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Inquiry into Health Funding

Submission to accompany testimony of Dr Ross Cartmill to the Committee – 16 March 2006

Introduction

Ross Ashley Cartmill is the Chair of the Australian Medical Association of Queensland (AMA Queensland) Visiting Medical Officer (VMO) Committee. He has held this position for over three years, during which time he has been involved in negotiations with Queensland Health for two VMO agreements. Dr Cartmill is also a Branch Councillor of AMA Queensland.

Dr Cartmill has been a medical practitioner for 36 years, and a registered medical specialist in urology for 25 years. He has a private practice on Wickham Terrace in Brisbane, and also conducts clinics in a number of other suburbs in the Greater Brisbane region. In addition, he conducts five sessions a week as a Visiting Medical Officer (VMO) at the Princess Alexandra Hospital (PAH).

VMOs

There are three main types of clinicians in hospitals: senior medical officers, junior medical officers, and VMOs. Full time medical staff; whether they are senior medical officers or junior medical officers, provide the daily core clinical services within the public hospital system. The senior staff in addition provide the full time clinical leadership as well as the principal training and research roles within the hospital.

The third clinical group, VMOs, also play an integral role in Queensland's health system. VMOs comprise of general practitioners, specialists and senior specialists who work principally in the private sector but do varying 'sessions' in the public sector. VMOs receive an hourly rate that is intended to compensate for the overheads they are continuing to incur in their private practice (such as ongoing rent, staff costs, indemnity, etc), whilst contributing to work in the public sector.

VMOs provide great stability within the system. There are rarely enough full time salaried staff available to meet the increasing demands within public hospitals, and undoubtedly VMOs assist in meeting service delivery targets. In addition, full time medical staff, both senior and certainly junior medical officers can be quite mobile as they pursue their developing careers. They can relocate because of better training opportunities, better research opportunities or more senior positions in more recognised hospitals. The VMOs on the other hand have established their private practice in that location and generally tend to be fully committed to the location, the community and the hospital.

VMOs provide vital, world-class training for undergraduates and junior doctors, and these shall be addressed in greater detail later. In addition, like their fulltime colleagues, they participate in important research projects, which can affect significant improvements in health outcomes over the long term.

It is for these reasons that the system should be interested in welcoming VMOs to the system.

Over the past two decades however, Queensland Health and the Government have chosen not to make this investment, and as a result, the pressures on senior salaried staff have escalated, and they too look to leave the system.

The Committee's attention is drawn to the example of the Radiology service at the Royal Brisbane Hospital - Queensland's largest tertiary referral hospital. The Radiology service is very near collapse, as radiologists cannot be found to accept positions there. This has a disastrous flow on effect to training, which shall be addressed further in this document. The point that needs to be made here is that there are many, many radiologists in private practice throughout Queensland. If Queensland Health attempted to staff the service, treat those staff well, and support its full time staff through VMO roles they may go someway towards having a fully functioning radiology department. However, it is predicted there will be a certain resistance from radiologists across Queensland to take up roles because of a long history of cultural issues with Queensland Health. The situation is the same with Pathology.

Queensland Health will be able to produce data that shows a decline in the numbers of VMO sessions occurring in the system. There are approximately 850 VMOs engaged by Queensland Health who work on average three sessions per week. The greatest numbers of VMOs are in the combined fields of surgery, where they balance their hectic private practice with their often-lifelong commitment to the public health system and teaching of junior colleagues.

There is a very real concern about the disproportionate number of doctors in private practice in Queensland who do not contribute to work in the public sector, and there are clear reasons for this. Whilst the VMOs reached a satisfactory agreement with Queensland Health in September of 2005 to improve VMO compensation (prior to this the average VMO would be losing money whilst working in the public sector), and similarly improved arrangements are in place that now give full time public hospital doctors parity with other states, there are trust and cultural issues that go beyond what this can achieve. It is these cultural issues that continue to act as deterrents for doctors considering working for Queensland Health.

Both the Morris and Davies Inquiries, and the Health Systems Review found evidence of terrible culture and mismanagement at the hands of Queensland Health as one of key reasons for the 'Patel' disaster.

There are very clear examples of these cultural issues. There is a constant battle at the PAH to maintain hygienic kitchen facilities, and change rooms in the theatre facilities. There is a complete lack of morning tea facilities for medical staff. The hospital has failed to even to pay staff at the industrially agreed rates. History shows months may pass before Queensland Health adjusts its payroll system to reflect current pay rates. In this round of negotiations, the new pay rates were agreed to in September 2005, for the first adjustment to occur 1 March 2006. However, remittance advice indicates that the adjustment has not been implemented yet, despite six months of available time for planning of this adjustment. By the time the new rates are applied, complicated back-pay calculations are involved and most clinicians are unsure if what they have received is correct.

These matters may appear trivial and easy to ameliorate, but VMO concerns within their Queensland Health workplace/employment environment are numerous and contribute to the general feeling of frustration and unrest among this specialised group of medical practitioners.

