EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT KATANNING
MONDAY, 21 SEPTEMBER 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 12 noon

BERGER, MRS FIONA MARGARET
Acting Director of Nursing—Health Service Manager,
Katanning Health Service,
examined:

DU PREEZ, DR NICOLAS
General Practitioner,
Katanning Health Service,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services, and also its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. At this stage I would like to introduce myself, Janet Woollard, and my fellow committee member, Mr Peter Abetz. We also have with us our research officers, Mr Tim Hughes and Ms Renee Gould, and our Hansard staff.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing, and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to the questions that we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: It is good that you are able to appear together today, because in that way you can add to each other's comments and paint a picture of what is happening here. The purpose of this hearing today is for us to get an understanding of healthcare services at Katanning District Hospital, and also about how your hospital—I think it is now part of what is called the Central Great

Southern Health Service—links with community services. So we will be asking you both about what is needed at the hospital—what upgrades, and what staffing and equipment—to enable it to cater for the community that you care for. We need you to paint that picture for us. We also want to know what needs to be done to improve the liaison between the GP services and the allied health services at the hospital, and what services are missing at the hospital, and also what services are missing for the community that you think the community would benefit from. Having had a look around the hospital this morning, we might, if that is okay, start with you, Fiona. Fiona, would you be able to help paint the picture in terms of what services, staff, accommodation and transport are needed at the hospital and in the community, and also give us a list—perhaps later by way of supplementary information—of your priorities?

Mrs Berger: I think staff would have to be the main one for us, particularly midwifery staff. I think Nickie would agree with me here. We have midwifery staff who are over 60 now. They are very experienced, but they are getting tired, and another girl has resigned, so that is going to make it really difficult. We have an active and very progressive midwifery unit, and I would like to keep it open.

Dr du Preez: I would like that, too.

The CHAIRMAN: What was the figure that you gave us? I think it was over 100 births on an annual basis?

Mrs Berger: It was 110 last year, and the obstetrics review that was done last year is indicating that our catchment area will actually increase a little bit. Also, we are the only what I would class as a regional hospital between Perth and Albany. We have a big catchment. It goes right out to Lake Grace and over to Tambellup. So, for me, midwifery would be first. The registered nurses would come after that. We can make do with those; we have enough of those. Accommodation is the next issue. For recruitment and retention, accommodation is one of the attractions. The previous director of nursing was very good. She has quite a number of houses that we have to offer. But the problem is actually maintaining them and finishing them. For instance, a lot of them are not air conditioned. Particularly if you are on night duty, you need window treatments, and you need to be cool in summer so that you can sleep. It is not so bad in winter. They need basic furniture to sit on. The other day we ended up buying some very cheap second-hand stuff just for the girls to sit on. They need mattresses that they can sleep on. That is another necessity.

[12.10 pm]

The CHAIRMAN: I noticed as we walked around the hospital with you this morning that you have some pieces of equipment that most people would assume would be provided by the health department but that had been provided by donations. I am talking in particular about the monitor that you have in the minor theatre.

Mrs Berger: Yes. That has been provided by the donations. The health department does not really have a lot of money at the moment, so I was asked to buy that out of our donations account. I struggled with that. I really feel that that is a vital piece of clinical equipment and it should have been bought with clinical equipment money. But we needed it. So we took $27 500 out of the donations account to provide a safe, effective and efficient service. We cannot take those patients into the major theatre—from an infection control point of view you just do not do that—and also today we had theatre on and we needed that other monitor.

The CHAIRMAN: I would agree with you. I would have thought that that would be a basic piece of equipment in a theatre. We have not come across this before. When we look at schools, schools need to have this many rooms, and they need to have wet areas and things like that. We will certainly follow up on that and see if we can find out what should be provided to the centres that you have got here, because that was a large amount of money from community donations that could

have been the icing on the cake for people here. It should not have had to be used to provide a piece of essential equipment.

Mrs Berger: You walked through the kitchen and the laundry on your visit this morning. Both those areas have had no money spent on them for 15 or 20 years. Both of them need to be upgraded and brought up to standard. We have all got standards that we have to abide by in the hospital. I showed you the Coleraine Wing. When HACC comes on board, we will need to make provision for extra meals.

The CHAIRMAN: Will the demand on kitchen services from HACC be Monday to Friday?

Mrs Berger: Yes.

The CHAIRMAN: For how many people—10 or 15?

