an opportunity and financial incentive to treat their private patients during publicly funded sessions.

Finding 3.7

Where private patients are treated during publicly funded sessions, hospital managers have a responsibility to ensure that VMOs compensate for this by providing an equivalent amount of their own time in performing other services within the hospital.

37 Austin Hospital, Submission to the Public Accounts and Estimates Committee, 3 December, 1993.
Recommendation 3.4

The internal auditor and/or the Medical Director should analyse theatre usage to identify VMOs who are allocating a significant number of private patients to public lists and not providing additional theatre time to compensate for this. Such cases should be followed up to ascertain if time has been delivered in the provision of alternative services. Where problems are identified, ongoing monitoring and verification procedures should be implemented to prevent and detect inappropriate VMO practices. Otherwise, periodic and systematic reviews should be utilised to ensure that future problems do not arise.

3.4.4 Paid Sick Leave

The Auditor-General, in his review, found prima facie evidence to suggest that some VMOs, while on paid sick leave from sessional hospitals, engaged in private practice. Audit concluded that there was a need for co-operative action by the State and Commonwealth authorities to investigate the irregularities identified during the audit and recommended that such cooperation should extend to the implementation of procedures to detect and, ideally, prevent future irregular sick leave payments.38

Some hospitals, in their submissions to the Committee have pointed out that it might be appropriate, in some circumstances, for doctors to undertake private work while on sick leave.

The Dandenong Hospital stated that:

"The question of undertaking private work while receiving sick leave payment has been raised with our medical staff. They have pointed out

several legitimate reasons why this could be appropriate. For example a surgeon may be unable to operate because of an infection or skin condition but can still undertake consultations in his rooms. Also, a Doctor can be called from his sick bed to attend an emergency."39

The Bendigo Hospital stated:

"This issue is not as straight forward as it would first appear. For example a surgeon may have an illness or injury that would make it inappropriate for he/she to be carrying out major surgery. For example a back injury or upper respiratory tract infection may preclude the surgeon from operating but not from consulting. Whether actually performing any such work in a private capacity during the allocated session time as appropriate is an issue."40

The Auditor-General's report provided a number of examples of Medicare payments for services provided by sessional VMOs, who had also received sick leave payments from their respective public hospitals at the time that the private services were provided. A review of the cases listed in the Auditor-General's report, indicated that some of the procedures performed were similar to those that would have been performed by the VMOs during sessional work at the hospitals. Accordingly, the argument that it might be appropriate for doctors, depending on the nature of their illness, to undertake some private work while on paid sick leave, cannot be utilised to explain or justify all of the cases identified by audit. Further, the Committee believes that if a specialist engages in private practice while absent from a rostered session, then there is no legitimate reason that he/she should also receive paid sick leave from a public hospital.

The VHA, at public hearing, pointed out that it is common practice for a relieving doctor to bill patients in the principal doctor's name and that this may have accounted for the audit findings relating to sick leave payments.41

39 Dandenong Hospital, Submission to the Public Accounts and Estimates Committee, 21 December, 1993.

40 The Bendigo Hospital, Submission to the Public Accounts and Estimates Committee, 24 December, 1993.

41 Victorian Hospitals' Association, Minutes of Evidence, 10 September, 1993, p. 4.
The AMA and the Austin Hospital, in their submissions to the Committee, made similar observations. The Austin Hospital submission stated:

"The Hospital recently had a situation where it appeared that a medical specialist was working in private practice whilst on paid sick leave. However, on more detailed review of the case, a locum was employed in the surgery. The bills for service were made out in the principal doctor's name. These situations would not be infrequent."\(^{42}\)

The submissions of the AMA, VHA and the Austin Hospital suggest that the checking of Medicare claims against hospital records, will not necessarily provide proof that a VMO has worked in private practice while on paid sick leave. Further, this situation will not be rectified unless all doctors, when providing services to patients, are required to provide Medicare with their own provider number.

Given the apparent problems associated with the accuracy of Medicare data, it is difficult to accurately determine the extent, if any, of irregular sick leave payments to VMOs. Nonetheless, this does not alter the fact that the existing system provides VMOs with an opportunity to claim sick leave payments from public hospitals while continuing to treat private patients. Given that many VMOs derive the majority of their income from private practice, it is possible that some VMOs will place a higher priority on their private practices and that the absence of controls, in the existing system, could render it open to abuse.

Information provided to the Committee by the Department, suggests that the Commonwealth members of the Australian Health Ministers' Advisory Council (AHMAC) working party are not intending to check for Medicare payments to doctors who are on sick leave from public hospitals. An internal Departmental memorandum concerning the first meeting of the AHMAC working party states:

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\(^{42}\) Austin Hospital, Submission to the Public Accounts and Estimates Committee, 3 December, 1993.
"The Commonwealth equally made it clear that the issue of billing Medicare whilst Visiting Medical Officers are on sick or other leave was an issue which individual States, or hospitals, may wish to take up but was not the prime concern of the work party."\textsuperscript{43}

Table 3.1 demonstrates that the amount of sick leave payments to sessional VMOs is relatively low in comparison to payments to other categories of staff within public hospitals. The costs associated with the implementation of a cross-checking mechanism to investigate and detect irregular sick leave payments may, therefore, outweigh the benefits.

Given that VMOs are contracted to their respective hospitals and are deemed by the AMA "to be contractors as opposed to employees,"\textsuperscript{44} there is no strong argument to support the premise that VMOs should receive sick leave entitlements. With the abolition of the Sessional Medical Officers Determination, it is possible that public hospitals, in negotiating contracts with their VMOs, might wish to remove sick leave entitlements. This would eliminate both the possibility of duplicate payments and the costs associated with checking Commonwealth data against hospital data in order to detect irregularities.

It could be expected that VMOs would require additional benefits to compensate for the loss of sick leave entitlements. In hospitals where VMOs utilise only a small percentage of these entitlements, hospitals may well be better off under existing arrangements. It is therefore recommended that hospitals should review their sick leave payments to VMOs and where it is believed that benefits can be derived, consideration should be given to removing sick leave entitlements when re-negotiating contract terms and conditions with VMOs.

\textsuperscript{43} Department of Health and Community Services, \textit{Internal Memorandum of 1/2/94 concerning the Australian Health Ministers' Advisory Council working party meeting of 25/1/94}, prepared by the Director, Public Health.

\textsuperscript{44} Australian Medical Association (Victorian Branch), \textit{Response of 3 June 1993 to the Auditor-General's Report}, p. 8.
Table 3.1

Paid Sick Leave as a Percentage of Basic Salary: 1991/92.

<table>
<thead>
<tr>
<th>Hospital Group</th>
<th>Sessional/Clinical - Percentage</th>
<th>Staff - All categories - Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0.6</td>
<td>2.5</td>
</tr>
<tr>
<td>B</td>
<td>0.7</td>
<td>2.4</td>
</tr>
<tr>
<td>C</td>
<td>-</td>
<td>2.4</td>
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<tr>
<td>D</td>
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<td>1.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Z</td>
<td>0.9</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: Data extracted from Rainbow Hospital Indicators "Victorian Hospitals Comparative Data" 1990/91-1991/92, Volumes 1 & 2, March 1993.

Finding 3.8

Sessional VMOs have the potential to engage in private practice while on paid sick leave from public hospitals.
Finding 3.9

VMOs, on average, do not take a lot of paid sick leave. The costs associated with the implementation of a Commonwealth/State cross-checking mechanism, to detect VMOs who bill Medicare while on paid sick leave from public hospitals, may outweigh the benefits.

Recommendation 3.5

Hospitals should review their sick leave payment to VMOs. Where it is believed that benefits can be derived, consideration should be given to renegotiating such entitlements with VMOs.

