PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE USE OF VISITING MEDICAL PRACTITIONERS IN THE WA PUBLIC HOSPITAL SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 5 NOVEMBER 2001

SECOND SESSION

Members

Mr D'Orazio (Chairman)
Mr House (Deputy Chairman)
Mr Bradshaw
Mr Dean
Mr Whitely

MORTON, MRS HELEN MARGARET,
General Manager,
Armadale Health Service,
PO Box 460,
Armadale, examined:

DOWLING, MR JOHN HERBERT,
Manager, Business Services,
Armadale Health Service,
PO Box 460,
Armadale, examined:

The CHAIRMAN: This committee hearing is a proceeding of the Parliament and warrants the same respect that the proceedings of the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you completed the details of witness form?

Mrs Morton: Yes.

Mr Dowling: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

Mrs Morton: Yes.

Mr Dowling: Yes.

The CHAIRMAN: Did you receive and read an information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

Mrs Morton: Yes.

Mr Dowling: Yes.

The CHAIRMAN: Have you made a formal written submission?

Mrs Morton: No.

The CHAIRMAN: As you are aware, this committee is inquiring into visiting medical practitioners. Armadale Health Service has a particular interest in this issue. Please explain how much of the service's budget is dedicated to VMPs. How does it work and how is it controlled?

Mr HOUSE: I would like to sort out the distinction between visiting medical officers and VMPs. The committee took evidence this morning that highlighted the difference between the two. Please explain how the Armadale Health Service differentiates between the two groups.

Mrs Morton: We use the terms interchangeably; they are the same to us.

The CHAIRMAN: According to Professor Stokes, they are not. One group works on a salaried-session basis and the other works on a fee-for-service schedule.

Mr HOUSE: Do the figures you are about to provide relate to both?

Mrs Morton: They relate to visiting medical practitioners; that is, people working on a fee-for-service basis.

The CHAIRMAN: Does your service have any salaried-session or visiting doctors?

Mrs Morton: Yes, it does. Some doctors are paid a salary.

The CHAIRMAN: We are talking about sessions.

Mrs Morton: Some doctors are paid on a sessional basis. They do a small number of sessions. None of the figures relates to them.

Mr HOUSE: What do you call them?

Mrs Morton: They are salaried or sessional doctors. The two groups are run together.

Mr HOUSE: Can you provide the figures for them as well?

The CHAIRMAN: They obviously have private practices elsewhere. That is what we are trying to establish.

Mrs Morton: Our emergency department doctors work on a sessional basis as well. They frequently do not have private practices. Some doctors working in rehabilitation and aged care services do so on a sessional basis. They do not work under fee-for-service arrangements anywhere else.

The CHAIRMAN: How do they occupy the rest of their time?

Mrs Morton: They might work only part time. Many are women who do not want to work full time.

Mr HOUSE: The committee needs those figures.

The CHAIRMAN: The committee would like a breakdown of the sessional figures. Members want to establish any overlap between the VMPs and the sessional doctors. They might do a session, but they might also have a fee-for-service arrangement with other hospitals.

Mrs Morton: That is correct. We know about that.

The CHAIRMAN: Members were astonished to hear this morning that there is no overall control. A doctor might be working at Armadale Health Service, but the Health Department would not know that he or she was also working at Osborne Park Hospital or somewhere else. I find that strange, given that it is all one health service.

Mr WHITELY: The sessional doctors are called "visiting medical officers."

Mrs Morton: I am happy if that is the terminology to be used.

Mr BRADSHAW: Some of us thought they were the same.

Mr HOUSE: They might be working part time, but they might be doing so in three or four hospitals. The committee is trying to establish the totality of the situation as it relates to particular doctors.

Mrs Morton: I know that is the situation for doctors in emergency departments.

Mr HOUSE: If you cannot provide that information today, please provide it as written evidence.

Mrs Morton: Yes.

The CHAIRMAN: The committee would like the breakdown of the amount paid to visiting medical practitioners as a proportion of the overall salary budget. What sort of work do they do? Who are they? We would like the names of the doctors, what they are receiving and how that is decided.

Mrs Morton: We do not have information detailing the total cost of medical practitioner salaries and fees for service to the service. We have brought information relating only to the fee-for-service doctors. We cannot provide this year's figures because the situation is evolving. The amount paid in 2000-01 was $4 584 940.

Mr HOUSE: I want all future witnesses, particularly those representing country hospitals, to understand clearly what figures the committee wants. If they do not, we will not get the evidence we need.

The CHAIRMAN: Is that the figure given to the Health Department that also appears in the annual budget? That figure does not ring a bell.

Mr DEAN: The figure we have is $5.086 million.

The CHAIRMAN: That is different.

Mr Dowling: The difference relates largely to our external medical imaging provider. We have a contracted service for people who read X-rays and who do that style of work. That is not included in these figures. It has come out of the Health Insurance Commission system. A substantial part of the difference relates to the radiography service.

The CHAIRMAN: Why would that not be included?

Mr Dowling: Primarily because those figures were sourced through the accounting system. They are paid through the Health Insurance Commission system, which is where we sourced these figures.

The CHAIRMAN: It will pay the hospital, which then pays the doctor. It is still coming out of your service's budget, perhaps from a different category. The Health Department has provided the committee with figures relating to each hospital. Members are trying to verify those figures and work out why they are different for each hospital.

Mr Dowling: I will provide the information that includes the radiography services as well.

Mr HOUSE: Does that figure include the goods and services tax?