Mrs Berger: Twenty for the day centre, so that is an additional 20 on top of the general ward and Kerry Lodge that they do now. They also do meals on wheels. So there is quite a number of meals coming out of there. The laundry has got washing machines that they feel have come straight off the *Titanic*. We are down to two of those. They work. The maintenance men keep them going, and they do a great job. That is another area that really needs some money spent on it as well. Another piece of equipment in the hospital is beds. We have got quite a few beds that are not electric, and from an occupational health and safety point of view they need to be replaced.

The CHAIRMAN: We heard in other areas that the beds that are purchased now need to be bariatric, because people are getting so large, and that is causing a problem in caring for those patients.

Mrs Berger: We have got all the minor equipment like the wheelchairs and the hoists. They do not cost that much money. But beds are big pieces of equipment, and they are out of the budget, so we need that allowance to be given to us so that we can specifically go out and buy them.

The CHAIRMAN: Can you explain how the funding works for a place like Katanning? Is there a pie that you then divide up into different areas?

Mrs Berger: Yes. Basically, Albany, being the regional centre, gets the bucket of money. At the beginning of the year, I do not actually get a bucket of money. Our costs are taken out, and at the end of every month I can see how we are travelling and where we are in a deficit. But we are not actually allocated any money. I was talking to the finance guy the other day, and he said that our budget has only just come down from Perth and has been loaded at Albany. So we are halfway through September, and we actually have no idea about how much money we have got for the year, and I still do not know. We have a clinical equipment list. We have to put our top five priorities, and we have to do a business case, which I have done. Then we have a non-clinical equipment list, again with the top five priorities, and a business case. Then we go on to minor works, which is a lot of the stuff that you have seen at the hospital.

The CHAIRMAN: I do not want to create a lot more work for you, or for Tim, in terms of having to provide supplementary information, but would it be possible for you to provide us with a copy of that list so that we can see what items you have actually requested? I am thinking in particular about the fact that you had to purchase that monitor. You have been able to list only five priority items. If all your dreams were to come true tomorrow, what else would you put on that list to improve patient care? Is it mainly the clinical equipment that is a problem for you? You said there was a clinical list —

Mrs Berger: And a non-clinical list, which is beds and things like that.

The CHAIRMAN: In that case, we had better have both those lists. We are up to the laundry.

Mrs Berger: Yes. We have also covered the kitchen. The emergency department, as you have seen, is very small, and so is the theatre. That whole area had a business case done for it and it has had its own plans drawn up. That was due to happen about 10 years ago, but the money disappeared. That

also took into account the need for a holding bay, which we do not have in the theatre. That area was all meant to be redeveloped. That is another area. I think Nickie would agree that when it comes to looking at people, just a little more room would be good.

Dr du Preez: Yes. Even a simple thing like a table would be good. We do not even have a table and a chair where we can sit down and write notes.

The CHAIRMAN: I did not realise how the GPs here have to be so multiskilled until I saw you intubating that patient this morning. That is not the average GP role, is it?

Dr du Preez: No. We do it slightly differently here!

Mr P. ABETZ: Before you go on with that list, you said that was supposed to happen 10 years ago. What actually happens in the system? If that planning was supposed to happen 10 years ago and it has not happened, is it the case that there was never any funding allocated for that? Is that basically the issue? What happened in the system?

Mrs Berger: I was not actually in the position at that time to know that. I think there was funding, but it was needed in other areas first.

The CHAIRMAN: But whether it was needed in other areas or not, 2001 was the state election

Mr P. ABETZ: Promises were made and not kept, perhaps.

The CHAIRMAN: Perhaps.

Mrs Berger: They would be the biggest areas that I would put down.

The CHAIRMAN: We are also looking at aged care. You said that you have got some support because one of the churches here has got some aged care beds. We know that the numbers will increase. Has someone looked at this area? Do you know in 10 years' time how many additional aged care beds you will need for this area and how many dementia beds you will need?

Mrs Berger: No, but Sue Millar is going to talk to you this afternoon, and that is more her area.

The CHAIRMAN: So she will have those statistics?

Mrs Berger: Yes.

The CHAIRMAN: Nickie, would you like to tell us about your role and the problems that you have?

[12.20 pm]

Dr du Preez: Yes. I have a list of them! I do not know whether you will be able to fix any of them, but I will spell them out as much I can. Basically, the role of a rural GP is slightly different from a city GP in the sense that we provide the GP services for the community, and then we run the hospital on top of that. The acute medicine goes as an extra. Like this morning, I had a whole day booked out with patients, and they all just had to go home, because there is no other doctor to take them up. They will now have to wait about two weeks to get an appointment. They will have be slotted in as doubles and extras and who knows what else.