3.5 RECORDING AND MONITORING OF FEE-FOR-SERVICE CLAIMS

3.5.1 The Auditor-General's Findings

The Auditor-General noted that the Economic and Budget Review Committee (EBRC), in its 1985 report, had highlighted various concerns relating to the adequacy of controls exercised by public hospitals over fee-for-service payments to VMOs. The EBRC had recommended that the VHA and the Department undertake discussions with a view to the adoption of a uniform process for monitoring and reviewing VMO services. The former government, in its 1988 response to the EBRC report had indicated that it would undertake discussions with the VHA and the AMA to enable the adoption of a uniform process. No action had been taken, however, by the Department to honour the government's undertaking. Nor had the
Department issued any guidelines to hospitals on monitoring and review processes.\textsuperscript{45}

The Auditor-General found that deficiencies in information systems, in some public hospitals, did not enable managers to review VMO practices and claim patterns. Patient records were not always updated and endorsed by VMOs, and even where they were updated, there was not always independent matching of VMO claims to medical records. Further, the checking of VMO claims, if conducted, was often infrequent and superficial and there was inadequate independent medical officer review of claims.\textsuperscript{46} A number of hospitals had attempted to enhance VMO accountability and had encountered strong resistance from VMOs. Resistance was also encountered from certain VMOs in response to attempts by a number of hospitals to require them to notate the medical records on each occasion they attended a patient. The Directors of Medical Services at a number of hospitals had expressed concern to audit that the absence of a notation in the medical record may not be defensible in litigation against the hospital or the VMO.\textsuperscript{47}

The Auditor-General concluded that the weaknesses in accountability had been compounded by the lack of guidance and support provided to hospitals by the Department. It was recommended that the Department take action to address these weaknesses.\textsuperscript{48}

\textbf{3.5.2 The Department's Response}

The Secretary to the Department, in response to the Auditor-General's report, stated that the Department strongly supports the implementation of appropriate accountability measures within hospitals but considers this to be the responsibility of individual hospitals. The Secretary also stated that the implementation of casemix funding from July 1993 would ensure that hospitals are paid by the State on a consistent basis for medical services

\textsuperscript{45} Victorian Auditor-General's Office, Special Report No. 21, op. cit., p. 41.
\textsuperscript{46} Ibid. p. 42
\textsuperscript{47} Ibid., pp. 45 & 46.
\textsuperscript{48} Ibid., p. 46
performed and that this would provide hospitals with a strong incentive to adopt cost-effective practices.49

As noted in section 3.3, the Department issued guidelines to public hospitals, in July 1993, on the verification of payments to visiting medical officers.

3.5.3 VMO Billing Systems

There are two VMO billing systems currently utilised in Victorian fee-for-service public hospitals. In some hospitals the VMO raises an account at the end of each month and submits this to the hospital. Where such a system is in place, VMO invoices, at a minimum, should record the patient's name, the date and time that the service was provided and a description of the service.

The agreed AMA/VHA protocol does not require the invoice to include the time of the visit except in cases where multiple visits occur or, for example, where an after hours loading is payable. The protocol also specifies that either the item number or a description of the service should be provided. Given that the item number may quite easily be recorded incorrectly it should not replace a description of the service. The time of service provision should be recorded in all cases rather than when the VMO deems it to be relevant. This will ensure that adequate information is available to the hospital when calculating VMO payments and for verification purposes.

The alternative billing system utilises a hospital claim sheet, which is normally attached to the medical record, to provide details of services delivered. This sheet is removed from the medical record, by hospital staff, on discharge of the patient or at the end of the month for long stay patients. The information contained on the sheet is then used to raise VMO payments.

It is believed that the claim sheet has advantages. It provides better control over cash flows by enabling management to control the timing of payments

49 Ibid.
to VMOs. It also provides a more reliable basis, for assigning medical costs to specific patients, because there are no unnecessary delays in accumulating these costs. The ability to identify and manage costs is a critical factor under casemix funding. The use of claim sheets also enables management to better monitor and verify VMO claims because claim details are recorded at the time of service.

The use of hospital claim sheets is not supported by the AMA who argue that the sheet may not be checked by the VMO before the hospital prepares the payment and that fees information should not be kept at the patient's bedside (refer agreed protocol at appendix C). The AMA's objections to the claim sheet are not considered to be valid. The VMO should record all details on the claim sheet at the time of service provision. If this is done properly, there should be no need to update or alter the sheet prior to the hospital preparing the payment. VMOs can nevertheless check hospital payments once received. Further, the sheet does not necessarily need to contain the dollar value of the charge and the Committee cannot see any reason for the AMA's objection to attaching the sheet to the medical record. A sample claim sheet is attached at appendix D of this report.

Finding 3.10

The Committee finds that the hospital claim sheet is the superior billing option in fee-for-service hospitals because it:

- provides better control over cash flows;
- enhances management information on VMO costs per patient; and
- enables improved monitoring and verification of VMO claims because claim details are recorded at the time of service provision.
3.5.4 Verification and Monitoring Procedures

Where an invoice is forwarded to a hospital by a VMO, invoice details should be checked against patient medical records to ensure that services have actually been provided. Verification procedures, in relation to both VMO invoices and hospital claim sheets, should also detect duplicate VMO claims and claims for compensable and private patients.

The protocol developed by the AMA and the VHA recognises the need for clinical justification of services. Given the volume of transactions in some public hospitals, it would not be practical to ensure that all services are clinically necessary prior to payment. If the hospital's information systems are adequate, however, apparent irregularities such as multiple visits on the same day should be identifiable and should be followed up by management prior to payment. The Medical Director should also perform periodic and systematic audits of VMO servicing patterns in order to prevent and detect over-servicing.

Hospitals will not be able to efficiently verify claims for payment unless they have adequate management information systems in place to enable them to do so.

The protocol states that "If a VMO cannot demonstrate either in the patient record or by other evidence, that a service has been performed, payment should not be made for the service." This presumably puts the onus on the VMO to demonstrate that patient care has been provided. Adequate evidence of patient care, may only be provided in the Committee's view, by way of the recording of relevant details in the medical record or on a hospital claim sheet. Where a claim sheet is used, the medical record would still need to be updated for medico-legal purposes as not all services will necessarily appear on the hospital claim sheet and/or insufficient details may be provided.

The Auditor-General in his report and at public hearing expressed concern that the absence of a notation in the medical record may not be defensible in litigation against the hospital or the VMO. A major weakness in the protocol developed by the AMA and the VHA is its failure to adequately address this matter. In fairness to the VHA, it should be pointed out that the
protocol it proposed (refer appendix B) suggested under section 1.2 - 'Accounts Raising and Payment', that:

"Visit details should appear in the patient record which ever option is chosen."

The suggestion was not incorporated into the protocol as the AMA's agreement was not obtained on this matter (refer appendix C).

The protocol states that "The hospital should impress upon its staff the medico-legal importance of recording in their section of the medical record when a VMO has attended the patient." This appears to assign responsibility for the notation of the medical record to hospital medical officers and other salaried staff rather than to the VMO. In the Committee's view, this is clearly inappropriate from a medico-legal viewpoint. Where specialist care is warranted and is provided to a patient, the medical record should clearly reflect this.

The AMA has demonstrated an obvious reluctance to require, or recommend to its members, that the patient medical record be updated on each occasion a patient is attended, and hospital managers do not always have the ability to overcome VMO resistance on this matter. In view of the importance of the medical record and the possible losses that could be sustained by a public hospital in the event of litigation, it is believed that Departmental action is required.

Hospitals are required to comply with various Departmental conditions in order to receive public funding. They must, for example, obtain Departmental approval for capital projects in excess of specific amounts and provide the Department with certain statistical and financial data. It is recommended that the conditions of funding should also require all public hospitals to ensure that their VMOs update the medical record on each occasion a patient is attended.
Recommendation 3.6

Where VMOs remit invoices to the hospital, details should be checked against patient medical records to ensure that the services have actually been provided.

Recommendation 3.7

Prior to payment, hospital claim sheets and VMO invoices should be checked, using available computerised information systems, for any apparent irregularities such as multiple visits to a patient on the same day. Verification procedures should also detect duplicate VMO claims and claims for compensable and private patients.

Recommendation 3.8

The protocol developed by the AMA and the VHA recognises the need for clinical justification of medical services. In large public hospitals, it may not be practical to verify that all VMO services are clinically necessary, prior to paying for these services. The Medical Director should therefore perform periodic and systematic audits of VMO servicing patterns in order to prevent and detect over-servicing.
Finding 3.11

The Auditor-General, in his report and at public hearing, expressed concern that the failure, by some VMOs, to notate the medical record on each occasion they attend a patient, may not be defensible in litigation against the hospital or the VMO. During his review, the Auditor-General found that a number of hospitals had attempted to rectify this problem and had experienced resistance from certain VMOs. The agreed protocol, which was developed jointly by the AMA and the VHA, does not adequately address the concerns expressed by the Auditor-General in this regard.