Mr Dowling: That will be excluded.

The CHAIRMAN: Health is exempt.

Mr HOUSE: Does the $4.5 million include GST?

Mr Dowling: No.

Mrs Morton: Most of the people from health services who will be speaking to the committee will come without that information.

The CHAIRMAN: We will ask for it. The inquiry will take some time. As it proceeds, we might ask for further information.

The CHAIRMAN: Who controls the process of employing visiting medical practitioners? Who decides the number to be employed and the procedures they will carry out? How is this process set up, who controls it and approves it, and what safeguards are in place?

Mrs Morton: The decision on whether the medical services are to be provided on a fee-for-service or a salaried sessional basis is taken by management. The decision takes into account cost, and the need for flexibility. We need to be able to stop and start, or increase and decrease the levels of service. With a salaried person, in place this flexibility is often not available.

Mr DEAN: Do you close down over Christmas?

Mrs Morton: Yes, we do. We have decreasing demands at Christmas and Easter, but we also have times when we want to increase or decrease certain types of procedural work. If we need to increase the level of orthopaedics and decrease the level of gynaecology, for example, we want the flexibility to be able to do that.

Mr BRADSHAW: Is that increase or decrease based on demand, or on how you feel it should be dealt with?

Mrs Morton: It is based on a number of factors, including demand. Urgency and waiting list information is another factors. If we feel, as is the case at Armadale at the moment, that we have a very short waiting list time for gastroenterology exploratory procedures, but that Fremantle has a larger waiting list in that area, we can choose to bring some of those cases over to Armadale, in

which case we will try to bring the doctors with them. The doctors who traditionally supply the service at Armadale would then have a decreased number of lists at Armadale. That flexibility is necessary to increase and decrease the sorts of procedures and the range of work that is being done at any one time, based on a number of factors. Urgency is a significant factor.

Mr DEAN: All that would be worked out in your bilateral negotiations, as to the number of scaled central episodes you can deliver?

Mrs Morton: The number of SCEs is total, but within that figure is included a whole range of different procedures that can be undertaken at any one time. We have to decide which areas of work are the most appropriate to be undertaken at Armadale, but the number must reach the total. Some are not variable, such as renal dialysis and some of our new chemotherapy services, which receive a set amount each year, but for a whole block we determine which procedures are increased or decreased to suit the population of our catchment area.

The CHAIRMAN: The reason I asked the question earlier about proportion, is that Armadale Hospital pays out nearly $5 million of its salary budget to visiting medical practitioners, but salaried doctors receive only $2.1 million, and they are the ones who are on tap all the time. This morning we heard that one doctor working at four metropolitan hospitals was earning $770 000 a year. Has someone done a cost-benefit analysis on the use of visiting medical practitioners as against the use of salaried doctors? You just said that if Fremantle Hospital has too many people on its waiting list, they can be transferred to Armadale, and use its resources. Would it not be sensible to have a salaried doctor who can cover both hospitals, or four hospitals? Such a doctor would earn far less, and provide the same service.

Mrs Morton: I do not know if it has been presented to this committee, but I have with me a copy of a letter from Armadale Health Service, written by the chairman of the medical advisory committee, that went to the previous Minister for Health, and an agreement by the minister to undertake a cost analysis. That cost analysis never proceeded, but the letter that went to the minister asked him to include many costs that are not usually looked at when calculating the straight salary costs. All the work of an outpatient clinic in a salaried hospital is picked up by the health service or the State. In fee-for-service arrangements, all the costs of the pre-hospital work on those patients is done in the private rooms of the doctors. Therefore, all the costs of pre-hospitalisation, the costs of the outpatient clinics, the receptionists, the capital costs of the building, the electricity, the diagnostic work contained in the pre-hospitalisation work-up of patient, and all the pharmaceutical costs, are not borne by the health service. Many other costs are absorbed by the fee-for-service doctor, including the staffing costs of annual leave, sick leave, superannuation, workers' compensation and study leave. All the doctors employed on fee for service absorb considerable costs, in the way of reception staff and nursing staff associated with the clinics. We have just finished building a $60 million hospital for the Armadale Health Service, and we have not built doctors' rooms around that facility to accommodate salaried and sessional doctors in all the different areas. Not only the capital costs of the buildings, but also the interest on borrowed money, the fit-out, the furniture, and the technology all need to be taken into account. Fee-for-service doctors carry their own vehicle costs - they lease their own vehicles and pay their own maintenance bills. Insurance and litigation costs and building insurance are also met by the fee-for-service doctors. I could go on about the costs. I would welcome the opportunity to see a full, proper and comprehensive cost analysis.

Mr DEAN: There would have to be, because you have only listed costs there, and you have not listed income. What are the income components?

Mrs Morton: There are also issues around productivity. In a fee-for-service arrangement, where a fast throughput of service delivery is required - an example might be in the operating theatre area - greater productivity is possible, for obvious reasons, than where people are being paid by the hour.

I come from a farming background, and I know that if we paid the shearers an hourly rate, they would shear far fewer sheep than if they were paid piece rates.

Mr DEAN: That would not happen if a rate were stipulated. I cannot agree with that.

Mr HOUSE: They might shear the sheep better.

Mrs Morton: They might shear them better. Arrangements are in place about clinical governance, more so at Armadale Health Service than at any other.

Mr DEAN: Clinical governance was raised here today. From what Professor Stokes was saying, they will have a very good look at clinical governance, overservicing and the degree of clinical responsibility. What you are saying is a bit hollow.