As far as the scope of skills is concerned, it has to be wider in the sense that we have to be able to intubate and ventilate and like that, which is not normally expected of a rural GP, or only in exceptional cases if someone collapses. I do not know the exact number, but at least once a month someone collapses or falls, or is in a motor vehicle accident. There is a long list of things that we have to do. We need to do anaphylaxis and obstetrics, and we need to do minor things. To keep up our skills with that obviously takes a lot of work. It is quite an undertaking to actually keep the skills going, because we have to travel to actually get to the training. For us it is 600 kilometres on a good day. So it takes much more organisation to actually do that. As far as the work goes, I think it is quite enjoyable. I think the problem that we have, as Fiona said, is recruitment and retention. For the new doctors that come out, lifestyle becomes quite an important issue. If I want to recruit

somebody to Katanning—you have come here and you have seen what it is like—I have to compete with Bunbury, Busselton and Perth and all sorts of other places, and they go there. They do not come here. They get much better offers as far as lifestyle goes from places that are nicer than Katanning in the sense that they have a beach or mountains or are closer to schools. Schooling is a problem. A lot of people leave because of schooling. That is especially high schools. Some people send their kids to boarding schools, but a lot of people prefer not to do that. They would rather move at that stage.

The CHAIRMAN: The 2003 country health services review states that the number of GPs in Katanning has declined over the past few years, and that attracting additional doctors to this town is a regional priority. For how long have you been here?

Dr du Preez: I have been here for seven years.

The CHAIRMAN: Have you seen an increase in those seven years? What were the numbers then? Do you remember?

Dr du Preez: Three years ago when I came here initially, we had Pieter de Klerk, Pete Lotter and Dr Qurshi, and me, so we had three and a half doctors. Then three and a half years ago, one left, so we were basically two at that stage. I have now got it up to six doctors, which most probably is the equivalent of about five. It took a lot of hard work to get to that. Whether they will stay or not, I do not know.

The CHAIRMAN: How many are here on a visa, which means that you could lose them in two years' time, and how many are local residents who might stay here for a while?

Dr du Preez: One is a local resident. She is married to a farmer, and she works part-time. She does not do much on-call work, because of distance and children and things like that. The others are all on visas.

The CHAIRMAN: They are on two-year visas, so at the end of two years you could lose them?

Dr du Preez: One got his residency last week, and whether he will stay or not I do not know. The problem is that they do get lured to go to places where the lifestyle is better. The problem with smaller towns is that the people burn out. I was up last night at six o'clock, and I was called at who knows what time of the night with various phone calls from the different hospitals. Today I am here again at the hospital. Your call frequency is quite high. I am not going to moan about it, because it is my choice to be here, but last night I was putting my daughter down for the night and I had a phone call in the middle of it, or I will be in the shower and the phone rings. It is non stop. It is not like being on call and being called twice a week. You get phone calls all the time. After a while, people get fed up with it. They want to have a life. I think the generation that just worked has gone. People want to have a lifestyle. The problem is that it is very difficult to provide that in smaller towns. It is very, very difficult.

The CHAIRMAN: Obviously because of the turnover, are people given incentives to come here? You have obviously worked hard to get people to come here, but what about government incentives to get people to come here? Have the government incentives been adequate? What other incentives do you think either the state or the commonwealth government should be offering?

Dr du Preez: That is a difficult one. There are incentives like rural and remote loadings, but as far as recruiting doctors goes, I got nothing. I paid $15 000 for each of the two doctors individually to get them to come here, because the only way I could get them was through a recruiting agency. That is a gamble that I had to take. It was a one-way ticket. It worked, so that was worthwhile. I do not know whether the answer lies just in money. I will be honest with you. I do not know. The thing is that money makes people do things for a while, but then it does not matter what you do after that. I liken it to the guys who work at the mines. They get double the salary. They work nine months of the year, and they bring it home. But there are very few guys who do it for 40 years. They do it for a short stay, and then the money does not make sense to them any more. They do not care about that.

I think more numbers and less frequency of call-outs is what we need. That is my answer. But we need to get the people here, and that is really not easy.

The CHAIRMAN: What about nurse practitioners? Would they help here? We have looked at those, and WACHS is looking at those way out in the future.

Dr du Preez: If nurse practitioners can work with us and can do the shifts on the weekends and after hours when we get called in, that will help, because the frequency of our call-outs will be less. Previously, we had things called standing orders, or whatever term you want to use these days. If a patient came in with an ear infection, the nurse would make a decision and treat the patient. Now we get a phone call every time.

The CHAIRMAN: Would you like to explain that a bit more, Fiona?

Mrs Berger: Yes. We used to have a protocol—the doctors all agreed on a certain protocol—and we were able to follow that protocol. Let us say it was for ear infections, or if the person had allergies et cetera. You would make a determination and follow them up. It was then decided about two years ago that those protocols would be withdrawn. We had a directive to take them off.