Recommendation 3.9

Departmental conditions of hospital funding should require all public hospitals to ensure that their VMOs update the medical record on each occasion a patient is attended.

3.6 GUIDANCE FROM THE DEPARTMENT

A recurring theme of the Auditor-General's report on VMOs relates to the lack of action, by the Department of Health and Community Services, in addressing the deficiencies identified by the EBRC in 1985. Further, the report made several references to the lack of Departmental guidance and support provided to those hospitals which faced problems (such as opposition from VMOs) in attempting to introduce procedures which would enhance hospital controls over VMO expenditure.

Government reforms aim to develop a hospital system that is free from centralised bureaucratic control and the Secretary to the Department of
Health and Community Services, has indicated that in line with this policy, the Department is distancing itself from the day to day operational decisions of hospitals.\textsuperscript{50} With the implementation of casemix funding, hospitals are now funded on the basis of outputs and will be free to decide how these outputs will be achieved.\textsuperscript{51} The Department believes that this will encourage hospitals to become more efficient and will also ensure greater accountability for funds expended by hospitals.\textsuperscript{52}

If hospitals are to be funded on the basis of outputs, there is little doubt that hospital managers should have sufficient autonomy to enable them to control the level of efficiency and resulting outputs. The Committee also accepts that this arrangement has resulted in hospitals becoming more aware of the need for efficient work practices and has led, in many cases, to a review of operational costs and work practices with the aim of improving efficiency.

It is believed however, that at times, consistently applied centralised policies and procedures will prove to be more effective and less costly than a decentralised approach. There is little to be gained, for example, in 150 hospitals developing separate accountability frameworks for VMOs, when one set of guidelines can be developed and distributed to all public hospitals. The Department has obviously recognised this and has incorporated VMO accountability guidelines into its 'Finance and Accounting Manual for Public Hospitals'. This manual is distributed to all Victorian public hospitals.

The Auditor-General's findings indicate that individual hospitals do not always have the capacity to obtain VMO acceptance to change.

The abolition of the Victorian Medical Officers Awards and Determinations may cause problems for some of the State's hospitals. Not all hospitals have

\textsuperscript{50} Secretary to the Department of Health and Community Services, Letter of 6 October, 1993.

\textsuperscript{51} Department of Health and Community Services, \textit{Minutes of Evidence}, 18 August, 1993, p. 31.

\textsuperscript{52} Department of Health and Community Services, \textit{Casemix Funding For Public Hospitals Victoria's Policy}, Acute Health Services Division, 1993, pp. 5 - 6.
the bargaining power required to ensure that they are not disadvantaged by
deregulation. It has been pointed out that country hospitals, in particular,
are not always in a strong position to negotiate with their VMOs. The
Bendigo Hospital submission stated:

"Deregulation has left individual hospitals with the problem of dealing
with requests for increased levels of remuneration where visiting
medical staff, because of shortages of supply of essential specialists such
as anaesthetists and obstetricians in rural areas, enjoy very significant
market power."53

The Wodonga District Hospital submission stated:

"The absence of a central remuneration fixing body, or a centrally
negotiated replacement for the Award, has resulted in those VMO
elements with greater economic negotiating power, ie the anaesthetic and
obstetric providers, seeking very large increases in their remuneration. I
believe this issue, unless resolved by DH&CS, has the potential to
produce considerable industrial disruption to health care in Victoria
and/or increase the proportion of the health care dollar paid to VMOs
whilst hardening attitudes against rational internal auditing
procedures."54

The Secretary to the Department at public hearing stated:

"The only measure of fortitude to come to bear on the department would be
if a hospital had a stand-off with its doctors. I would hope that the Minister
would say, "You sort it out, we will not bail you out if you cannot make
your arrangements. The fiscal pressure on hospitals will do as much to see
these things sorted out."55

53 The Bendigo Hospital, Submission to the Public Accounts and Estimates Committee, 24
December, 1993.
54 Wodonga District Hospital, Submission to the Public Accounts and Estimates Committee,
55 Department of Health and Community Services, Minutes of Evidence, 18 August, 1993,
p. 29.
The argument that fiscal pressures on hospitals will force them to reach suitable arrangements with their VMOs is considered to be without foundation.

Hospitals do not have any control over the availability of specialist practitioners. Nor are they able to ensure that they have the bargaining power required to minimise VMO costs or improve the accountability of VMOs. Hospitals may be placed in an untenable position if faced with VMO demands for levels of remuneration that are higher than amounts received under casemix. Recent disputes involving VMOs at the Werribee Mercy Hospital and also in Canberra indicate that VMOs are willing to withdraw their services to public hospitals if the terms that they are offered are deemed to be unacceptable. The Department is likely to have more influence than would an individual hospital, and should therefore provide its full support to those hospitals that face problems in negotiating with their VMOs to improve VMO accountability measures.

Finding 3.12

Individual hospitals do not always have the capacity to obtain VMO acceptance to change.

Recommendation 3.10

The Department is likely to have more influence with the AMA and/or VMO groups than do individual hospitals. It is therefore recommended that the Department should provide its full support to those hospitals that face problems in negotiating with their VMOs to improve VMO accountability measures.
CHAPTER FOUR: OTHER ISSUES RELATING TO VISITING MEDICAL OFFICER ARRANGEMENTS

4.1 ABSENCE OF A STATE/COMMONWEALTH CROSS-CHECKING MECHANISM

4.1.1 The Auditor-General's Findings and Conclusions

The Auditor-General, in his report on visiting medical officer arrangements, noted that the Commonwealth Health Insurance Commission cannot monitor payments made to VMOs by public hospitals due to confidentiality provisions contained in the Victorian Health Services Act 1988.\(^1\) It was also noted that the Victorian Economic and Budget Review Committee, in 1985 and the New South Wales Public Accounts Committee, in a 1989 report, identified the need for the establishment of a Commonwealth/State cross-checking mechanism which would prevent and detect occurrences of VMOs being remunerated by both public hospitals and Medicare for the provision of the same service to a public patient.\(^2\) Further, the Department of Health and Community Services had not taken any action to develop suitable arrangements with the Commonwealth to address this issue.\(^3\)

The Auditor-General's comparisons of Medicare data against hospital records revealed:

"...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

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\(^1\) Victorian Auditor-General's Office, Special Report No. 21., Visiting Medical Officer Arrangements, April 1993, p. 53.
\(^2\) Ibid.
\(^3\) Ibid.
provision of the same service and, due to the lack of a cross-checking mechanism, these duplicate payments had gone undetected."4

The Auditor-General recommended that at a minimum, there is a need for the release of relevant information between the State and the Commonwealth authorities, which would provide the framework for the detection of irregular payments.5 It was also suggested that details of the irregularities identified by audit should be released to the Commonwealth Health Insurance Commission, subject to the approval of the Victorian Minister for Health, so that the irregularities could be fully investigated.6

4.1.2 The State's Responsibilities In Relation to Duplicate VMO Claims

When asked about fraudulent practices by VMOs, at public hearing on 1 September 1993, the Minister for Health stated that the Commonwealth Government had not taken any formal action to instigate the implementation of a Commonwealth/State cross-checking mechanism. The Minister further indicated that it was the Commonwealth's responsibility to act upon this matter as "...it is the one that is being over serviced and paying the piper to the extent that it does happen."7

The costs associated with fraudulent billing practices and over servicing are borne by all Australian taxpayers. Accordingly, the absence of checks in the existing system to discourage and to detect inappropriate practices, is a problem that ought to concern both the Commonwealth and State governments.

4 Ibid., p. 55.
5 Ibid., p. 56.
6 Ibid.
7 Department of Health and Community Services, Minutes of Evidence, 18 August, 1993, p. 20.
4.1.3 The Release of Data to the Commonwealth

When asked about the release of State data to the Commonwealth at public hearing the Minister stated that:

"The Department would have to be careful and sensitive to the requirements of confidentiality in the Health Services Act. There is, however, discretion of the Minister for appropriate purposes. That is the qualification I have when I indicate that we will cooperate regarding any request by the Health Insurance Commission or the Federal Minister or the department that it be precisely for the purpose of addressing alleged but substantiated evidence of fraud and over-servicing that our records would be made available."8

The Committee accepts that the Minister and the Department are required to comply with the confidentiality requirements in the Health Services Act 1988. The absence of monitoring and verification processes ensures, however, that there is little likelihood of fraudulent claims or over-servicing being detected. Over-servicing, in this context, refers only to private patients as the costs associated with treating public patients are borne by public hospitals rather than by the Commonwealth.

