AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

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Mr Sean Crumlin
Director, Performance Audit
The Audit Office of NSW

Re. Performance Audit: Visiting Medical Officers and Staff Specialists

Dear Mr Crumlin,

Thank you for your letter of 15th March 2011 to the Australasian College for Emergency Medicine seeking our views in relation to this audit. As the NSW Faculty Chair for ACEM I am happy to provide the response on behalf of NSW emergency physicians. In relation to the three questions which the audit aims to answer, I will response to them in reverse order as the first question is the most complex in relation to emergency physicians and will take some time to answer.

*Are agreed rights of private practice adhered to?*

Under the Medicare Act patients cannot be billed for emergency services. Therefore emergency physicians receive an allowance as part of salary in lieu of rights of private practice earnings. This is an Award condition for level 1 staff specialists and is incorporated into the payment schedule for VMOs. As such there are few issues in relation to adherence.

*Are payments made for agreed and delivered services?*

Staff specialists are salaried and, as above, emergency physicians are employed as level 1 staff specialists with an allowance in place of rights of private practice. There are no particular issues in relation to fortnightly salary payments.

In 2009 there has been an outside Award special agreement between the Department of Health and the Australian Salaried Medical Officers Foundation (ASMOF) on behalf of emergency physician staff specialists. Under this agreement staff specialist emergency physicians are paid a special allowance if they demonstrate they have complied with eight conditions. A declaration to this effect is signed each six months, with the payment made six months in arrears. There have been persistent and widespread issues with delays to payment of the special services allowance. Whilst there has been some overall improvement

over time, the usual time to payment remains at 4 to 6 weeks from submission of declarations.

In relation to VMOs, payment is made once a signed timesheet for the period worked has been submitted. Whilst the period to payment is quite variable between Area Health Services (now Local Health Networks) it is my understanding that overall these payments are made in a timely fashion.

*Has NSW Health adequately planned its demand for visiting medical officers and staff specialists?*

In relation to emergency physicians:

- there has been extremely poor (if any) planning of demand in relation to either VMO or staff specialist workforces by NSW DOH
- recruitment to emergency physician positions at hospital and Area Health Service level has been driven by financial and/or political factors rather than with any view to health service planning.

Total Emergency Physician workforce

In 1997 the Australian Medical Workforce Advisory Committee (AMWAC) released its first report in relation to the emergency medicine specialist workforce. This report estimated a requirement for 1200 emergency physicians nationwide by 2007. The demand calculations were based on data supplied by State and Territory Departments of Health. These calculations were based on major referral hospitals having 11 FACEMs, (Fellows of the Australasian College for Emergency Medicine) district hospitals 6 FACEMs, paediatric hospitals 3 FACEMs, and major rural hospitals 2 FACEMs. Table 1 of the report identifies NSW as having 9 major referral, 2 major paediatric, 17 'other capital city', 4 'other urban', and 18 major rural emergency departments. Based on these figures the estimated requirements to staff these hospitals would be 267 FTE (full time equivalent) FACEMs. This did not include private hospitals with emergency departments.

At the time of this report 38% of all emergency physicians (n = 83) were in NSW, and that 96% of males and 60% of females were working full time. NSW also reported the highest vacancy rate both for FACEMs (37% of all vacant positions) and training registrars. Of FACEMs working part time, females worked fewer hours than males. Females represented 16% of FACEMs but 29% of trainees, indicating a likely increase in female FACEMs over time.

In 2002 the AMWAC working group was re-convened due to below projection recruitment of registrars into the emergency medicine training program. The revised FACEM requirements by 2012 were in the range of 1,067 to 1,464 across Australia, and 360 to 496 in NSW. The supply predictions were that 1,030 to 1,271 FACEMs would likely be available in 2012. As of 2010 there are 1,137 FACEMs in Australia and 310 in NSW. At the rate of growth of FACEM numbers in NSW between 2006 and 2010, the number of FACEMs in NSW in 2012 will be 361.