The CHAIRMAN: Who made that decision?

Mrs Berger: That came from Albany.

Dr du Preez: The impression that I got is that it was a WACHS initiative. The standing orders were not acceptable in the sense of the medico-legal environment that we live in, because the nurse was seeing the patient, making a diagnosis and giving a treatment without having the appropriate training, or whatever. She was taking on the whole process without involving the doctor.

The CHAIRMAN: But if the nurses have competencies in those areas, they should be able to do that.

Mrs Berger: Yes. Basically they are nurse practitioners, but without the piece of paper.

The CHAIRMAN: I would think that most of you should have become nurse practitioners under the grandfather clause when that legislation came in. It is a shame that WACHS possibly was not on the ball to get you registered as nurse practitioners.

Mrs Berger: That is right, because most of us were happy to do that. I would agree with you there. I do not think we ever really had any issue with it, did we? That is because the new grads never did it, and we always told them that they did not have to follow those guidelines if they felt they were unsafe.

The CHAIRMAN: Would it be very difficult to find that directive?

Mrs Berger: From WACHS?

The CHAIRMAN: Yes.

Mrs Berger: It would just be a matter of a search.

The CHAIRMAN: It may well be worth following up on that, because Fiona knows, but I do want to mention to you, Nickie, that my background is nursing.

Dr du Preez: That is good.

[12.30 pm]

The CHAIRMAN: I have worked in a similar area. I worked in the Middle East for a while. So I understand, if I may say, some of the problems that you are having here. I would certainly like to see that directive, because I for one—I do not know about the full committee—would certainly be willing to back you up in looking at those competencies. That would take some of the pressures off Nickie, because it would mean that the call could come to the hospital, and the nurses would be able

to deal with a lot of things, and the GPs here would not need to be called out. So we can certainly follow that up. If Fiona is able to find that out, we can look into that for you.

Dr du Preez: Yes, that would make a difference.

Mrs Berger: I think Nickie has also forgotten to mention that when the doctors have to do their upskilling, or even when they want to have a holiday, how they often are not able to get a locum, and also how much it cost to get someone to come and help.

Dr du Preez: Yes. We are finding that to get locums, especially procedural GP-locums, is next to impossible, and if we do find them, financially it just does not make sense. You pay for the locum, and then you pay for your holiday, so it becomes an expensive business to go away. It is not that it is all about money, but there has to be some sense in it. The other thing, just to give you an indication, is that no GPs ever retire out of a place like Katanning. The last GP who retired from here, because he worked until the end, was Dr Christie. He died a couple of years ago, and he was ninety-something. That was 20 years ago. They burn out.

The CHAIRMAN: They retire when they are in their coffin!

Dr du Preez: Yes! They last for 10 or 15 years, or three years or two years, and they just burn out. They go. They just do not last the process.

Mr P. ABETZ: Ideally, if you had some retired GPs in the town, when you went on holiday they could fill in for a month, and they would probably quite enjoy doing that, but it just does not happen.

Dr du Preez: Yes. They just do not work through to retirement, because they burn out before that. They just do not last the distance. The workload is too much.

Mr P. ABETZ: So we really have a major problem in that there are not enough GPs—that is the number one problem—and the other problem is that we are putting the Bunsen Burner under you guys and it is just becoming impossible for you to keep up the pace. With the seeming ongoing shortage of GPs, and with the ageing of the population and so on, it does not appear that any surplus of GPs will be produced by the universities in the coming years.

The CHAIRMAN: In five years' time, the numbers will have increased. They increased about three years ago.

Mr P. ABETZ: Yes, by about 20 per cent.

The CHAIRMAN: Yes. So in five years' time, some of the pressure is going to come off—or maybe four years from now.

Dr du Preez: I think you are right. But the problem that I see with that is, again, that the city will follow, and then the outer metropolitan will follow, and then places like Albany will follow, and then Geraldton, and then eventually they will get here, once they have nowhere else to go. That is the nature of the game. I do not think you can change that.

The CHAIRMAN: I would have thought that with 100 births a year, you would have medical schools trying to get their students here and the universities trying to get their students here. How does that work, because hopefully that would help to attract some people to come back to Katanning?

Dr du Preez: I get UWA and Notre Dame students—as much as I can get them—basically one a month. They stay for a month. When they come here, they are all very keen, they all like it, and they all say they are coming back, but when it comes to the nitty-gritty of actually packing their bags, it is a different story. Other options are more attractive. That is the problem.