The Committee has subsequently been advised that a working party of the Australian Health Ministers' Advisory Council (AHMAC) comprising representatives from the Commonwealth and each of the states/territories has been established by the Federal Minister for Health to examine and assess the matters raised in the Victorian Auditor-General's report. The AHMAC working party has the following terms of reference:

1. In consultation with the relevant professional groups, advise on what action can be taken to address the matters raised in the Victorian Auditor-General's Special Report No. 21 on visiting medical officer arrangements insofar as they may affect all states and territories.

8 Ibid., p. 21.
2. Having regard to existing privacy legislation, examine the information exchange arrangements that can be implemented to satisfy the responsibilities of the Commonwealth and the states/territories for ensuring that payments made to VMOs and the patients of VMOs are justified.

3. Identify any impediments to an ongoing exchange of information that would support the prevention, detection and prosecution of abuse.

4. Advise on what action can be taken to overcome any barriers to the detection of abuse.

At the first meeting of the working party which was held in January 1994, the states and territories were asked to advise on their capacity to provide the Commonwealth with access to hospital data, including any significant barriers to the provision of that information, such as privacy and confidentiality issues and/or legislative barriers. In Victoria, the Minister for Health is able to authorise the release of data in the public interest. The disclosure of patient names raises concerns in relation to privacy. Victoria, however, currently collects Medicare number as part of the Victorian Inpatient Data Set and may therefore provide the information to the Commonwealth without disclosing patient names.

An extract from the minutes of the AHMAC working party meeting of 28 February 1994, provides an insight into the Department's current position on this matter:

"The Victorian Department of Health and Community Services would be prepared to ask the Minister to authorise, in the public interest, disclosure of relevant patient hospitalisation data."

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9 Department of Health and Community Services, Internal Memorandum of 1/2/94 concerning the Australian Health Ministers' Advisory Council working party meeting of 25/1/94, prepared by the Director, Public Health.

10 Ibid.
A request was made to the Victorian Minister for Health, by Senator Richardson, for specific details of the apparent irregular payments identified during the Auditor-General's review on VMO arrangements. The data has not been released to the Commonwealth because confidentiality requirements in the *Audit Act* 1958 preclude the Auditor-General from releasing the available details to either the Department of Health and Community Services or to the Commonwealth. The Minister does not possess the information and therefore has no power under the *Health Services Act* 1988 to authorise its release.\(^{11}\)

4.1.4 The Development of a Cross-Checking Mechanism

There is now an opportunity to develop a system which will ensure that the controls over the medical profession are brought into line with those applying to other professions.

The introduction of a cross-checking mechanism to detect fraud and overservicing will necessitate Commonwealth access to State data and will provide the Commonwealth with the opportunity to better identify cost shifting. Under the terms of the Medicare Agreement, this could result in reductions in Commonwealth funding to the State (discussed in section 4.2 of this report). If an individual state/territory is not to be financially disadvantaged, in relation to its counterparts, any checks by the Commonwealth, should apply across Australia.

The development and implementation of an effective system will require a co-operative, planned approach. This should not be jeopardised by state isolationism or actions which are motivated by self-interest. The ability to successfully address this issue will assist in protecting the Australian taxpayers who are ultimately required to meet the costs associated with any unethical medical practices.

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\(^{11}\) Ibid.
Finding 4.1

The existing absence of a cross-checking mechanism between the states and the Commonwealth means that any inappropriate practices by medical practitioners, such as duplicate billing and over-servicing, are not likely to be detected.

Finding 4.2

The costs associated with over-servicing and duplicate claims by medical practitioners are borne by all Australian taxpayers. The Commonwealth and the states each have a responsibility to actively contribute to the establishment of a Commonwealth/state cross-checking mechanism which is designed to prevent and detect such practices.

Finding 4.3

It is preferable that the checking mechanism apply on a national basis so that participating states and territories are not financially disadvantaged.

Recommendation 4.1

The Victorian Minister for Health should, in the public interest, accept the Department's recommendation to authorise the release of hospital data to the Commonwealth to enable the implementation of a cross-checking mechanism which will discourage and detect inappropriate billing and servicing practices by medical practitioners.
4.2 THE SHIFTING OF COSTS TO THE COMMONWEALTH BY PUBLIC HOSPITALS

The Auditor-General's review revealed that, in contravention of the Medicare Agreement, some public hospitals had shifted various inpatient costs from the State to the Commonwealth. In the main, the shifting of these costs involved the billing of Medicare, rather than the hospitals, for pathology, radiology and other medical services to public inpatients.12

Under clause 8.1 of the Medicare Agreement, the State has agreed to ensure that hospital services within Victoria "are available to all eligible persons without charge as public patients."13 This means that the Commonwealth should not be charged for medical services which are provided to public patients in public hospitals.

Under the terms of the Medicare Agreement, the State's base hospital funding grant may be reduced if the Commonwealth incurs additional costs, or if savings accrue to the State, by reason of the State's failure to comply with clause 8.1.14

The Medicare Agreement also attempts to discourage any excessive shifting of costs by the states by penalising those states with high levels of Medicare expenditure. Under the Agreement between the Commonwealth and the State of Victoria, the amount of the base hospital funding grant which is payable by the Commonwealth, will be reduced if Victoria's Medicare expenditure per capita is more than 11 percent above the national average.15

While the Medicare Agreement gives the State responsibility for ensuring that costs are not shifted by public hospitals to the Commonwealth, the State

12 Victorian Auditor-General's Office, Special report No. 21, op. cit., p. 57.
13 Agreement Between the Commonwealth of Australia and the State of Victoria in Relation to the Provision of Public Hospital Services and Other Health Services from 1 July 1993 to 30 June 1998, clause 8.1.
14 Ibid., Schedule C, Clause 2.4.
15 Ibid., Schedule C, Clause 2.3.
does not have access to Commonwealth data and would therefore experience some difficulties in identifying such practices. The Auditor-General was able to identify instances of cost shifting because he was able to compare hospital records against Commonwealth Medicare data.

The Australian Medical Association, in its response to the Auditor-General's findings stated that:

"The AMA has been and still is concerned about the improper shifting of State health costs to the Commonwealth by public hospitals and has repeatedly warned the profession, the Health Department Victoria (now the Department of Health and Community Services), the Federal Department of Health and the Health Insurance Commission of its concerns in this area. Specifically, detailed correspondence dated 28 May 1992 was sent to Commonwealth and State Auditor-Generals outlining the above concerns, with poor response."16

The Commonwealth Government is obviously aware that public hospitals have both the opportunity and the financial incentive to shift some of their costs to the Commonwealth. It is considered unlikely that cost-shifting is confined to Victoria. Rather, similar practices are probably employed throughout Australia.

Under casemix in Victoria, hospitals are funded on the basis of outputs with those hospitals that can efficiently provide services and/or perform more complex procedures receiving more funding. Those hospitals, however, that are shifting a portion of their costs to the Commonwealth, have a financial advantage over hospitals that do not employ such practices. Accordingly, where this occurs and it remains undetected, the Department cannot ensure that the more efficient hospitals are receiving more funding or that the public is receiving value for money in acquiring hospital outputs.

The implementation of a Commonwealth/State cross-checking mechanism to detect fraud and over-servicing (as recommended in section 4.1 of this report) will provide the Commonwealth with the opportunity to identify and assess the extent of cost shifting by public hospitals. Based on the information made available to the Committee, by the Department, it does not appear that the AHMAC working party has attempted to address the issue of cost shifting.

As noted previously, where cost shifting occurs, the Commonwealth under the terms of the Medicare Agreement, may reduce the amount of funding to the State. It is believed that any monitoring and/or checking by the Commonwealth should apply on a national basis. A common mechanism across Australia will enable comparable and measurable outcomes and will provide greater opportunity for the efficient and effective use of the limited funds which are available for expenditure on health care.

The extent of cost shifting by the states is not known at the current time. Accordingly, it is also unknown as to whether the benefits associated with the identification and prevention of this practice, will outweigh the costs. It is believed that an initial assessment is required to identify the extent of cost shifting and to ascertain the cost-effectiveness of implementing ongoing checks. Should the results of the assessment indicate that the problem is not significant, it is suggested that reviews be conducted on a periodic basis (for example every two years) to ensure that the problem does not escalate.