The CHAIRMAN: Worse than that, you are suggesting that doctors do the pre-hospitalisation work at their surgery and then send those patients to your hospital to be treated as public patients.

Mrs Morton: All patients who are not yet admitted to Armadale Health Service are the individual business of the individual doctor in the community. If that arrangement were transposed to King Edward Memorial Hospital, just to take gynaecological work as an example, those patients turn up at the gynaecology outpatients clinic at King Edward Memorial Hospital, and all that work is done at the cost of the State.

The CHAIRMAN: I would have a problem if the visiting medical practitioners were actually treating those patients before they came to the hospital. If that has happened, there is an obvious ability to influence the process to send them to the hospital to be treated in the public system, while at the same time, as I said in the question I brought up earlier, charging them as private patients.

Mrs Morton: If you go to see a general practitioner, you are a private patient of that general practitioner. The general practitioner makes a decision whether or not you need to have any further work undertaken in a hospital. Until the decision is made that a person needs to be admitted, he is the individual business of that doctor, except where an arrangement exists under which a patient can go to a publicly-funded outpatient clinic. You will find that no peripheral hospitals have publicly-funded outpatient clinic. All that work is undertaken in the community by doctors.

The CHAIRMAN: I understand that, but I have a problem if that particular doctor has visiting medical practitioner rights at the hospital and sends his patient to that hospital, where the patient is treated as a public patient. There is an obvious incentive for the doctor to send the patient to that hospital, so the doctor can treat the patient as a visiting medical practitioner.

Mr BRADSHAW: There could be a procedure that needs to be done in a hospital that cannot be done in the doctor's surgery, and the patient would then be admitted to hospital.

The CHAIRMAN: I understand that, but what is wrong with referring the patient to one of the other hospitals, rather than the one at which the doctor has visiting rights, and would then do the procedure? No clinical check mechanism is involved. If the doctor did not have visiting medical practitioner rights, he would probably refer the patient to Royal Perth Hospital, and the visiting medical practitioner rates would not have to be paid. This morning reference was made to a single doctor who earned $770 000. There is no way in the world that all the costs of cars and other things will ever reach that amount.

Mrs Morton: I know the doctor you are referring to, and we have taken steps at Armadale recently to change that system. We have initiated an arrangement under which we have brought in additional obstetricians and gynaecologists to spread the workload across more than one person. That does not mean that the same amount of work will not get done.

The CHAIRMAN: The system itself is an incentive for that doctor. There must be some regulation to ensure that the doctor cannot treat private patients at a particular hospital. The case must go to another visiting medical practitioner at different hospital, so that the same incentive is

not there to send a patient to your hospital. There is otherwise no guarantee that this doctor will not keep sending patients, because he is sending them to himself.

Mr DEAN: Can you provide a breakdown of visiting medical practitioners into general practitioners and specialists? Do any general practitioners have admitting rights?

Mrs Morton: Many of the general practitioners have admitting rights.

Mr DEAN: What proportion of the visiting medical practitioners are general practitioners?

Mrs Morton: I cannot provide that information off the top of my head.

Mr DEAN: Could you obtain that information for the committee please? It is important, because my understanding is that admission to hospital would more that likely come from a specialist after referral from a general practitioner, rather than from a general practitioner admitting a patient directly.

Mrs Morton: General practitioners provide some anaesthetic services at Armadale.

Mr DEAN: If the written information could be provided at a later stage, I would appreciate it.

The CHAIRMAN: Do you realise that Western Australia is the only State that has visiting medical practitioners in the metropolitan area?

Mrs Morton: I understood that Tasmania still does, but I may have that wrong.

Mr HOUSE: You are only operating under the instructions of the department, and you cannot make that decision within your own system. Do you have any contracts with doctors or groups of doctors that are not fully utilised? Is there a system under which you would contract a service and pay a certain fee to a doctor or group of doctors and then not fully utilise the service for some reason?

Mrs Morton: What you are referring to is some sort of contract arrangement with a group of doctors. I cannot think of any such arrangement. The only contractual arrangements we have relate to radiology, but they are certainly fully utilised.

Mr HOUSE: I will propose a hypothetical situation. Suppose you contracted the radiology services for, say, $1 million a year, and they were not fully utilised, would you still have to pay the $1 million?

Mrs Morton: No, we make payment on a usage basis to the radiologist.

Mr HOUSE: Is that also the case with country hospitals like Albany, Bunbury or Kalgoorlie?

Mrs Morton: I am sure it would be the same.

Mr HOUSE: If you could change the system that exists now to make your hospital run more efficiently - in other words if we gave you the magic wand in regard to the issue of visiting medical practitioners or any contractual arrangements - what would you do?

Mrs Morton: The current arrangement has already determined which services are best paid for on a salaried and sessional basis. For example, running those two together, the rehabilitation and aged care service, the mental health service and the emergency department operate on a salaried and sessional basis. There is a quick turnover required in acute hospital services and I prefer that to stay as a fee-for-service arrangement for the reasons I have already indicated. However, I would like to have the flexibility in my own right to tweak the amounts paid for each different procedure or service so that those that are considered as being -

Mr HOUSE: I thought you said you did that now?

Mrs Morton: No, I cannot. A standard fee across the State is paid to someone who performs a particular procedure.

Mr HOUSE: Are you talking about the fee for the service, not about the availability of the service?