Mr P. ABETZ Is the housing an issue?

Dr du Preez: We pay for your own housing. You have to get your own house. When I came here, I had to find a house. I had to go and rent until I found my own accommodation.

Mr P. ABETZ: If the government were to provide reasonably good quality accommodation, would that help to attract people to stay here?

Dr du Preez: It would definitely help, especially for younger people, because then they could live here in work accommodation and then go and buy a house somewhere else.

Mr P. ABETZ: With the nurse practitioners that you were talking about before, I seen in Warburton how the nurses do everything, because there is no doctor in Warburton. They stitch up wounds and do all sorts of things. They are allowed to prescribe medications and get it from the pharmacy. That seems to work reasonably well from what I have seen there. Is it purely the bureaucrats that are saying no, you cannot do that here? It seems to me that we really need to do something fairly urgently to safeguard the long-term wellbeing of the GPs who are in the town, because otherwise we will end up with even fewer GPs and it will be a downward spiral.

Dr du Preez: I think the nurse practitioners can work if they can take some of the work away from us. I think that the fear from the doctors—I am speaking as a generalisation here—is that the nurse practitioners are going to set up next to them and work the nine to five and take all the coughs and colds, which is the easy medicine, away from them and leave them with all the difficult things, and the call outs, so why would they want to do that? I think that is the fear. It will depend on how it is structured. If we can work together in, say, one practice, then from my perspective if the nurse practitioners can work at the hospital and take the nuisance calls away from us, that will make my life much easier, or even if I lost a doctor I could get the nurse practitioner to work in the practice so that she—or he for that matter—can see some of the snotty noses, or even triage and treat some of them. That would help if it was structured like that.

The CHAIRMAN: From what Nickie is saying, what I believe a lot of GPs would like is to have practice nurses working with them, because then they would be working as part of the surgery as a team, rather than having that competition. The way it could work here is that you could have nurse practitioners or clinical nurse specialists. You could have several of those staff. Clinical nurse specialists are for a designated area. It might be that for the emergency calls, your staff could be assigned as being competent in certain areas. They could then help you to get some additional remuneration by being competent in those areas. That would mean that so many of calls that came in could be dealt with by those nurses. They would not necessarily need to be nurse practitioners, because they missed out on getting on board under the old grandfather clause, and they have one year to get that upgrade. That might be a way of looking at that. We might be meeting with the ANF and the College of Nursing later in the year. That is something that the College of Nursing might be able to assist with more, because it has a fairly active maternal and child health group. I think this might be something that it would be interested in. I will certainly take this back to the full committee, and, if the committee is happy with that, make some further inquiries for you about that matter.

Mr P. ABETZ: If the nurse practitioner kind of person handled the after-hours calls, you would get a bit of family time and that would take the pressure off.

Dr du Preez: It would make a huge difference. If you look at the workload, as a percentage more or less, the workload that goes through the surgery itself is about 80 per cent. We do most of our work in the surgery itself. About 20 per cent of the work is in the hospital with calls and things like that. The 20 per cent that you actually get from that is about 80 per cent of your headaches and your interruptions and all sorts of other things. The thing is that from a financial point of view, if you lose that 20 per cent of income, and you do not have to go on call, it is quite easy. You will just do that 80 per cent, because it is nice and structured and you can go to work and you sit with patients, and you do not get the phone calls at three o'clock in the morning, and if you want to have a glass of wine you can have a glass of wine, and on it goes. I think that is where people start questioning

what they doing with their lives. This is a small component of what I generate as income, but for my lifestyle and my family time I pay a big price for it, and is it worth it?

[12.40 pm]

The CHAIRMAN: Are the six GPs who are practising here all in the one centre?

Dr du Preez: We all work in the one centre. It is a hospital building that we are leasing, or renting, from the hospital. It is too small.

Mrs Berger: It is one of the old nurses' quarters.

Dr du Preez: It is too small, and we are running out of space there.

The CHAIRMAN: Do you have a practice nurse with you there?

Dr du Preez: I do have a practice nurse with me there, yes.

The CHAIRMAN: Because the other way around it would be to increase the number of practice nurses. I am not sure how far it has got with having practice nurses linked to provider numbers.

Dr du Preez: It is very limited. They can do assessments for you, but when it comes to claiming for any Medicare item, I think they can do immunisations and wound dressings and pap smears, and that is $10 each.

The CHAIRMAN: But it is very limited areas?

Dr du Preez: Yes. You still need to see the patient. You can use them to make it more efficient, and we do that, but even if I did get another nurse, she would have nowhere to sit.

The CHAIRMAN: So an emergency nurse would probably be of greater use to you?