It was recommended to increase annual trainees entering the program to 130 (95 entered in 2002), with 44 per year in NSW (there were 28 in 2002). Females then represented 18% of FACEMs and 40% of training registrars. NSW had 141 FACEMs (now second to Victoria with 143), with a compound annual increase of 9.6% (vs 12.5% nationwide). Again NSW had the highest reported vacancies (funded unfilled positions) at 32. The issues of access block and hospital overcrowding were identified as important factors in terms of workforce supply.

Despite these two reports indicating a need for ongoing recruitment and retention of emergency physicians, the recruitment of emergency physicians was not co-ordinated centrally but occurred in a piecemeal fashion within Area Health Services. The NSW DOH, despite having provided the demand data for the AMWAC report, subsequently attempted to distance themselves (and to discredit) the report data and findings.

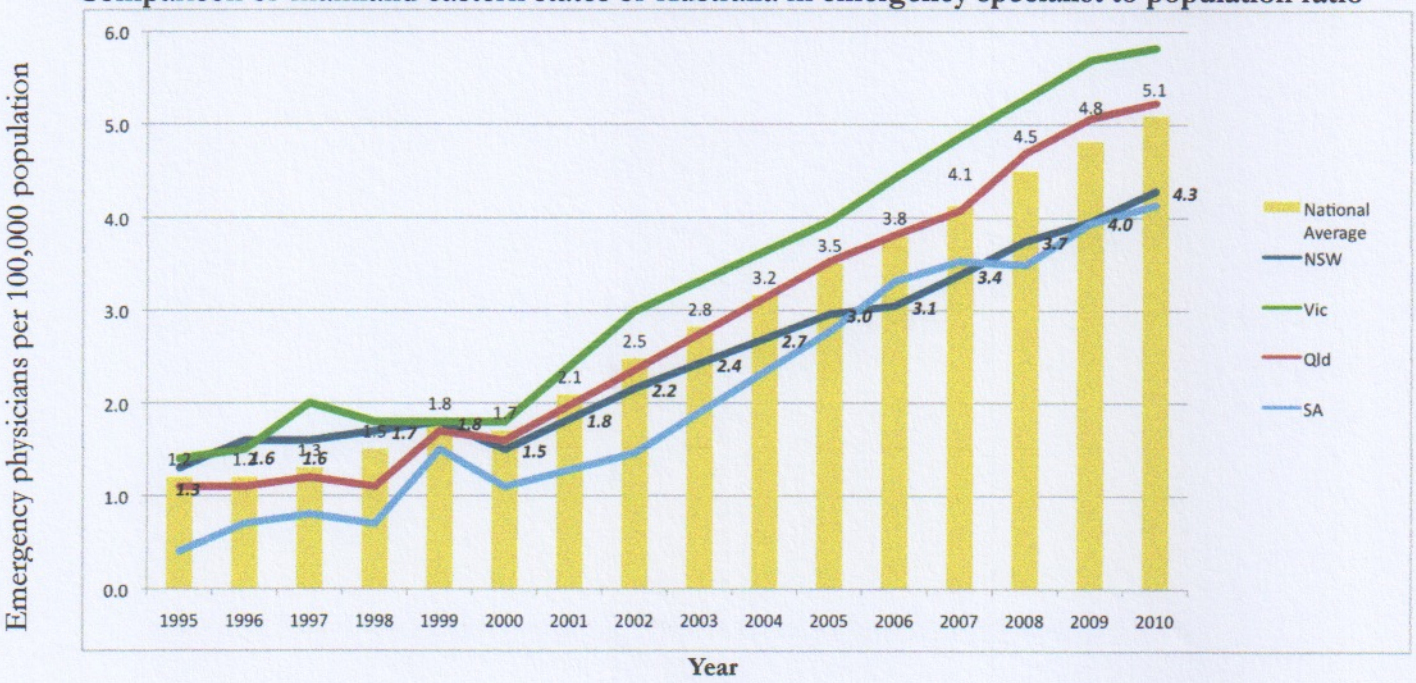
The creation of new positions and/or the replacment of vacant positions at given hospitals was largely dependent on financial ebbs and flows, rather than part of an organized process of service planning at either an Area Health Service or Department of Health level. There was no oversight or regulation of these processes leading to substantial differences in senior staffing even in geographically close EDs with similar activity levels. For example the EDs at Auburn, Ryde, Concord, and Canterbury Hospitals see similar numbers of patient presentations per year and yet all have differing senior staff levels (ranging from 1.0 FTE to 6.5 FTE).

