PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT GERALDTON HOSPITAL BOARD ROOM, GERALDTON
TUESDAY, 20 NOVEMBER 2001

SECOND SESSION

Members

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

ANDERSON, MRS ELIZABETH ANNETTE,
Director of Nursing, Geraldton Health Service,
Shenton Street,
Geraldton, examined:

GLOVER, MR ALAN MORTON,
Manager, Finance and Support Services, Geraldton Health Service,
Shenton Street,
Geraldton, examined:

SNOWBALL, MR KIM,
General Manager, Geraldton Health Service,
Shenton Street,
Geraldton, examined:

The CHAIRMAN: The committee hearing is a proceeding of the Parliament and warrants the same respect that proceedings in 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 contempt of Parliament.

Have you completed the Details of Witness form, and do you understand the notes attached to it?

Mr Snowball: Yes.

The CHAIRMAN: Did you receive and read any information for witnesses briefing sheet regarding giving evidence before the parliamentary committee?

Mr Snowball: Yes.

The CHAIRMAN: Can you give us an outline of how the visiting medical practitioner services operate here and how they are controlled? I believe that you have resigned. Is that official or unofficial?

Mr Snowball: My contract finishes at the end of December, so I will not continue beyond that date.

Medical cover for the Geraldton Health Service is provided by private general practitioners and private medical specialists. It also has a number of salaried positions, including the director of the public health unit, which is a medical position, and psychiatrists with the mental health service. The general hospital services and the accident and emergency department are run entirely by private practitioners under fee-for-service arrangements per the visiting medical practitioners agreement. Sixty-five VMPs were paid last financial year and 62 in the year prior to that. I have provided to the committee the details of those practitioners, their payments over that time and their provider numbers as requested.

The CHAIRMAN: That will be formally incorporated into the evidence. This is in response to a subpoena through the department.

Mr Snowball: It is. The accident and emergency arrangement has been the most topical issue in the community. I think it was mentioned by those who gave evidence previously that in about 1999, we were short four to five general practitioners in this community and there were problems with people accessing those services. A number of the practices closed their books to new patients as they could not handle any more. People were waiting six to eight weeks for a routine consult. We found that a lot of people then came to the accident and emergency department to receive GP-type services. In response to that, we sought, through the board, discussions with practitioners to

look at increasing recruitment to Geraldton. The alternative for us was to move to salaried doctors to man our accident and emergency service, because of the concerns with the ability of too few GPs to respond as quickly as we would like and to properly cover the accident and emergency department. Over a period we went through a process to establish what should be the right number of general practitioners for a community this size. We looked at national benchmark levels, at other States, at other health services in Western Australia and at professional bodies. We arrived at a ratio of about 1:1300, which was approximately the right level for this community. Obviously, that range depends on the demographics and make-up of the population in terms of its health needs. We went through that process and established that there needed to be at least 24 GPs in Geraldton servicing our needs.

The CHAIRMAN: Is this only in private practice?

Mr Snowball: This is the total primary care service. General practitioners are the gatekeepers to the health system - that is, ensuring people have reasonable access to general practice-type services. We then met with the GPs and encouraged them to recruit to at least that level. The alternative was that we would employ our own doctors to run the accident and emergency department. Having done that, a number of other issues were agreed at that time. This is an extract from our board meeting on 17 January 2000, and I am happy to submit this to the committee. The option of salaried doctors versus continuing with fee-for-service VMPs was discussed at that meeting. In essence, the recommendations and the approval of those indicated that three additional doctors be recruited immediately to each of the group practices and the Geraldton Regional Aboriginal Medical Service. A commitment to establish a rural training practice in Geraldton should be supported, which would create a third group practice in town. One of the issues was that new doctors did not want to go into solo practice; they wanted to go into group practice. The response to that was that there was a need for a third group practice in Geraldton. The board approved the establishment of a half-time director of medical services to manage our relationship in terms of the clinical services provided by our private practitioners. It also approved the establishment of a working party for improved patient management and customer service between surgeries, particularly in the accident and emergency department. People who went to a surgery and were told to see the people in A and E and vice versa needed to be sorted through. It also recommended a review of the on-call arrangements and how they were organised and put in place. There was a commitment by the board that it would not recruit resident, salaried doctors for a minimum of three years, while the medical work force remained at a minimum of 24 full-time doctors.

The CHAIRMAN: Why would such a commitment be given?

Mr Snowball: For two reasons: first, doctors needed to expend a fair amount of money in recruitment. Most of the recruitment took place from overseas. It costs up to $5 000 and more to recruit a GP from South Africa, the United Kingdom or wherever. They simply were not able to get local recruitment; that is, Western Australian or Australian graduate doctors. In fact, at that time the minister declared this area an area of need, which then allowed practitioners to recruit overseas-trained doctors for entry into Western Australia. That was the main reason for making that guarantee. If GPs were prepared to come to Geraldton and they came to Geraldton, one could say that resident doctors have been established in the service. Obviously, that will reduce their capacity to both exercise their procedural skills and, indeed, maintain their income at the level they would have been expecting had there not been resident doctors. Part of the arrangement was that they do that, exercise those skills, spend the money, recruit the doctors and the board would be prepared to honour the agreement that it will not recruit resident doctors for that period, provided that 24 full-time doctors are maintained. That arrangement would also be reviewed after a period, and the board has obviously done that.