Dr du Preez: A nurse practitioner would be. The problem with nurse practitioners is that it boils down to dollars and cents again. Someone has to pay for them. They are not going to work for free. You need to get money for them. Also, you cannot employ someone and not get anything from them. You need to get either money or time or something out of them.

Mr P. ABETZ: Can people claim Medicare if they see a nurse practitioner?

The CHAIRMAN: I think they will be able to under the proposal from Nicola Roxon. But I think you would have trouble with the government in getting a nurse practitioner in this area, because WACHS wants to move them to the remote areas. It might be possible to get something done about the competencies. Under the directive for assistance, or whatever it is called—I am not sure how you worded it before—it might be possible to get something drawn up in terms of protocols and competencies so that the nursing staff at the hospital could take the calls. I am sure that WACHS is looking at that, but we will look into that a bit further too. Fiona, is there anything that you would like to add?

Mrs Berger: Yes. I want to come back to the gaps that I have noticed with patients coming through the ED. Community health has not replaced our health promotions officer. I think that for long-term benefits and greater efficiency, we need to have those sorts of people on the ground. I remember coming to Gnowangerup in 1980 and the number of Aboriginal people who were coming in with the types of diseases and illnesses that they had. Now you do not see that that all. So in the long-term, I think they certainly make a difference.

The CHAIRMAN: Health promotion pays.

Mrs Berger: It certainly does. Also, they provide services that help keep people in the rural areas rather than all drift to Albany and Perth. It can be provided more cost effectively here, too. Visiting surgeons is also something that we need to maintain.

The CHAIRMAN: In fact, in relation to visiting specialists, you said that you have some visiting specialists from Albany, you have one from Narrogin, and you have some from Perth. You know

the population here and the prevalent diseases or conditions in the area. What visiting specialists do you have now; and if you could have additional visiting specialists, what additional visiting specialists do you need for this community?

Mrs Berger: We have Dr Offerman from Albany. He is an eye specialist. He consults every six weeks, and he operates four times a year. He could probably do with a few more operating days. We have Dr Lai, who is a general surgeon. He comes from Narrogin once a week. He does some endoscopies, and he also does a multitude of general surgery. He could probably do with another day a month. We also have Dr Openshaw. He is an orthopaedic surgeon from Bunbury. He comes four times a year, and he consults probably six times a year. He is a bit limited with the surgery. If we could offer him the ability to do the surgery, he could probably do shoulders, and maybe knees. At the moment he just does very minor arthroscopies.

The CHAIRMAN: Is that because you do not have the equipment in the operating theatre for doing shoulders and knees?

Mrs Berger: Yes. We have ENT four times a year, and he operates four times a year, and he consults for two days, one either side of the operating day. The wait list is not too bad for that. It was really bad at one stage, but that has gone down a bit. That is about it. Nickie does one day a month for all his ladies' bits and pieces. We have also Pete Lotter. He does some general things like vasectomies and ganglions and things like that. I cannot see that we would need anything other than probably cataracts, because as Dr Offerman says, everyone has got two eyes. His waiting list seems to be something that we are always having to manage.

Dr du Preez: The only thing I can think of that would be useful to us is probably a general physician. I do not think there is enough work for a cardiologist, and I do not think there is enough work for a diabetes specialists or an endocrinologist, but if we could put them together, I think there would be more than enough work to keep them busy every couple of months for a full day. They do not need to do angiograms and ultrasounds and all the other things, but they could do the follow-up. We also have Edmond Brice and Keith Lane going to Narrogin, so we do use them. We also use John Lindsay from Albany to a great extent. What we could probably use most is a general physician, but they are a rare breed. They are not many of them.

Mrs Berger: What about a urologist? The urologist in Albany has gone, and I know that they are having terrible difficulty in getting someone down there.

Dr du Preez: As far as other things that we need, basically we have a physio in town who works privately, and there are a couple of others, but if we have people in the ward and we want physio to be done on them, we can just forget it.

The CHAIRMAN: You do not have a physio?

Dr du Preez: We do, but to get the service is really difficult.

Mrs Berger: They visit the outlying towns as well.

Dr du Preez: If I have got someone who had pulled a muscle in his shoulder or has ruptured his medial ligament, it is very difficult.

The CHAIRMAN: So, as Fiona said before, you need more medical and nursing staff. For the allied health staff that you are talking about, how many FTE equivalents do you need in physio, or do you need them across-the-board? It is interesting that you said physio. We are also looking at child and community healthcare. We know that in Perth there are waiting lists for speech therapists, not only for children to have an assessment, but also to start their treatment. There are also waiting lists for occupational therapists. Do you know how many children in your area require speech therapists and occupational therapists? Are there long waiting lists for those children?