Mrs Morton: That is right. However, if there were concerns about a particular doctor earning more than $700 000 a year and if some of the procedures that he currently performs were valued by us at $20 instead of whatever he charges, he would be less likely to do that work and we would prefer it not done. I would rather have an optional fee-for-service arrangement for the services that we want to use with the ability to vary the amount.

The CHAIRMAN: To negotiate the fees?

Mrs Morton: Yes, on individual procedures.

Mr HOUSE: Is that the only change you would make?

Mrs Morton: We are implementing a number of changes that I believe address issues about clinical governance. The undertaking of clinical governance is a management initiative. Armadale Health Service has a full-time director of medical services, part-time directors of anaesthesia and a director of internal medicine. We have been seeking a director of obstetrics and gynaecology. Other peripheral and non-metropolitan hospitals either do not have directors of medical services or have only part-time directors and they certainly do not have these other director positions. In the past three years, we have put a huge emphasis on clinical governance through which we have been able to weed out the doctors who were not working to an acceptable standard and whom we did not want to continue working at Armadale. Through those processes and by taking some of the lists off those doctors, etc -

Mr HOUSE: I take it that you have been there for three years, from what you are saying.

Mrs Morton: About four and a half years.

Mr HOUSE: Where did you come from?

Mrs Morton: I was the general manager of finance and resources in the Department of Health.

Mr HOUSE: With respect to you, you have been quite defensive. You started off by defending the doctors' salaries by reading out a list of services for which they are paid. You are now defending your position. I understand that and I am not being critical when I say that. However, this committee is not here to create a problem; it is about trying to improve the system and the processes.

Mrs Morton: I agree.

Mr HOUSE: I am trying to establish whether you, as manager of a large metropolitan hospital, have any ideas outside the circle about how that could be done. I have asked you twice - this is the third time - and on both occasions you have come back to me with a defence of what you are doing. I am not as interested in that as I am in what must be done to fix the problems that exist now, because there are problems and we all admit that. You may be managing them better than others because of the things you are doing. You may well be a better manager; that is outside my sphere of judgment. However, I want to know whether there is anything outside the circle that is not being done and needs to be done.

Mrs Morton: As I said, tweaking the amounts that you want to pay for any particular procedure would be a really important benefit.

The CHAIRMAN: On that point, we have just been told that an agreement is being negotiated now that will be in place in two weeks which is approximately nine per cent above the schedule fee. Are you suggesting that is not a good way to go and that we should allow individual hospitals to negotiate their fees directly with general practitioners to a maximum point? In other words, the nine per cent would become the maximum fee, not the norm, and hospitals should be given a free hand to negotiate below that figure.

Mrs Morton: I agree with that.

The CHAIRMAN: That is obviously going to happen. We have been told this morning that the fees will be negotiated across the board, which means that everybody will get up to nine per cent above the schedule fee. Are you saying that should be the ceiling and you should have the ability to negotiate below that fee?

Mrs Morton: Yes, we would want some procedures to be less than that.

The CHAIRMAN: Have the administrators in the Department of Health who are negotiating these fees been advised of that?

Mrs Morton: I was in the working party in the previous round of negotiations that dealt with the new visiting medical practitioner arrangements and that came up in discussion on a number of occasions. However, it is not an initiative that is commonly believed to be beneficial and it therefore did not get any support.

The CHAIRMAN: Would that not go against the whole basis of the various court decisions about anti-competitiveness? In other words, the fee will be set at the schedule fee plus nine per cent. As you indicated, in some circumstances doctors are performing one million arthroscopies on knees. They may not need nine per cent above the schedule fee because they are doing 30 a day as opposed to someone who is doing one or two a day and therefore you should be able to negotiate a better fee than the schedule fee plus nine per cent.

Mrs Morton: I agree with you, but it is not a commonly held belief in the Department of Health.

The CHAIRMAN: Whether that view is held, if it is the right thing to do, we should consider it.

Mrs Morton: I agree.

The CHAIRMAN: Just for the record, have you raised that matter with the Department of Health? We do not want to say things if that matter has not been formally raised in the Department of Health.

Mrs Morton: It was raised by me as a member of the working party. However, that working party ceased to exist a month prior to the last election and I have not been a party to any further negotiations since then.

The CHAIRMAN: Was that a formal recommendation made to the department?

Mrs Morton: No. You might be able to find it in the minutes. I do not recall whether it was recorded in the minutes but it was not a formal document that the department received on our behalf.

Mr HOUSE: What else would you do, apart from tweaking, because the tweaking bit will save a little? I am talking about how we can make the system more efficient.

Mrs Morton: Can I talk outside of Armadale Health Service?

Mr HOUSE: Absolutely.

The CHAIRMAN: We want you to, because that is what we are talking about.

Mrs Morton: I accept that I have a radical position on it, but I would introduce a fee-for-service system in some of the teaching hospitals. The introduction of that system would eliminate to a large degree outpatient departments in some teaching hospitals. Those services could be provided by community-based doctors, which would get rid of waiting lists almost overnight.

Mr HOUSE: They are not going to invite you to their Christmas party!

Mrs Morton: I know that but I believe that both systems are needed.

The CHAIRMAN: How would you eliminate waiting lists overnight because I am intrigued about that?

Mrs Morton: I shall use a simple example of a gynaecological outpatient clinic at King Edward Memorial Hospital. If consultant doctors who provide gynaecological services at King Edward were not required to put a certain amount of time into an outpatient clinic as a condition of their salary package, the patients whom they want to admit to hospital for gynaecological work would be seen in their private rooms. If that were to happen, the number of people visiting outpatient clinics would reduce significantly, if not disappear. Waiting lists are produced primarily from those outpatient departments. A combination of reduced outpatient departments and fee-for-service arrangements in some of the procedural areas in which you want to see a quicker turnover in hospitals would result in a marked reduction in waiting lists.