Finally, the management of medical work force planning into the future would be the responsibility of the division of general practice. One of the issues was that, when it got down to four too few,

who was responsible for addressing that? That was not clear. The doctors work in their own practices, so if somebody else is short of doctors, that is his problem. Likewise, the health service does not have responsibility to directly recruit doctors unless it employs them itself. It was not clear who had that responsibility. Applying that and agreeing to that was the responsibility of the division of general practice as the main body involved in work force planning and management.

Having gone through that process and in arriving at that position, we also assessed the financial comparison between salaried doctors and VMP arrangements. I have two papers here and I am happy to provide copies to each member. The first one is the costing of resident doctors for the accident and emergency department. This is assuming that a salaried doctor is located in the accident and emergency department 24 hours a day, seven days a week. The total employment cost is established there. It identifies a number of straight salaried plus other support costs, which came to a total of $756 000. The equivalent cost at that time for using visiting medical practitioners was $526 000. At that time, the fee-for-service arrangement was approximately $230 000 cheaper than using salaried doctors.

The second paper looked at a combination -

Mr DEAN: Are you saying that it costs $230 000 per annum per doctor to staff the accident and emergency department?

Mr Snowball: No. It is $230 000 cheaper to use the fee-for-service arrangement to support our accident and emergency department than it is to have salaried doctors.

Mr DEAN: What is the average cost per doctor?

Mr Snowball: In salary?

Mr DEAN: Yes.

Mr Snowball: The cost of residents paper lists it as $168 000, which is inclusive of superannuation, private rental, access to a vehicle and medical indemnity. We used an estimate, because obviously indemnity is paid and covered by the health service and government.

The CHAIRMAN: You are not comparing apples with apples. You are comparing a visiting medical service, which may or may not provide adequate cover, with seven days a week, 24-hour coverage. People could walk into the service and be guaranteed that a doctor would be there to see them. Under the VMP service, people may or may not be seen. You are not comparing apples with apples. It also discourages competition. As indicated by the consumer advocate, it is very difficult to get bulk-billing in Geraldton. A doctor told me that there is a clinic that bulk-bills. The evidence shows that it was costing $47 per patient to see a doctor. People who are in a low economic bracket cannot afford to pay $47 to see a doctor when they can see them for nothing here. You must compare apples with apples.

Mr Snowball: This attempted to look at purely financial issues. I have other evidence on general services, which I am happy to cover as well.

Mr WHITELY: Can we go through these assumptions again? It says that it is 24-hour-a-day coverage, seven days per week. That is under a salary arrangement. What was the basis for your comparison? The cost differential is a key issue for us. How did you make that cost comparison with the visiting medical officer system?

Mr Snowball: Because it is a fee-for-service arrangement, the doctors come in when asked to attend. That is the only time they are paid. They are paid for treating a patient in the accident and emergency department.

Mr WHITELY: The quality of the difference would be that somebody would be there when the patient arrives; whereas under the VMO service they would come in.

Mr Snowball: Exactly. There are a number of issues with coverage. If we went with a salaried doctor, patients would be guaranteed that there would be a doctor there. However, there is one doctor. During peak times, people will wait longer to see one doctor. Under the current VMP arrangement, up to four GPs can come in to treat a patient at any given time. Four doctors could treat four patients at one time versus one doctor who would treat patients in turn.

The CHAIRMAN: They could, but does it happen?

Mr Snowball: Yes.

The CHAIRMAN: If that were the case, and it was required, there would be four salaried doctors to do the same work. Surely there could still be four people on call if the salaried staff need backup?

Mr BRADSHAW: No, not necessarily. How do the visiting medical practitioners work? Is there a roster of every doctor who is prepared to do it, or do different surgeries have different arrangements with the hospital?

Mr Snowball: The four groups have their own independent rosters. If a patient comes into the accident and emergency department and says that he is with the Victoria District Medical Doctor, that practice will then provide the doctor. Those doctors rotate on call. In addition, there is a town doctor who is there to see any patient. If a visitor to the town needs a doctor and does not have a doctor in town, the town doctor would see that person. That is how it rotates. One of the benefits of that arrangement is that there is some choice of doctor, or at least a choice of practice. It might not be the patient's doctor, but it will be a doctor from that patient's practice. That is when there is access to a greater number of doctors. Because it is on a fee-for-service basis, the doctor is called in when needed, as opposed to having a doctor wait for patients to come in. In that circumstance, patients do not have a choice of doctor; they will see the doctor who is employed by the hospital, which is the public system. That is what people are trading off; in one sense they are trading off the security of knowing that there is a doctor in the hospital. There are pros and cons to both options. People will have confidence that there will be a doctor in the hospital if they need him. If they are a category one or two, they will know there is a doctor in the A and E department waiting. That is the issue. The problem is that if we have five category ones or twos coming in, we still have only one doctor. Under this arrangement, we have five patients coming in who have access to five doctors who are on call to the hospital. If we want the best of both worlds, we must pay a price. Having a doctor present all the time costs $230 000 more than it does to bring in fee-for-service doctors. That is based purely on the volume of work. During the peak periods, the salaried doctor is more cost-effective for after hours. From 10.00 pm to 7.00 am, there is a doctor sitting there twiddling his thumbs waiting for -