**Finding 4.4**

*Under the Medicare agreement, the State is responsible for ensuring that costs are not shifted by public hospitals to the Commonwealth. The State, however, does not have access to Commonwealth data and would therefore experience significant difficulties in identifying such practices.*
Finding 4.5

Those public hospitals that are shifting a portion of their costs to the Commonwealth have a financial advantage over hospitals that do not employ such practices. Accordingly, where this occurs and remains undetected, the Department cannot ensure that the more efficient hospitals are receiving more funding under casemix or that the public is receiving value for money in acquiring hospital services.

Finding 4.6

The introduction of a Commonwealth/State cross-checking mechanism to prevent and detect fraud and over-servicing will provide the Commonwealth with an opportunity to identify and prevent the shifting of certain health costs, by public hospitals, to the Commonwealth.

Finding 4.7

The extent of cost shifting by public hospitals is not known at the current time. Accordingly, it is also unknown as to whether the benefits associated with the identification and prevention of this practice will outweigh the costs. An assessment is required to identify the extent of cost shifting and to determine the cost-effectiveness of implementing ongoing procedures to minimise this practice.
Recommendation 4.2

In developing a cross-checking mechanism to detect fraud and overservicing, the various state/territory governments together with the Federal Government, should utilise the opportunity to establish the extent of cost-shifting, by public hospitals, so that the impact of this practice on the efficient and effective utilisation of scarce health care resources can be assessed. Should the results of the assessment indicate that the problem is not significant, periodic rather than ongoing reviews should be conducted to ensure that inappropriate practices do not increase.

4.3 RESTRICTIONS ON PUBLIC PATIENT ADMISSIONS

4.3.1 Public Hospital Funding Arrangements

Private patients pay their doctors for services provided and pay a daily fee, to the hospital, for accommodation and nursing care. Public patients, on the other hand, pay nothing to the hospital and the hospital pays for the services provided by doctors. The Auditor-General noted therefore that the net costs of private patients to public hospitals are substantially lower than for public patients. These funding arrangements provide hospitals with a financial incentive to give preference to private patients and some hospitals had imposed restrictive public patient admission practices, primarily for budgetary purposes. It was concluded that these restrictive admission practices together with an increased demand for public hospital elective surgery (primarily as a result of reductions in private health insurance

17 Victorian Auditor-General's Office, Special Report No. 21, op. cit., p. 61.
18 Ibid., pp. 61 - 63.
coverage) adversely impacts on the State's ability to reduce public patient waiting lists.\textsuperscript{19}

The Secretary to the Department of Health and Community Services, in response to the Auditor-General's findings, stated that this issue would be addressed in the Department's casemix funding arrangements to be introduced from 1 July, 1993.\textsuperscript{20}

The Committee believes that further consideration of this matter should occur when casemix funding has been operating for at least a year.

4.3.2 Administration of Theatre Lists in Sessional Hospitals

The Auditor-General noted that as a consequence of the use of mixed theatre lists, 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.\textsuperscript{21} Further, at sessional hospitals where VMOs effectively administer elective surgery waiting lists and/or the process of allocating patients to operating theatre lists, hospital management are not in a position to ensure that all patients are admitted on the basis of clinical need.\textsuperscript{22}

Under the terms of the Medicare Agreement, the State is responsible for ensuring that access to public hospital services is provided on the basis of clinical need.\textsuperscript{23} Similarly, to be eligible for State funding, individual hospitals are required, under the Department of Health and Community

\textsuperscript{19} Ibid., p. 63.
\textsuperscript{20} Ibid.
\textsuperscript{21} Victorian Auditor-General's Office, Special report No. 21, op. cit., p. 64.
\textsuperscript{22} Ibid.
\textsuperscript{23} Agreement Between the Commonwealth of Australia and the State of Victoria in Relation to the Provision of Public Hospital Services and Other Health Services from 1 July 1993 to 30 June 1998, p. 9.
Services "Hospital Conditions of Funding 1993/94", to ensure that access to their services is on a clinical needs basis.\textsuperscript{24} This system aims to ensure that all Victorians, irrespective of their health insurance status, have similar opportunities to receive treatment in public hospitals. The rights of those with private health insurance are protected to the extent that they are able to obtain access to the specialised facilities which are available in some of the large public teaching hospitals. Many private hospitals do not possess these facilities.

There is no evidence to suggest that the new casemix formula, including the linkage of additional funding to the throughput pool, will ensure that patients are admitted to public hospitals on the basis of clinical need. Access to the additional throughput pool, under casemix, is contingent on hospitals achieving reductions in the number of urgent and semi-urgent cases on their waiting lists. The Department believes that the linkage of additional funding to waiting lists will provide hospitals with an incentive to treat urgent and semi-urgent cases promptly.\textsuperscript{25} Such linkage, may in fact, provide hospitals with an incentive to manipulate their waiting lists in order to ensure eligibility for additional funding. Advice received from public hospitals, during Committee visits, indicated that under casemix, some hospitals are not able to fully recoup the costs incurred in performing some surgical procedures. Hospitals therefore, could have a financial incentive to discourage VMOs from placing such cases on waiting lists. This could be achieved, for example, through a quota system.

There is little doubt that VMOs are often best qualified to establish clinical necessity. Many visiting doctors, however, derive the majority of their revenue from their private practices. In order to maximise private practice fees, VMOs may have a vested interest in ensuring that their private patients obtain prompt admission to hospital. This financial incentive will exist regardless of whether a VMO is engaged on a sessional or a fee-for-service basis. In view of this, hospital management have a responsibility to

\textsuperscript{24} Department of Health and Community Services, \textit{Hospital Conditions of Funding 1993/94}, Health Policy and Programs Division, p. 6.

ensure that procedures are in place to prevent and detect inappropriate practices by VMOs. Management should ensure that waiting lists and theatre lists are independently reviewed on a regular basis so that any apparent significant biases by VMOs, in assigning their private patients to hospital lists, can be identified and actioned. These reviews should be performed by the Medical Director and where practicable, assistance could be provided by the internal auditor.

Under the Medicare Agreement, the State has an obligation to ensure that access to public hospitals is provided on the basis of clinical need. Notwithstanding this requirement, it is also arguable that the State, through the Department of Health and Community Services, has a social and ethical obligation to ensure that this occurs. The Auditor-General's findings indicate that past reliance, on public hospitals, to ensure that patients are admitted on the basis of clinical necessity, has not always proved to be effective. The Committee therefore believes that the Department should take a stronger role in ensuring that this occurs.

It is suggested that at a minimum, the Department should utilise statistical data to identify any substantial and unexplained changes in the mix of private and public patients within individual hospitals and also to enable comparisons between hospitals. Action should be taken by the Department to ascertain the reasons for any irregularities identified.

The Auditor-General, during his review, received advice from the Department that data submitted by the hospitals by way of elective surgery activity returns was incomplete and inconsistent and that any reference drawn from such data would be questionable. Prior to analysing the data received from the public hospitals, the Department will first need to ensure the completeness and accuracy of such data.
Finding 4.8

Visiting medical officers are often best qualified to establish clinical need. Given however, that visiting medical practitioners may have a financial incentive to place their private patients ahead of public patients on hospital waiting lists, hospital managers should ensure that procedures are in place to prevent and detect inappropriate admission practices.

Recommendation 4.3

Hospital waiting lists and elective surgery lists should be reviewed on a regular basis by the Medical Director as assisted by the internal auditor, where practicable, so that any significant biases, by visiting medical officers, in assigning their private patients to hospital waiting lists, can be identified and investigated.

Finding 4.9

The State, through the Department of Health and Community Services, has a legal obligation under the Medicare Agreement as well as a social responsibility to ensure that all persons are admitted to public hospitals on the basis of clinical need. The Department should therefore take a stronger role in ensuring that this occurs.
Recommendation 4.4

The Department should utilise statistical data analyses to identify any substantial changes in the mix of private and public patients within individual hospitals and also to undertake comparisons between hospitals. Any irregularities should be investigated. The Department will first need to ensure the completeness and accuracy of the data obtained from public hospitals.
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14 July, 1993

The Australian Medical Association (Victorian Branch)

Dr C. Scaife, Chairman, Branch Council; Dr E. R. Mason, Executive Director and Miss L. Moore, Assistant to Executive Director.