Dr du Preez: I do not know. I cannot say. I just refer them. I know that if parents have a kid who needs something, they have an amazing ability to find the help that they need to get. The exact

waiting list I have no idea. I know that with the physio services that are provided at the hospital, there is a list of things that people can get, and for other things people just have to go somewhere else.

The CHAIRMAN: If you were putting in a request for additional nursing staff and medical staff, who would put in the request for the allied health services?

Mrs Berger: I think you spoke to Juan Clarke last week in Albany. He is in charge of community health.

[12.50 pm]

The CHAIRMAN: We have asked about that. Hopefully within two weeks you will be able to see what he has put down in his evidence, because, just like you, he will have 10 days to read and get the transcript back to us. Because you come under Albany, we asked questions about the hospitals that feed into Albany, and about shortages, so you will be able to see what response was given at Albany and whether that suits your demands and needs; and, if not, you can follow that back up the line as well.

Dr du Preez: Can I just say two more things. We do not have a diabetes educator, and we have a lot of diabetics here. They need to wait two weeks to see her, because she travels from Albany. There are a lot of people with diabetes, and a lot of them are Aboriginal. To get them to wait and to follow them up is already difficult. That is not ideal. That is just my opinion.

Mrs Berger: I would add to that a continence advisor. He also comes from Albany.

Dr du Preez: The frequency of his visits is just not enough. But I am sure there is a waiting list in Albany as well. The other issue that I need to mention is equipment. You saw the patient today who had been ventilated. We do not have a blood gas machine. I had to ventilate that patient for five hours without a blood gas machine. It just does not exist.

The CHAIRMAN: What about in your pathology centre? Do they not have one there?

Dr du Preez: No. I do not have a blood gas machine. I once had to ventilate a patient for eight hours. That is the longest I had to ventilate a patient for until they came to pick him up, and I cannot do a blood gas.

The CHAIRMAN: There is no blood gas machine in your theatre?

Mrs Berger: There is a little story behind that.

Dr du Preez: We putting a case forward for that. That is a basic requirement. We are not living in a third-world country. In South Africa where I come from, you see that. This should not happen in Australia. That is not acceptable in my opinion. That is also a problem from a medico-legal point of view.

Mr P. ABETZ: How expensive are those sorts of machines?

Mrs Berger: They cost $15 000.

Mr P. ABETZ: That is not a lot of money in the scheme of things.

Mrs Berger: The consumable cost about $10 000 a year. Through the MAC —

The CHAIRMAN: That is the Medical Advisory Committee?

Mrs Berger: Yes. I have done a business case through the MAC. My hospital and Collie hospital are the other two hospitals that need this machine.

The CHAIRMAN: You each need this machine?

Mrs Berger: Yes, we each need a blood gas analysis machine. Pauline Crommelin, who is the equipment person for WAHCS, contacted me and said that she wanted me to hold off, because WAHCS wants to make sure that all the hospitals have a standardisation and we are not all going

off and buying whatever we fancy. I can understand that we need to have a standardisation. Also, they need to be careful with the calibration of these machines, because some of them they do not think are accurate. So I have withdrawn my application to the clinical equipment meeting, because they are now looking at that. They call it point-of-care testing. Under the community healthcare guidelines, all newborn babies are meant to be having their core blood done. That was one of my reasons for wanting that machine. We also need them for the ventilated patients. As Nickie was saying, one time had an intubated patient, and the RFDS could not come down, so we had to spend many, many hours sitting there —

The CHAIRMAN: How many hours might you to have to wait for the RFDS? We have met with the RFDS, and they have explained that there is a doctor who takes the calls, and they have to prioritise, so unfortunately some places do have wait.

Mrs Berger: Yes.

Dr du Preez: This lady was intubated just after nine o'clock, I think, and when I left there at quarter to 12, we did not even have a time of arrival for the RFDS. That was just short of four hours. It is a cumbersome process for the RFDS. They need to get the aeroplane here.

Mrs Berger: It may also depend on the weather.

Dr du Preez: Yes. I think that we should have that equipment.

The CHAIRMAN: Nickie, you mentioned that you have a large Aboriginal population here.

Dr du Preez: Some towns have a bigger Aboriginal population than others. Katanning has got some, Tambellup has got a lot, Broomehill does not have many, and Salmon Gums has got some. Population wise, I do not know the exact figures. It would be on some government statistics somewhere. As far as the care that needs to be provided, it is more than their percentage as part of the population. They take more healthcare resources from us.

Mr P. ABETZ: Do you find that they make up a big percentage of the after-hours presentations as well?