Mr BRADSHAW: Could you do that with public patients as well as private patients?

Mrs Morton: Absolutely, because everybody is a patient of a doctor. Patients decide when they walk through a hospital's doors whether they want to be admitted as public or private patients. At Armadale Health Service, only three per cent of the 14 000 patients are private patients.

Mr DEAN: Do you maintain those figures?

Mrs Morton: Yes.

Mr DEAN: I have been trying to find those figures in various other hospitals and they do not maintain them.

Mrs Morton: In the past financial year, only 82 patients out of 9 300 fee-for-service VMP discharges were private patients. Armadale has a very small number of private patients.

The CHAIRMAN: That contrasts completely with the number of the population who are members of private health funds.

Mrs Morton: It is possible. I am saying that they are not choosing to go to Armadale if they are private patients. They perhaps choose to go to Gosnells Family Hospital or another private hospital.

Mr HOUSE: Like any good practical farmer, you have come up with a good solution. Why has somebody not picked up on it? Waiting lists have been the bane of all of us for a long time.

Mrs Morton: Yes. I am about to be radical in what I say, but it actually suits the purpose of the teaching hospital clinicians to have big waiting lists.

The CHAIRMAN: Why?

Mrs Morton: It maintains pressure on government and pressure for increased funding to those services.

The CHAIRMAN: Are you telling me that clinical physicians in the hospital system are extending the waiting lists so that they have more political pressure?

Mrs Morton: I am not saying they are extending it. I am saying that I believe that they are not keen to get rid of waiting lists and not keen to change them in the way I have suggested because they would lose some leverage in the system.

The CHAIRMAN: What happened to the theory that a doctor should treat a patient as best he can and as quickly as possible?

Mrs Morton: These are the same views that I used when I referred to our fee-for-service doctors. The majority of them are well-intentioned and have good standards; very few are not and only one or two have come to your attention. By far the majority of our 40-odd doctors are credible, honourable and genuine medical practitioners. Very few fall into the category that I call gaming the system and we monitor and deal with those who do.

The CHAIRMAN: I am glad you said that you monitor them because the Department of Health did not know that $770 000 was paid to an individual doctor. How the hell could the department monitor that if it did not even know?

Mrs Morton: We know the figures from our perspective.

The CHAIRMAN: That is the problem; it is from your perspective but not collectively. In relation to monitoring the hospital, do you have any figures on admissions to Armadale hospital of patients referred by a VMP and then treated by that VMP? In other words, a VMP with private patients who have gone into your system and been treated by that VMP through the public system?

Mrs Morton: I do not have those figures.

The CHAIRMAN: Can you get a breakdown of each of the doctors?

Mrs Morton: You are asking for figures on patients admitted by the doctors, other than anaesthetists who are called in? Anaesthetists do not admit or discharge patients. Therefore, when a patient is seen by a GP, two things can happen. The GP determines that the patient either needs to be admitted to hospital or referred to a specialist who subsequently determines that the patient needs to be admitted. All patients therefore who come into the hospital under the fee-for-service arrangement do so, with a couple of exceptions, by referral from a doctor in the community whom they have consulted.

The CHAIRMAN: Exactly. I am asking whether you have figures that relate the doctor referring them to the doctor who treats them in hospital?

Mrs Morton: It would be 100 per cent except for the patients who come in from our emergency department, which has two arrangements. The person in the emergency department is asked whether he or she has a local doctor who has admitting rights at the hospital, in which case that person will come in under that doctor's name and be seen by that doctor within 12 hours of being there. That person would have been worked on by the emergency department physicians. If that person does not have a local admitting doctor, such as an itinerant person, there is a roster of admitting doctors from which a doctor would be assigned to the person who is admitted and that doctor would be required to see the patient within a certain time.

The CHAIRMAN: Do you not have a problem with the referring doctor being the treating doctor and the obvious incentive for his admitting as many patients as he can because he will be paid by you guys as part of the public system?

Mr HOUSE: A person cannot be admitted except by a doctor.

Mrs Morton: Yes.

The CHAIRMAN: But if I as a patient consult you as a doctor and you treat me in your private practice and say I need to go to hospital and you will treat me in the public system, there is no check on whether the service provided by the hospital and by that doctor is needed. He is the doctor at the surgery and has told a patient to go to a certain hospital, where he will treat him. One case, which resulted from that process, was that of a doctor who received $770 000 for procedures he had obviously recommended to himself.

Mrs Morton: The length of stay for the majority of medical cases that come to Armadale Health Service is about three days. More than 60 per cent of our procedures are daily procedures. The opportunity for a doctor to benefit greatly at the hospital, especially from a medical case, is not great.

The CHAIRMAN: Have audits been undertaken? Do you have any audits that can verify that you are not doing things that do not need to be done? In other words, is there some way that you, as the general manager, can say, "I have total faith that this doctor has referred a case that should be here."