Without VMOs in the system, there is a real concern that the number of fulltime hospital doctors would not be able to service the health needs of the Queensland public. In addition, without VMOs, junior doctor training will suffer and Queensland's ability to graduate doctors in the required numbers, and specialists in relevant categories, will be seriously impaired.

Planning

These cultural issues are highlighted when staffs are forced to work in an encumbered environment. Poor planning by successive Queensland Governments led to a reduction in bed numbers over the last three decades. This means that Queensland hospitals run at over 95 per cent capacity, which is problematic for a number of reasons. AMA Federal President Dr Mukesh Haikerwall covered this in his testimony to the Committee, but it is worth reiterating that if hospitals run at this level, it is dangerous: dangerous because there is no room to fluctuate in the event of epidemic, major accident, or bio-terrorist attack.

It also means that on a daily basis, there is great difficulty for doctors to find a bed for patients coming into the hospital, say via the emergency department. This is called 'access block'.

Access block is worsened by 'exit block'. Not only are there no beds to admit patients to, there is great difficulty discharging patients at the other end appropriately because there is a severe lack of 'sub acute' or 'step down' care to meet the needs of patients that no longer require intensive hospital attention, but still need a level of clinical support or rehabilitation in a community setting.

This is perhaps an issue that should be of great interest to this Committee, as this is just one example where there is a great chasm between State and Commonwealth responsibilities, and an apparent lack of commitment on both sides to address it. Many patients at the exit block end will either be discharged to a nursing home (in the case of young people, very inappropriately, but there is often no alternative), or they will be sent home prematurely to make room for the demands on the hospital, only to reappear as a readmission because they were unable to cope alone and deteriorated in the community. Queensland has the highest rate of unplanned readmissions in the country.

Another flawed plan in the public hospital sector is to restrict the operating hours. Most hospitals adopt a policy that all surgery is to be completed by 4pm. This results in a massive waste of possible surgery time and patient throughput, as a patient that may be able to have a procedure commenced at 3pm, may be cancelled if it is presumed the surgery will go beyond 4pm. It would seem the public hospital sector is more interested in restricting the number of services available, as ultimately, services mean consuming a portion of the budget.

The inability for the public hospital sector to admit and treat patients has resulted in the hospital reporting systems being perversely used as an indicator as to who will get treated, not when. The Category One, Two, and Three

indicators used by the Australian Institute of Health and Welfare to benchmark surgery waiting times across states generally tells who will not be treated. That is, most category three patients. Category Three patients are considered non-urgent, which may be true in a life and death sense, but this crude categorisation takes no account of Quality of Life. Most reasonable persons would consider a Category Three patient with an enlarged prostate, experiencing pain and difficulty urinating, as deserving of prompt attention.

The State and Federal Governments need to implement costing systems that genuinely reward efficiency, and take account of patient's quality of life indicators.

Training

The three missions of public hospitals, teaching, service and research, remain essential elements of our health system today, yet with the increasing demands of a growing population and poor Queensland Health management, the primary role of public hospitals has moved. Teaching and research have been gradually subsumed by the escalating demands of service delivery.

Postgraduate medical training depends on the traditional 'apprenticeship' model of education. This model relies heavily on the support of senior doctors to provide clinical supervision and mentorship within the context of the three 'missions' of teaching hospitals. The junior medical staff provide the majority of the daily service commitment within the public hospitals, under the supervision of senior staff who facilitate their learning. Teaching is considered to be an essential part of a specialist's role and commitment to a medical career. It is a reason why many VMOs retain contact with the public sector, as no training occurs in the private sector.

The progressive erosion of the teaching capacity across Queensland public hospitals has reduced numbers of training positions, affected retention of quality senior clinician teachers, and caused an erosion of staff morale.

The effects of this will be even more disastrous in the future as Queensland will not have the capability to absorb its increasing numbers of medical graduates as interns, then as registrars, and eventually as specialists in the public sector.

It is one thing to train more graduates, it is another to have the infrastructure in place to turn them into independently qualified doctors.

In many areas because of the difficulties with recruitment and retention, procedural skills simply do not exist within public hospitals. Without specialist medical staff the hospital cannot provide adequate training to doctors through exposure to patients and procedures. These elements are all taken into account in accrediting intern and specialist training places. In rural areas the Government is not able to attract full time staff and the public system is not sustainable without the support of private colleagues, be they specialists or generalists.

The solution to this is possibly two-fold. Firstly that the public sector needs to invest in specialist medical staff so that the hospital can provide the exposure to patients and procedures required for the accreditation of intern and specialist

training places, through both full time and VMO appointments. The second is that innovative solutions of training in the private sector may need to be examined.

There are a number of barriers to this. The first is refusal of the State jurisdiction to extend indemnity insurance into the private sector for junior medical staff. Another is the question of where the wage for the junior doctor will come from, as private sector encounters are funded entirely by the patient, private health insurer or a combination of the two.