18 August, 1993

The Department of Health and Community Services

The Honourable M. Tehan, Minister for Health and Dr J. Paterson, Secretary, Department of Health and Community Services.

1 September, 1993

Victorian Auditor-General’s Office

Mr C. Baragwanath, Auditor-General; Mr G. Hamilton, Assistant Auditor-General, Mr R. Walker, Chief Director of Audit and Mr S. Naylor, Director of Audit.

10 September, 1993

The Australian Medical Association (Victorian Branch)

Dr E. Robyn Mason, Executive Director and Dr Clyde Scaife, Branch Council.
LIST OF WITNESSES

10 September, 1993

The Victorian Hospitals' Association

Mr A. Hughes, Executive Director; Mrs M. Smith, Director, Secretariat; Mr S. Capp, Chief Executive Officer, Mornington Peninsula Hospital and Honorary Board Member of the VHA and Mr J. Smith, Chief Executive Officer, Nhill Hospital and Deputy Chairman of the VHA.
LIST OF ORGANISATIONS AND INDIVIDUALS PROVIDING SUBMISSIONS TO THE COMMITTEE
LIST OF ORGANISATIONS AND INDIVIDUALS PROVIDING WRITTEN AND ORAL SUBMISSIONS TO THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE.

Angliss Hospital

Austin Hospital

Australian Medical Association (Victorian Branch)

Dandenong Hospital

Department of Health and Community Services

Dr Breheny, James E., Partner-National Director, Health Economics Consulting, Deloitte Touche Tohmatsu

Fairfield Hospital

Monash Medical Centre

Mornington Peninsula Hospital

Sandringham and District Memorial Hospital

St. Arnaud District Hospital

The Bendigo Hospital

The Royal Melbourne Hospital

The Royal Women's Hospital

Victorian Auditor-General's Office

Victorian Hospitals' Association

Wangaratta District Base Hospital
LIST OF ORGANISATIONS AND INDIVIDUALS PROVIDING WRITTEN AND ORAL SUBMISSIONS TO THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE.

Western Hospital

Wodonga District Hospital

Wonthaggi and District Hospital
APPENDIX A

HOSPITAL CONTROLS OVER THE REMUNERATION OF VMOS

Minimum Processes Identified by the Auditor-General's Office Including an Extract of Departmental Guidelines
APPENDIX A

HOSPITAL CONTROLS OVER THE REMUNERATION OF VMOs

INTRODUCTION

The process that should be adopted by hospitals to substantiate the provision of services by Visiting Medical Officers (VMOs) is no more onerous, difficult or different from the practices adopted, or expected to be operating, in respect of the normal verification of expenditure associated with the purchase of any service.

The objectives associated with improving accountability are generally accepted. However, the debate is about the mechanisms which should be implemented by hospitals to improve the control over the acquisition of these services.

MINIMUM PROCESSES IDENTIFIED BY VICTORIAN AUDITOR-GENERAL'S OFFICE

The minimum processes should be:

Engagement (fee for service and sessional)

• VMO vacancies should be subject to open competition;

• appointments should be based on set criteria; and

• contracts should be entered into which include accountability requirements and private practice arrangements.

VMOs engaged on a fee for service basis

• All VMO services (date and time of service, details of service provided) should be recorded on the patient's medical record which enables accountability for service provision and standard of care;
• The invoice from the VMO should record date and time of attendance/service, description of service provided and the patient name;

• Invoice details should be checked against patients medical records to verify that the service has actually been provided, (and not paid for previously) and that the patient is not a private or compensable patient;

• The amount of individual claims should be checked against agreed contract schedule of rates;

• Directors of Medical Services should verify whether services were deemed to be necessary and appropriate to the condition of the patient; and

• A framework for peer review and quality assurance should be established by hospitals to review the methods of service provision and the quality of services.

VMOs engaged on sessional basis

Sessional VMO rosters should be maintained for both in-hours and out-of-hours work by the Director of Medical Services which clearly detail the agreed work allocation for each VMO and include:

• number of sessions to be worked;

• classification of session, (i.e. theatre/ward/outpatients/administrative);

• type of session, (ie. standard, composite or abbreviated); and

• an indication of whether the VMO is on exclusive or consultative recall.
In respect of each pay period, a sessional VMO should submit a record of attendances (dates and times) including details of any out-of-hours work and leave taken.

All services involving direct patient care should be recorded by the VMO on the patient's medical record.

The Director of Medical Services should verify whether:

- all sessions were in fact worked and correspond to the rostered sessions;

- any leave taken had been authorised; and

- out-of-hours work (exclusive or consultative recall) was in fact undertaken.

The Director of Medical Services should ensure that the number of private patients treated by each sessional VMO during publicly paid sessions is in accordance with the VMO's contract of engagement and hospital policy.

Rates and allowances to be paid to VMO's should be in accordance with the contract entered into.

INSTRUCTIONS ISSUED BY THE DEPARTMENT

The Department of Health and Community Services recently released (July 1993) an updated Finance and Accounting Manual for Public Hospitals which include instructions on Payments to Visiting Medical Practitioners. These instructions, which are listed below, are consistent with the recommendations of the Auditor-General.

"These payments and the documentation supporting them must be subject to controls which are similar to those applying to other suppliers, that is:
• checking of invoices against patient records to ensure that the service has been rendered;

• checking to ensure that the service is closely related to the patients' needs;

• checking for appropriate pricing with respect to Commonwealth Medical Benefits Schedules;

• checking that the charge does not duplicate another attendance;

• checking that on-call and recall charges are appropriate; and

• checking that the invoice has been received by the hospital in accordance with its usual procurement and payment terms.

A number of the above checks require access to patient records and should be performed by a medical records officer prior to signed approval of the invoice by the Director of Medical Services or his/her deputy.

The internal controls are to be supplemented by a delegated Finance Department officer checking the invoice and initialling it prior to payment. The invoices must accompany the cheques when presented to the cheque signatories who should evidence their approval on the invoices or batch summary sheet.”
APPENDIX B

VICTORIAN HOSPITALS' ASSOCIATION - VISITING MEDICAL OFFICERS - AGREED AMA/VHA PROTOCOL
MEMORANDUM TO: Chief Executive Officers 
Divisions 1 - 4

SUBJECT: VISITING MEDICAL OFFICER ARRANGEMENTS

You will recall that as a consequence of the Auditor-General's Report on VMOs, VHA was invited to appear before the Public Accounts and Estimates Committee to discuss VMO accountability issues and other more general matters.

VHA and AMA have now developed a jointly agreed protocol which covers a number of issues relating to the accountability of VMOs. The protocol has now been forwarded to, and accepted by the Public Accounts and Estimates Committee. A copy is attached.

Whilst VHA and the AMA have reached agreement on the majority of key issues, there remains a few areas of disagreement, as follows:

Clause 1.2 Account Raising and Payment
VHA believes that systems based on recording of details of medical services on a sheet kept with the patient record are in place in many hospitals and meet the requirements of the medical officers and hospitals. Each entry is signed and the sheet is accepted as a claim following discharge of the patient. The system should only be used by mutual agreement.

AMA is not supportive of the use of the sheet in the patient record.

Clause 1.5 Guidelines - VMO Services
VHA supports establishment of agreed guidelines for hospitals and medical staff and believes that their existence will minimise disputation. Guidelines will only exist if mutual agreement is reached.

Guidelines covering issues such as those included under 1.4 (a, b, c, d) would be useful.

Clause 2.1 Letters of Appointment/Contract
Time of session to be worked should not be incorporated with the contract but should be agreed with the VMO and should be able to be varied by agreement without variation to the contract.

The number of sessions to be worked, rather than specific times is considered to be sufficient, and potentially more flexible.
Clause 2.8  Recording of Recall

VHA believes that medical staff should not be subject to accusations of overservicing if their visits are as a result of recall by hospital staff.

The AMA holds the view that VMOs when recalled by other hospital staff, should not be required to record such recall, i.e. the staff member initiating the recall should make the recording.

The differences between VHA and AMA are not considered to be significant. The intent in issuing this protocol is to assist members address a number of accountability issues relating to visiting medical staff arrangements. This protocol should be read in conjunction with the DHCS Finance and Accounting Manual section relating to "Payments to Visiting Medical Practitioners" p.53.

I trust you will find this information useful.