The last centralized process of emergency physician appointments was in November 2007 when the then Minister for Health, Ms Reba Meagher, announced the creation of 21 new emergency physician positions across a range of hospitals. These increases were intended to bring those hospitals up to 10.75 FTE for major referral EDs and 6.0 FTE for urban district level 5 EDs.

The recently released NSW Dept of Health "Emergency Department Workforce Analysis Tool" contains data on 64 NSW emergency departments (35 of which are listed as metropolitan) in Appendix A. Of these, 33 NSW EDs are accredited for training with ACEM as of January 2011 which includes 5 sites listed by NSW DOH as 'rural'. Therefore, there are seven metropolitan EDs in NSW which do not have the 2.5 FTE FACEMs required to obtain ACEM accreditation as of January 2011. However, this report and the associated workforce assessment tool (developed at considerable cost) does not address shortages of emergency physicians. On page 4 of the report it states that "it has not been developed as a tool to determine specific staff numbers".

In terms of comparative data with other States the measure used by AMWAC was the 'specialist population ratio' which indicated the number of emergency physicians per 100,000 of population. Below I have provided a graph of this measure over time for NSW, Victoria, Queensland and South Australia compared with the national average (a graph including all States and Territories has been included as an Appendix to this document). The graph clearly demonstrates that NSW has progressively fallen behind the national average and the gap between NSW and the national average continues to widen.

**Comparison of mainland eastern states of Australia in emergency specialist to population ratio**




Note: Data from 1995 to 2000, and from 2002 was derived from the AMWAC report of 2003. Data from 2005 to 2010 was obtained from the ACEM annual report (FACEM numbers) and the Australian Bureau of Statistics (estimated resident population). Interpolation using averages of adjacent datapoints has been used to provide a complete dataset.

Of greater concern is that data, such as this, which is based on headcount underestimates the shortages of emergency physicians in terms of emergency department service provision. The AMWAC figures suggested that 267 full time emergency physicians were required in NSW EDs. Although the figures of 11 per tertiary ED and 6 per metropolitan district ED underestimate what FTE is required to provide a sustainable day and evening specialist roster across seven days, let us assume that the required figure is correct.

In early 2010, NSW had 290 emergency physicians in NSW. In my role as NSW Faculty Chair I attempted to determine what this represented in terms of emergency physician FTE in NSW emergency departments. by contacting ED directors and individual FACEMs in relation to permanent FTE. I successfully obtained FTE data on 250 of the 290 FACEMs. Of these 250 emergency physicians, only 101 (40%) were working full time in emergency departments. The cumulative FTE of the group was 139 FTE in NSW public EDs, and a further 5 FTE in NSW private EDs, representing an average FTE of 0.56 per NSW emergency physician.

Thus, even on a 'best case' scenario (assuming the 40 uncontacted emergency physicians work full time in EDs) the total statewide FTE in public EDs is 179, which is 88 FTE below the AMWAC recommendations (also noting that AMWAC did not include private EDs, nor non-major rural EDs in their requirements).

Staff Specialist

In early 2009 an agreement, known as the Emergency Physician Special Services (EPSS) Agreement, was reached between the NSW DOH and the NSW branch of the Australian Salaried Medical Officers Foundation (ASMOF), acting on behalf of NSW emergency physicians. This agreement was the conclusion of a four year, quite acrimonious industrial dispute between the parties.

From the emergency physician perspective there had been a failure by NSW DOH to address key factors essential to recruitment and retention of emergency physicians within NSW. The issues underlying the dispute centred on:

(1) lack of planning and lack of acknowledgement of shortages of EPs within NSW,
(2) lack of appreciation of value of emergency physician clinical support ('non-clinical') time and of emergency physicians to the public health system,
(3) lack of incentives for young doctors to train in emergency medicine, including but not confined to remuneration comparative with other States and with other critical care disciplines (such as anaesthetics and intensive care),
(4) lack of action in relation to work intensity and provision of satisfactory working conditions, particularly in relation to access block and emergency department overcrowding.