Mrs Morton: Everything that is being done at the hospital needs to be done at a hospital, whether it is at our hospital or another hospital. I can say that because we have a theatre advisory committee that monitors cases. There is substantial monitoring of the type of work being done. At the end of the day, nurses can raise incident reports if they feel it is necessary. Occasionally, someone has been subjected to something that was inappropriate. That happens once in a blue moon. It may be

that Armadale is admitting some cases that would have to wait if that patient was being admitted to a different hospital, such as a teaching hospital, because he was not considered a priority one case but was a priority one, two or three case. Some of the teaching hospitals cannot get their priority two or three cases seen. I understand that, but we also have an extremely good management system for priority one cases, making sure that we do not have any priority one patients waiting longer than an acceptable period. We will alter theatre lists or actively manage the utilisation of beds. If the nurse manager feels that a doctor is attempting to admit a patient who is less in need than another patient, the manager will block that admission.

Mr HOUSE: I am a little confused about the outpatient admission procedures that occur at teaching hospitals and at your hospital. I obviously did not understand something. What you said earlier was that waiting lists could be reduced by changing the process at teaching hospitals. Am I correct up to that point?

Mrs Morton: That is correct.

Mr HOUSE: From what you said, the process that has been put in place at Armadale sounds a little different. There is greater management of the admission of outpatients. Is that the difference?

Mrs Morton: We do not have any outpatients. We do not have any outpatient clinics.

Mr HOUSE: I want to be clear about this point. You are saying that if the teaching hospitals had the same system, in other words that they did not have outpatients, waiting lists would be considerably reduced. What about those people who go to outpatient clinics? Do they need to go to a doctor first? Is that correct?

Mrs Morton? That is correct.

Mr HOUSE: I will give an example. What would happen if a young bloke got a belting in a football match and needed his nose stitched? It is a Saturday afternoon and he is somewhere near Sir Charles Gairdner Hospital. What does he do?

Mrs Morton: That person would go to an emergency department. That is not an outpatient clinic.

Mr HOUSE: What I am getting at is that somebody will be critical of what you are saying and I want to know, as a member of this committee, what the answer is. The answer is that there is a way to deal with that problem.

Mrs Morton: A person who has had an accident and requires immediate stitching or bone setting, or even a person with a cardiac problem or something like that, would turn up at an emergency department. The outpatient clinics are for people who have been told by their general practitioner that they might need this, that or the other done, and the GP wants them to go to the outpatient clinic at King Edward Memorial Hospital for Women or Royal Perth Hospital for the problem. That person might wait to get into an outpatient clinic. There is a waiting time in some of those areas. A person might wait six months to get an appointment at an outpatient clinic. It might take three weeks; they vary. There are horrendous waiting times to get into outpatient clinics. If those doctors were not at outpatient clinics but were working in their normal practices within the community, those patients would be booked in to see that doctor for exactly the same procedure at the doctor's community-based clinic.

Mr HOUSE: So they would wait just as long to go to the private clinic as they would to go to the hospital, or would it be quicker -

Mrs Morton: I sound very critical of some teaching hospital practices. I have been a patient at teaching hospitals, a provider of services and have worked in the health system. I know that all patients who turn up, for example, at the King Edward Memorial Hospital for Women outpatients' clinic get an appointment at nine o'clock and one o'clock. If a person happens to be seen at half past twelve, he has still turned up for his nine o'clock appointment. People wait and wait and wait.

The doctors who run those clinics believe that they have other important things to do and that people sometimes have to wait for their services. Most consultants in the teaching hospitals believe that they should treat patients for 50 per cent of their time. Having attained consultancy status, they expect registrars and residents to do most of the work for them. The other 50 per cent of their time is used for supervision and teaching purposes. It is quite different at Armadale-Kelmscott Memorial Hospital. We do not have registrars and residents in most areas. I am talking about the throughput areas. The consultants work all the time because they do not have anybody to supervise. They are employed to do the work themselves on a fee for service arrangement. If I were required to employ the same calibre of doctors on a salaried and sessional basis, productivity would reduce again because they would not work on a salaried and sessional basis 100 per cent or 120 per cent of the time, as they currently do. They would expect to work 50 per cent of the time and the other 50 per cent of the time would involve non-clinical work. I do not have any physicians who are Fellows of the Australian College of Emergency Medicine. I do not have any FACEM-qualified people working in the emergency department. I have senior emergency physicians who work 100 per cent of the time dealing with patients who come through the door. If I were to get FACEM-qualified physicians to work at Armadale, they would expect to work 50 per cent of the time and spend the other 50 per cent supervising and undertaking reviews, teaching or training. It suits our purposes, for many reasons, to keep a fee for service arrangement.

The CHAIRMAN: I have two questions before I must go. The first relates to visiting medical practitioners who refer patients to hospitals. Only three per cent of patients are treated as private patients, which is ridiculous when they are coming out of the state system. Is there some process by which private patients can be identified? The only difference is in the ticking of a box, but it makes a hell of a difference to the public system and how much money comes out of it. If they were to tick the private box, a hell of a lot more money would come out of the private system to go to help the public system. Is there some way, under the employment of VMPs, to have some sort of agreement for them to identify private patients who have private cover? The level of service would be the same; who would pay the bill would differ.

Mrs Morton: I agree. It is probably unlikely given that we have just built a major new facility at Armadale and a private hospital is collocated on the campus. The same doctors work across the public and private facilities. The private patients will probably go to the private hospital. It does not mean that a patient coming into the public hospital cannot choose to be a private patient in the public hospital, but it is less likely that there would be an increase in the status of private patients at Armadale Health Service. Public and private hospitals work under different philosophies. Doctors enjoy working with their private patients in private hospitals. I do not think that they will be encouraged to bring patients into the public system as private patients.