Yours sincerely,

THE VICTORIAN HOSPITALS' ASSOCIATION LIMITED

ALLAN D HUGHES
EXECUTIVE DIRECTOR

cb
- PROTOCOL -
VISITING MEDICAL OFFICER ARRANGEMENTS

1. FEE FOR SERVICE:

1.1 Accounts/Claim Generation
The account for every patient should contain:

- Patient name
- U.R. Number if provided by hospital or other agreed identification, e.g. address, date of birth
- Date
- Time where relevant (this is required in fee-for-service hospitals in cases of multiple visits or where an after hours loading is claimed and in sessional hospitals for fee-for-service claims)
- Item number or description of service sufficient to enable an item number to be allocated
- Doctors name
- Fee

1.2 Accounts Raising and Payment
VMO account should be submitted and paid within a reasonable time of patient separation, or monthly in the case of longer stay patients. In any case, the agreed time frame should be included in the contract between the VMO and the hospital, including how arrangements may be varied by mutual agreement.

Option
Whilst the above approach is recommended, it is recognised that the following approach is already in place in some hospitals.

The VMO to record account details on a sheet in the patient record. The hospital will accept and process claims from this sheet.

Visit details should appear in the patient record which ever option is chosen. The accounts sheet does not form a permanent part of the patient record.

1.3 Verification of Claims
The primary purpose of the medical record is to facilitate care of the patient, however, VHA and AMA acknowledge that the content can be used to verify attendance. The hospital should impress upon its staff the medico-legal importance of recording in their section of the medical record when a VMO has attended the patient.

It the VMO cannot demonstrate, either in the patient record or by other evidence, that a service has been rendered, payment should not be made for the service.
1.4 **Clinical Justification for Services**

Claims based on the VMOs view of the medical needs of the patient will be accepted.

Medical administration authorisation of claims should include assessment of:

a) the appropriateness of self-initiated ward rounds e.g. Saturday mornings).

b) Pre-operative and post-operative consultations - consideration to size and structure of hospital, and availability of HMO staff or Registrars. Normal post operative care should not be billed under fee-for-service.

c) Assistance at operations.--The availability of HMO staff or registrars should be considered.

d) Parallel consultations.

Claims for service provided to improve the efficiency of the hospital's handling of patients (e.g. semi-elective procedures scheduled out of hours) may be subject to administrative disallowance if these are not in accordance with hospital guidelines.

If medical administration's routine audit of these claims raises concerns and they cannot be resolved by discussion between the VMO and Director of Medical Services, the issue will be referred to a peer process.

The peer process is to be determined by the VMO group subject to approval by the hospital.

1.5 **Guidelines - VMO Services**

Guidelines/protocols relating to VMO services should be agreed between the hospital and medical staff.

2. **SESSIONAL**

2.1 **Letters of Appointment/Contract**

These must specify the number, type (i.e. standard, composite or abbreviated) and classification (i.e. theatre, ward, outpatients, or administrative) of sessions to which the VMO is to be engaged. The approval process for additional services beyond the number of services stipulated should be clearly stated.

These terms of appointment must formally state the mechanism for any variation to sessions, terms of contract, and level of services to be provided.

2.2 **Rosters**

These must specify the type of on-call arrangement where these apply (i.e. exclusive or consultative).

2.3 **Record of Attendance**

This should include a record of dates and sessions worked. An attendance record for each VMO should be provided by the hospital. The attendance record must be completed and signed by the VMO.
2.4 Additional Claims

These should occur only if the approved process as outlined in 2.1 has been followed. Brief details should be noted on the record of attendance.

2.5 Absence from Rostered Sessions

This should be handled as for any employee of the hospital. Leave should, as much as is possible, be approved by hospital administration in advance.

2.6 Medical emergency

Absence due to medical emergencies for which a VMO has responsibility is always an acceptable reason for absence. Medical administration may randomly audit such claims for unscheduled absences. No claim should be raised by the VMO if he/she is absent throughout an entire session by reason of an outside medical emergency. Rest after a medical emergency (e.g. operations during the night) is also a valid reason for absence. Claims for payment should be honoured if the emergency in question involves a patient of the hospital. Disputes arising as to the appropriateness of such claims should be adjudicated by the Chairman of the hospital’s Senior Medical Staff Association.

2.7 Verification of Extra Claims

Claims based on the VMOs view of the medical needs of the patient will be accepted subject to 2.1.

No extra claims need be paid unless a contemporaneous record exists in the patient record to verify provision of the service.

Medical administration authorisation of claims should include assessments as in 1.4.

Claims for services provided to improve the efficiency of the hospital’s handling of patients (e.g. semi-elective procedures scheduled out of hours) may be subject to administrative disallowance if these are not in accordance with hospital guidelines.

If medical administration’s routine audit of claims raised concerns and they cannot be resolved by discussion between the VMO and Director of Medical Services, the issue will be referred to a peer process.

The peer process is to be determined by the VMO groups subject to approval by the hospital.

2.8 Recording of Recall

It is acknowledged that it is right and appropriate to have self initiated recall. When a VMO is recalled to the hospital, the name of the person requesting the recall should be recorded in the patient records as a protection for medical staff against accusations of over-servicing.

2.9 Recalls During On-Call

The maximum number of recall hours in an on-call period should not exceed the number of total on-call hours (i.e. 10 hours on-call, maximum recall hours payable is 10 hours at recall rates).
APPENDIX C

AUSTRALIAN MEDICAL ASSOCIATION (VICTORIAN BRANCH) - VISITING MEDICAL OFFICERS - AGREED AMA/VHA PROTOCOL
7 February 1994

MEMORANDUM:

TO: CHAIRMEN OF SENIOR MEDICAL STAFF

FROM: EXECUTIVE DIRECTOR, AMA (VICTORIAN BRANCH)

RE: VISITING MEDICAL OFFICER ARRANGEMENTS

As a consequence of the Auditor-General's Report on VMOs, the AMA (Victorian Branch) was invited to appear before the Public Accounts & Estimates Committee to discuss VMO accountability issues and other more general matters.

The AMA (Victorian Branch) and VHA have jointly developed a protocol which covers a number of issues relating to the accountability of VMOS. The protocol has been forwarded to, and accepted by the Public Accounts and Estimates Committee. A copy is attached.

Whilst there has generally been agreement between the AMA (Victorian Branch) and VHA on issues raised in this protocol, there are a few points of disagreement and reference to these is included in the document.

In the absence of a centralised process for establishment of terms and conditions for VMOs, the AMA is unable to directly determine implementation of this protocol. It should therefore be seen as a guide for VMOs undertaking negotiations at any individual hospital. In such negotiations, members should ensure that audit arrangements are acceptable to themselves.

Dr E Robyn Mason
EXECUTIVE DIRECTOR
AGREED AMA/VHA VISITING MEDICAL OFFICER ARRANGEMENTS
29 OCTOBER 1993

1. FEE FOR SERVICE:

1.1 Accounts/claim generation

The account for every patient attended should contain:

* Doctor name
* Patient name
* U.R. Number if provided by hospital or other agreed identification (e.g. address, date of birth)
* Date
* Time where relevant (this is required in fee for service hospitals in cases of multiple operations or where an after hours loading is claimed, and in sessional hospitals for fee for service claims)
* Item number or description of service sufficient to enable an item number to be allocated
* Fee

1.2 Account raising and payment:

VMO accounts should be submitted and paid within a reasonable time of patient separation, or monthly in the case of longer stay patients. In any case, the agreed time frame should be included in the contract between the VMO and the hospital, including how arrangements may be varied by mutual agreement.

** NOTE 1 **

VHA in their advice to CEOs have recognised the practice of VMOs recording account details on a sheet in the patient record and have supported hospital acceptance of this sheet.

AMA is concerned that these account sheets in the medical file may not be checked by the VMO before the hospital prepares payment based on the entries. Furthermore records at a patient's bedside should not contain fees information, yet this is essential for rendering the account.

This account sheet will not form a permanent part of the patient record and therefore where it is in use, VMOs should ensure that there is, for each attendance, an additional contemporaneous clinical record within the patient's record.
1.3 Verification of services:

The primary purpose of the medical record is to facilitate care of the patient. However, VHA and AMA acknowledge that the content can be used to verify attendance. The hospital should impress upon its staff the medico-legal importance of recording in their section of the medical record when a VMO has attended the patient.