The four tenets of the EPSS were therefore in relation to remuneration, recruitment & retention, aceess block, and professional recognition. The remuneration package (negotiated for the three year period of the agreement, with no guarantee of continuation beyond this) involved a 25% allowance on top of current salary. Even with this substantial increase in pay, the remuneration was still less than that received by an equivalent staff specialist emergency physician in Queensland or South Australia (and almost certainly Victoria, although details of their locally negotiated packages are not publically available).

In relation to recruitment of emergency physicians, NSW DOH undertook to identify and quantify the emergency physician vacancies across the State and to advertise these periodically until filled. The importance of providing positions to newly graduated NSW emergency physicians was also to be of high priority. There has been no action on this issue two years after the agreement was reached. There are currently emergency physicians who became FACEMs in NSW in 2010 who are without permanent employment.

Visiting Medical Officer

Until the last five or so years VMO positions for emergency physicians were rare, predominantly due to the substantially higher VMO pay scale by comparison with the Staff Specialist Award. With the advent of shift penalties for evenings and weekends under the NSW Staff Specialist Award and the increased staff specialist emergency physician remuneration under the EPSS (as above), the differential between VMO and staff specialist pay scales (particularly on weekends and public holidays, when substantial shift penalties are applied) has dramatically narrowed.

This, in combination with the NSW DOH lack of appreciation of the value of emergency physician clinical support time, has led to a rapid increase in VMO positions being made available. In support of this reasonably cynical use of VMO contracts are the following trends:

(a) The majority of emergency physician VMO contracts are so-called 'zero hours' contracts. Under these contracts the employer is not obliged to provide any regular hours (shifts) to the employee. It is, in essence, a permanent 'casual' rather than a substantive position.
(b) The VMO contracts are almost exclusively for the provision of clinical service, even in locations where there are substantial deficits in clinical support activities (quality assurance, teaching, policy and procedure development, etc).
(c) Almost all clinical shifts offered under these VMO contracts are after-hours work (ie. evening, weekend, or public holiday shifts).

Conclusions

Despite modeling and data since 1997 indicating likely shortfalls in requirements for emergency physicians, there has been a failure of NSW DOH to plan its emergency physician workforce, to define the requirements & vacancies or to actively co-ordinate the recruitment of this workforce. The piecemeal politico-financial process of recruitment adopted by the Area Health Services, in the absence of DOH co-ordination, had led to NSW continuing to fall further behind the national average of emergency physicians per 100,000 population.

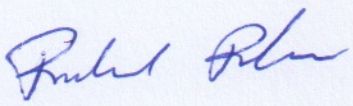
The recent EPSS agreement brought NSW emergency physicians closer in terms of relative remuneration to their interstate colleagues as well as to other critical care disciplines within NSW. It also included specific agreement to identify emergency physician vacancies and advertise them. Rather than capitalize on these factors and improve emergency physician staffing within NSW EDs, there has been a lack of action in terms of staff specialist recruitment. Instead, with the EPSS due to expire in one year, there has been a dramatic increase in the utilization of 'zero hours' VMO contracts and the emergence of a pool of permanent 'casual' emergency physicians in the face of persistent, substantial and systemic staff shortages not being addressed.

Should the EPSS not be renewed next year, the combination of unavailability of permanent substantive positions in NSW EDs together with the re-emergence of a more than 25% remuneration differential between NSW and adjoining States will almost certainly worsen the emergency physician staffing situation in NSW.

There is an urgent need for NSW DOH to develop a plan for the recruitment of emergency physicians to public hospital EDs in NSW in a co-ordinated fashion so as to improve the availability and equality of access of emergency physician services to the NSW population.

I would be very pleased to meet with you if you wished to obtain further information or discuss any of these issues in more detail.

Regards,



**Appendix A:**

Number of FACEMs per 100,000 population over time