Dr du Preez: Yes, they do. I not know exactly why—I am not a social sciences person—but I also think they present quite late. There are social issues involved. As far as the money side of it, most of them get bulk-billed in any case, so it is not as though we charge them. If you could answer that question, I think everybody would be happy to know why. Definitely they present after hours much more so than other people.

Mr P. ABETZ: There was also an issue in Warburton with the referral situation there. They really started to put the pressure on the Aboriginal community and they actually sent them away if it was not really urgent. They said, "This is the hours when you should be coming in. This child must already have had this earache at three o'clock this afternoon, so do not ring the nurse and get her out of bed at eleven o'clock at night." You really need to try to educate them and be quite forceful, in a way, to put the pressure on them that you are not there at their beck and call, and it must be a case of genuine emergency. But of course it is a slow process to try to get that culture change happening. I guess part of the problem is that the community health promotions officer has not been replaced, because such a person could also help to alleviate that situation somewhat.

The CHAIRMAN: Do you have any Aboriginal health workers here? How many Aboriginal staff do you have?

Mrs Berger: There are four—a nurse, and three Aboriginal health workers.

Dr du Preez: Can I say something that may not be politically correct —

The CHAIRMAN: We have a reporter from the *Great Southern Herald* sitting at the back of the room here!

Dr du Preez: That is okay. I think that some Aboriginal people do not want to see the Aboriginal health workers because of family connections or because it is confidential, or whatever. So I do not know how much of that is actually taken up by the Aboriginal community. The impression that I get—I may be wrong; this is a personal opinion—is that they want to be treated like everyone else and not differently from everyone else. They have got separate issues that need to be resolved, but they want to go through the same process and be seen as the same and not have different treatment. But I may be wrong. That is just my opinion.

The CHAIRMAN: At our hearing in Kalgoorlie, we heard about some research that has been done, particularly in relation to children, about the higher incidence of renal disease in the Aboriginal community. Have you noticed anything like that here?

Dr du Preez: Yes. There is definitely much more diabetes and renal disease, and a lot more heart disease—a lot more. There are a lot more ear infections, hearing problems, perforated eardrums, chronic discharge from ears. I think that most probably has an effect on their ability to learn and stay at school and to concentrate and pick things up.

The CHAIRMAN: I am going to give you each two minutes to flag anything else that you want to address, because I am sure there are things that you would have liked to cover but that you have not been able to cover, perhaps because we have stopped you and have interjected with questions. Also, when you leave here today, if you think that you would have liked to have put such and such on the table, or if you think of another area that we really need to address, you can also provide that additional information to us by way of supplementary information. Fiona, would you like to go first with your summary?

Mrs Berger: Thank you. Dental has not been covered. We do not have a dentist in town. Little children get a school dentist with a van, but after that they are on their own. Our only government dental clinic is in Albany, so people needs PATS, and usually they do not have a car or someone to take them there. We get then the resulting infections and abscesses from that. I would also like to have an Aboriginal manager situated in Katanning. I do not think it is good enough that we are run out of Albany. It does not work. We need to have people on the ground. I would like to see the Aboriginal workers going into the houses and actually visiting rather than waiting for people to go to them. I have heard from HACC workers that in the new units, there are children crawling on the ground and there are dogs inside and pooping all over the new floors. How can we expect them to learn? I think we need to go back to basics, like talking to the school teachers in the schools. We have got the tooth brushing program, and the sneezing and blowing program, which is helping with their ears, but we need to go back to the basics of sewing, cooking, cleaning and budgeting. These are just basics for all of us. Another issue is staffing and recruitment to keep our midwifery unit going. I would also like to see some more money for basics. Our ED badly needs doing up, as does our theatre, and we need some money for the kitchen and laundry. I would also like the health promotions officer to be replaced—maybe 1.5 FTE—because that can encompass the Aboriginal health as well.

The CHAIRMAN: Do you have anything to add, Nickie?

Dr du Preez: The only thing that I can say from my perspective is that we need to get a better system for call-outs, because I am going to burn out, and the next guy is going to burn out and the next one. The previous guy summed it up correctly—they grab you, they use you and they spit you out, and then they grab the next one.

Mr P. ABETZ: You cannot keep that up.

Dr du Preez: No.

Mrs Berger: That is especially the case with the anaesthetist. We are down to one GP-anaesthetist, and he is on call 24/7. That is not sustainable. If you are offering an obstetric service, you need to be safe.

The CHAIRMAN: I would like to thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections, and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return the corrected transcript. Thank you both again very much for appearing today.

Hearing concluded at 1.03 pm