If the VMO cannot demonstrate, either in the patient's records or by other evidence, that a service has been rendered, payment should not be made for the service.

1.4 Clinical justification for services:

Claims based on the VMO's view of the medical needs of the patient will be accepted.

Medical Administration's routine audit of claims shall include:

(a) The appropriateness of self-initiated ward rounds.

(b) Pre-operative consultations - consideration of the size and structure of the hospital and the availability of Hospital Medical Officers (HMOs) or Registrars. Routine post-operative care should not be billed under fee-for-service.

(c) Assistance at operations - the availability of HMO staff or Registrars should be considered.

(d) Parallel consultations.

Claims for service provided to improve the efficiency of the hospital's handling of patients (e.g., semi-elective procedures scheduled out of hours) may be subject to administrative disallowance if these are not in accordance with hospital guidelines.

If medical administration's routine audit of these claims raises concerns and they cannot be resolved by discussion between the VMO and the Director of Medical Services, the issue will be referred to a peer process.

The peer process is to be determined by the VMO group subject to approval by the hospital.
1.5 Guidelines - VMO Services:

Guidelines/protocols relating to VMO services should be agreed between the hospital and medical staff.

**NOTE 2** Whilst VMA recommends the establishment of agreed guidelines/protocols relating to VMO services, the AMA does not support the development of prescriptive protocols relating to clinical-practice since it is the legal and ethical responsibility of the treating VMO to determine medical care appropriate for each individual patient.

2. SESSIONAL VMOs

For most VMOs in most sessional hospitals the terms and conditions are based on the recently expired Sessional Medical Officers Award.

2.1 Letters of Appointment/Contract

These must specify the number, type (i.e., standard, composite or abbreviated) and classification (i.e., theatre, ward, outpatients or administrative) of sessions for which the VMO is to be engaged. The terms of appointment must formally state the mechanism for any variation to number, type, classification and time of sessions. The notice period before any variation becomes operative should also be stated.

**NOTE 3** The AMA believes the letter of appointment must specify times of sessions to be worked. It is appropriate for Sessional Medical Officers to be given defined times so that they can accommodate their other clinical commitments. Such a requirement is also necessary for the implementation of good audit process.

2.2 Rosters:

These must specify the type of on-call arrangement, where these apply, i.e., exclusive or consultative.
2.3 Record of Attendance:

This should include a record of dates and times of attendance. An attendance record for each VMO should be provided by the hospital. The attendance record must be completed and signed by the VMO.

2.4 Additional Claims:

These should only occur if the approved process as outlined in 2.3 has been followed. Brief details of the basis for the claim should be noted on the record of attendance.

2.5 Absence from Rostered Sessions:

This should be handled as for any employee of the hospital. Leave should, as much as is possible, be approved by hospital administration in advance.

2.6 Medical Emergency:

Absence due to medical emergencies for which a VMO has responsibility is always an acceptable reason for absence. Medical administration may randomly audit such claims for unscheduled absences. No claim should be raised by the VMO if he/she is absent throughout an entire session by reasons of an outside medical emergency. Rest after a medical emergency (e.g., operations during the night) is also a valid reason for absence. Claims for payment should be honoured if the emergency in question involves a patient of the hospital. Disputes arising as to the appropriateness of such claims should be adjudicated by the Chairman of the hospital's Senior Medical Staff Association.
2.7 Verification of Claims:

Claims based on the VMOs view of the medical needs of the patient will be accepted.

No extra claims need be paid unless a contemporaneous record exists in the patient's records to verify the service.

Claims for services to improve the efficiency of the hospital's handling of patients (e.g., semi-elective procedures schedules out of hours) may be subject to administrative disallowance if no prior approval in accordance with hospital policy has been given.

If Medical Administration's routine audit of these claims raises concerns which cannot be resolved the issues will be referred to a Clinical Utilisation Review committee for peer review.

The peer process is to be determined by the VMO group subject to approval by the hospital.

3. RECORDING OF RECALL:

It is acknowledged that it is right and appropriate to have self-initiated recall. When a VMO is recalled to the hospital, the name of the person requesting the recall should be recorded in the patient's records.

4. RECALLS DURING ON-CALL

The maximum number of recall hours in an on-call period should not exceed the number of total on-call hours (i.e., 10 hours on-call, maximum recall hours payable is 10 hours at recall rates).
APPENDIX D

DOCTORS' BILLING FORM - SAMPLE
APPENDIX E

AN OVERVIEW OF THE COMPONENTS OF THE CASEMIX FUNDING FORMULA
APPENDIX E

AN OVERVIEW OF THE COMPONENTS OF THE CASEMIX FUNDING FORMULA

Extracted from the document prepared by the Department of Health and Community Services entitled "Casemix Funding for Public Hospitals Victoria's Policy."

Fixed Grant Components

G1. Non-admitted Patients Grant
The non-admitted patients grant will be based on each respective hospital's outpatient expenditure in 1992-93. Hospitals with unusually high costs per outpatient occasion of service will be identified and their budgets adjusted accordingly.

G2. Training and Development Grant
This grant captures the teaching, training and research component of hospitals that are not part of the patient services.

This grant provides hospitals with an allowance which specifically recognises non-service related component of the cost of those health professionals who perform dual functions within the hospital. Details of the various components of this grant are outlined in Appendix 2. It covers an allowance for hospital medical officers and registrars, a supervisory allowance for full-time and academic staff; allowance for nurses; other health professionals; an a research grant based on size of hospital plus a 10 per cent loading in Group A and B hospitals to cover the cost of providing undergraduate education.

G3. Benchmark Overhead Grant
This grant is a fixed annual element which is related to hospital size and hence to benchmark 'overhead' cost. The benchmark overhead grant can be regarded as reimbursement for the composite cost of all those activities which keep a hospital ticking over, but which are, at least in the short run, little affected by the immediate level of clinical activity.

This grant will be based on 1992 calendar year throughput and has been set at $850 per weighted inlier equivalent separation. Group E hospitals will receive a further $50 per weighted case to take account of their increased costs of long service leave.

G4. Specified Grants
These grants include those services previously unidentified, but contained in the Compensation Grant which do not relate to inpatient care. These grants will be funded as program line items and include items such as:

- Victorian Maintenance Dialysis Program
- Rehabilitation
- Statewide Pathology Reference Laboratories
- Non-English speaking background grant
- Accreditation Allowance
- Koon Hospital Liaison Officers
- Other Grants

These grants will be described in individual hospital health service agreements.

G5. Compensation Grant
The compensation grant is calculated as a residual by subtracting all other payments to the respective hospital in 1992–93, from the total budget of that hospital in the same year. The grant is therefore a balancing item or top-up grant which principally will reflect inefficiencies within the hospital. The compensation grant will be targeted in hospital budget cuts.

Variable Case Payments

P1. Unit DRG and Outlier Payment
The Unit DRG inpatient payment will be calculated by multiplying the number of DRG weighted inlier equivalent separations by a unit cost set at short-run marginal cost levels. In 1993–94 the unit cost will be set at $800.
P2. Public Medical Payment

The Public Medical Payment compensates hospitals for differences in their public/private mix and accounts for the fact that medical costs of public patients are paid by the hospital, whereas for private patients these costs are met by the Health Insurance Commission or by the patient themselves.

In 1993–94 the payment per DRG weighted public inpatient will be $300.

P3. Rural/Isolated Hospitals Payment

This payment covers an allowance to isolated and other rural hospitals for the additional costs (compared to hospitals in the metropolitan area) for ambulance services. It is based on an analysis which indicated that ambulance costs per weighted inpatient are higher in isolated hospitals and other rural hospitals when compared to metropolitan hospitals (including Geelong). Isolated hospitals are defined as those hospitals located more than 60 kilometres from a level 3 or higher surgical service.

The payment to be provided is:

Isolated Hospitals = $35 per weighted inpatient

Other Rural Hospitals = $14 per weighted inpatient

P4. Nursing Home Type Patient Payment

The DRG system was developed to classify acute inpatients, so it is necessary to provide a separate payment unit for non-acute inpatient care in acute hospitals. A nursing home type patient is defined as an inpatient who has been hospitalised longer than 35 days, unless a medical practitioner has completed a 3B Form which confirms that the patient is still in need of acute care.

The payment for nursing home type patients is set at $110 per nursing home type bed/day.
REPORTS OF THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE
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