Mr DEAN: That is not strictly true. We learnt this morning that the fee for service for certain procedures is higher in the public hospitals.

Mrs Morton: That is where the tweaking needs to occur.

Mr DEAN: We have the same problem in Bunbury. St John of God Health Care is collocated on the same campus as the Bunbury Regional Hospital. For example, ophthalmology is carried out at Bunbury Regional Hospital because it is a higher fee for service.

The CHAIRMAN: We are losing money from the public system because the fee has been set too high.

Mrs Morton: I agree with you.

Mr DEAN: In a situation like this, I do not think that doctors give a rat's fat about whether they interact with their private patients in a private hospital.

Mrs Morton: I totally agree that some of the fees need to be made more appropriate, but I also agree that doctors enjoy benefits other than just money-related ones by having private patients in private hospitals.

The CHAIRMAN: It was highlighted this morning that the Department of Health has no idea who is working at which hospital. Would it not benefit the system if VMPs were contracted on a joint basis? In other words, would it not be better to have some sort of transitional arrangement for VMPs to work at Armadale, Osborne Park and Swan District hospitals under the one umbrella and employed by a group. For example, if a registrar was needed at Swan District Hospital to man the emergency department, a doctor could be transferred there. The department would not have to be closed down because no-one wanted to go there. It seems that we all want to lock ourselves in a little envelope and say, "I am protecting my empire and no-one is going to rain on it." Enormous inefficiencies seem to be generated because no-one wants to talk to anyone else.

Mrs Morton: There are some areas where that would be beneficial. Anaesthesia is a good example. For many years, we have sought either a metropolitan-wide or a regional basis upon which to employ anaesthetists for a given area. I do not know how many anaesthetists travel to Armadale at the moment, but they must also travel to Joondalup, Swan District or Peel hospitals. At one stage we worked out that 40 hours a week of anaesthetic time was wasted in travelling to and from Armadale. It would be beneficial if those people were relocated to a regional area and rostered or employed on a different arrangement and were still paid on a fee for service basis or whatever. I think that the anaesthetists would welcome that.

The CHAIRMAN: Why has someone not already done that?

Mrs Morton: Good question.

Mr HOUSE: Because some of them will not live there. That is the problem.

The CHAIRMAN: If a person was working in Armadale, he could still live in Perth. It is not as if the person was travelling to Bunbury. It is in the metropolitan area.

Mrs Morton: There are difficulties with the location. Historically, Armadale has not proved attractive for doctors to live in and around the area. The majority of doctors live in the City Beach and seaboard areas. Part of the reason our redevelopment included both a specialist centre and a private hospital was to enable doctors to base their businesses in Armadale so that they could do all their public, private and outpatient work at the one location. This has been quite successful. Our specialist centre is now fully booked. We have noted that a number of specialists have started to buy property and to bring their families to live in the area. Until we have addressed that even more comprehensively, Armadale will continue to be seen as a difficult place to get to or an unattractive place in which to live and run the majority of one's work.

Mr HOUSE: It is fascinating evidence when compared with the other places in the State that we must service. If one has trouble getting the doctors from City Beach to Armadale, one can recognise the problems that we have getting them to go a little further over the other side of the Darling scarp.

Mrs Morton: Previously, I was the regional director for health in the wheatbelt and the mid west-Gascoyne area. The amount of the work that went into getting specialists to travel to those areas was quite significant. However, with the right incentives it was achievable. It involves a lot of hard work.

Mr HOUSE: I agree with that and acknowledge the work that has been done by a lot of people. What is the differentiation in fees between the specialist areas of radiology, gynaecology and whatever else there is in a doctors salary scale? I understand that radiologists are paid a lot more than other specialist professions. Are there reasons for that and are there ways that we can address this problem? I fail to understand why there should be such a differentiation as a lay person, but perhaps there is. Is there a way of solving that problem?

Mrs Morton: The salary scale is also linked to the Medicare schedule fee.

The CHAIRMAN: Please excuse me from the committee for now.

Mrs Morton: An elaborate valuing system works out what each procedure is worth in terms of doctor's time and expertise and other factors. That is also used by the Medicare arrangement with regard to their payments and our system is linked to that.

Mr HOUSE: In other words, if one specialises in radiology, one can expect a higher pay scale; is that correct?

Mrs Morton: I do not know whether it is determined by what one specialises in. It is considered around the complexity of the procedure that takes place.

Mr HOUSE: Who makes that decision?

Mrs Morton: It might be done Australia-wide. However, it is certainly done for the Health Insurance Commission.

Mr HOUSE: Do the federal-state issues visit themselves on your abilities as an administrator? In other words, if health was run solely by the State or the Commonwealth, or if we could resolve the problems that arise between the State and the Commonwealth, would that allow health to be managed in a better way for the average person in the street?

Mrs Morton: The majority of our work is covered by State funding. Some overlap with services that are funded by the Commonwealth occurs when an arrangement involves general practitioner practices, which are all funded by the federal Government. The problems associated with running state and commonwealth health systems in a parallel manner was of greater concern when I was responsible for a community that was trying to attract funding for nursing homes, aged care, and home and community care from the federal Government, as well as dealing with state-funded services. I am now solely responsible for the running of a health service that is state funded and those problems are less evident.

Mr HOUSE: However, they manifest themselves in rural Western Australia in a greater way.

Mrs Morton: I agree with that but the system seems to work better in the metropolitan area.

Mr WHITELY: Talking in a global sense, your preferred model is a fee for service model -

Mrs Morton: A flexible arrangement in which we have salaried and sessional doctors in some areas and fee for service doctors in other areas. I do not want to lose the salaried and sessional doctors in the Emergency Department or in the mental health area.

Mr WHITELY: The benefit of a fee for service model is that it creates the incentive to work hard. However, how could the problem of overservicing be overcome?

Mrs Morton: There are two options that I have thought about in that regard. One is changing the value of some of the services provided so that the incentive to deliver that service is reduced if the price of the service is decreased. We are also considering information on a "per head of population" basis for certain procedures. If a certain procedures is undertaken at a higher rate in our area than the state average, or in a comparative sense with other areas, we will look at that in more detail and start to question the practice of an individual doctor, if we can identify the particular doctor involved. It comes down to clinical governance. Unless there is a commitment and investment in clinical governance, which, in another form is like the medical administration that takes place inside a hospital, the issues cannot be dealt with. Apart from our own service in which we have put a lot of emphasis on clinical governance in recent years, there has been little commitment to clinical governance in the non-tertiary sector.

Mr WHITELY: If hospitals are funded on the level of service delivery that occurs - the number of cases that they manage - is there not an incentive for overservicing on the part of the physicians and the hospital? The hospital will then get a bigger budget at the end of the year -

Mrs Morton: They would run over budget.

Mr WHITELY: If the hospitals have serviced more cases?

Mrs Morton: I know what is being asked but I think there needs to be differentiation between the tertiary and non-tertiary sectors. The majority of the non-tertiary sectors do not run over budget at the end of the year. If hospitals do more work, they must then find an efficient way of doing that within their budget

Mr WHITELY: A case can still be built on having a bigger budget. When a hospital sees 12 000 cases rather than 10 000 cases, it can say that its budget should be increased. In the short-term you are right, but how is that overcome in the long term?

Mrs Morton: There must be good clinical planning based on the total population. Armadale's total population is 200 000 -

Mr WHITELY: A demographic audit is needed.

Mrs Morton: Yes, and there are normative rates for certain procedures that need to be undertaken. In a normal population of a certain size, there are rates for certain procedures that should or should not be undertaken. Those rates take into account things like the number of women that are of child bearing age in that population, the number of kids, or the number of elderly people. If it is seen that your area is significantly above average once that information has been obtained, then one must -

Mr WHITELY: We have talked about how the Armadale hospital would handle gastroenterology procedures if its case numbers were under average and how the patients would come across to that service. However, the doctors services do not come across and they are employed as a visiting medical practitioner; is that correct?

Mrs Morton: From time to time we have done it both ways.

Mr WHITELY: Would they be employed at Fremantle Hospital on a sessional or a part-time basis to be able to work as VMP at the Armadale hospital?

Mrs Morton: We have dealt with both cases. The doctors can work at the Armadale hospital using our capacity as part of their salaried arrangement with Fremantle Hospital. Fremantle then recoups us for that. On the other hand, not all of the doctors work full-time at Fremantle Hospital and they can then choose to work under the fee-for-service model at the Armadale hospital.

Mr WHITELY: How is it decided which way they are employed?

Mrs Morton: Through a negotiating arrangement. We will consider what works best for us and if the contract will only be for a short period of time or something that we want to continue for a longer time. We will also consider if the numbers are small to start with and if we are trying to influence the referral patterns of local GPs so that they refer to the Armadale hospital in the first instance, rather than the outpatient clinic at Royal Perth Hospital or wherever. A variety of those factors are taken into account and a doctor would not be attracted to work at Armadale hospital if they were not being paid at least an equivalent amount to what they were earning at Fremantle Hospital or Royal Perth Hospital.

Mr BRADSHAW: A number of medical directors have been employed at the Armadale hospital and it is looking for one in the obstetrics and gynaecological area. Do medical directors do procedural work or do they just oversee procedures? Do they also look at what work is being done by the private doctors who are working in the hospital?

Mrs Morton: Yes, they do. For example, our director of anaesthesia is also the anaesthetist who works in our local service. However, over the last two and a half years he has been significantly involved in both a review of the performance indicators, the incident reports and the clinical review matters of all anaesthetists. He has also managed the theatre advisory committee and our medical advisory committee, which both involve a broader range of doctors. Therefore, the director of

anaesthesia is accountable to a director of medical services but under a specific requirement to look at standards of practice and other issues around anaesthesia to ensure that we have policies and protocols in place and that a clinical review is taking place in an educative way with the anaesthetists there. The same will apply to our director of internal medicine and if we had a director of obstetrics and gynaecology, he would undertake the same work. In the absence of a director for that area, we undertake the work with the director of medical services and we call in specialist advice to assist on various matters.

Mr HOUSE: We have now run out of time. The witnesses have agreed to provide some more information to the committee and if they are in doubt about what that information was, the principal research officer can provide the details. If there is any more information that the witnesses would like to provide to the committee as a consequence of this discussion, please feel free to do so. The committee's objective is to come up with a positive solution to get a better service. This is not about witch-hunting or trying to denigrate anyone but about doing a better job. If the witnesses have any other ideas, could they please let us know. I congratulate them on putting forward a very positive idea, bearing in mind that it will get some publicity.

Mrs Morton: Can I table the documentation that was provided on all of the different costs that need to be put into a comprehensive cost analysis.

Mr HOUSE: Yes. If there is any further information that the witnesses want to provide to the committee at sometime, please do.

Committee suspended from 12.28 to 2.12 pm.