Mr WHITELY: It is a naive approach to have one doctor on duty all the time, regardless of workload. Did you do any modelling work when you had two doctors on at peak time or a doctor scheduled on when it was likely to be moderately busy -

Mr Snowball: There is a variety of ways of looking at this issue. That is why I went through having resident doctors, which is what was called for at that time. The other scenario, which I have not come to, also looks at those doctors providing some procedural work, including seeing a patient in the emergency department and continuing to treat him as an inpatient or providing some procedural work. They would do anaesthetic work and obstetric work too. In that case, we would start to get more cost-effective scenarios. There are other options, such as not manning the department from 10.00 pm and 7.00 am. We would go back to an on-call arrangement. All those options have financial and service implications.

Mr WHITELY: Have you costed those other arrangements?

Mr Snowball: Yes. We have obviously gone through the peaks and troughs.

Mr WHITELY: Are those costings here for the other modelling?

Mr BRADSHAW: The problem with that is bringing in salaried doctors to suit your needs. The others might tell you to get lost and that they will not service your needs after hours.

The CHAIRMAN: That is the breaks. It works in Broome, why can it not work in Geraldton?

Mr BRADSHAW: It is different in Broome.

The CHAIRMAN: There are doctors who are not providing any service at all to the hospital.

Mr BRADSHAW: That is what I mean; they are not providing any service to the hospital.

The CHAIRMAN: The salaried officers pay for the operation of the hospital. I find it strange that Geraldton, with its budget, has no salaried doctors. Other regional centres of the same size use a substantial portion of their budgets to pay for salaried doctors.

Mr Snowball: It is an issue of numbers. It comes to a point at which the size of the community and the volume of work warrant having salaried doctors. Albany runs in very much the same way and it is much the same size. Kalgoorlie has a rotation of registrars, as does Bunbury. They have their own problems. We would be substituting one set of problems for another set. That is one of the issues. The point about losing the skills of the doctors was raised when we looked at residents versus continuing the VMP system. They are saying they do anaesthetics and we need that capability to be able to deal with resuscitation. We want access to that range of skills for category 1 patients. They are saying that if we are not going to do that, they will start to lose these skills and we will not be ready. We would need to have that as part of our salaried doctor make up. It is not about getting a junior doctor; it is about getting senior doctors with experience. There is nowhere else to go here. It is not as though we can bypass to another hospital or whatever. This is it. We must have full backup with full services. Ours is a regional service.

Mr WHITELY: I understand that. The general surgeon earns $233 000 and spends half his time working here. There is obviously scope to employ a full-time salaried surgeon here at much less than that who would provide the cover. Obviously a mix is required. I am not suggesting that the VMPs be done away with altogether. There is obviously some scope for that activity - you need a general surgeon. Why not have one on staff? It would cost far less than $233 000.

Mr Snowball: I was looking at accident and emergency services in this case. That is obviously the pressing issue. I refer to general surgery, physicians, orthopaedics and obstetrics. Many of the GPs also provide those services. They do obstetrics, minor surgery and anaesthetics. The size of the community has grown such that they are moving from general practice with procedural skills to specialist services. We get to a point at which the volume of work warrants moving to a salaried service. It is the point on that continuum that determines what a community can reasonably sustain. At the moment, we have three general surgeons. If we were to employ one general surgeon, he could probably do the procedural work of at least two of the existing surgeons. However, we must also provide 24-hour cover. They not only do the general procedures and elective work; they also cover for the emergencies and do the on-call work. At the moment, we are paying for access to the three general surgeons for emergency cover as well as elective surgery works versus paying $230 000. How many general surgeons would we need to employ to cover that same range? I am happy to do the same numbers for each area.

General surgery is the obvious area, because that is the major volume area. What is the breakeven point in determining that we should have a salaried service? I do not think we are at that point.

The CHAIRMAN: A salaried surgeon indicated that $233 000 represents less than half his salary. That means he is earning $500 000. For that amount you could employ four or five full-time surgeons at $230 000 plus on-costs.

Mr BRADSHAW: I do not think you would do that.

Mr WHITELY: I do not think we know that those figures are correct.

The CHAIRMAN: Even if it is one-third, you must consider salaried positions, which would provide on-call and emergency services. That is what he is doing now.

Mr Snowball: At the moment those surgeons provide consultations in their rooms. They are the initial consultations. Then they make an appointment to do elective surgery and provide the post-acute care. That is paid for under Medicare. If we decided to provide a salaried service, you would be providing the consultations as well, and they would be paid for by the State. That is one of the issues in all of this - commonwealth responsibility and state responsibility. There are grey areas. We are talking about cost shifting across those areas. That is what this is about to a large degree.

Mr HOUSE: The VMP figures for Albany and Geraldton are almost identical, at 3.5 and 3.6.

Mr Snowball: Yes.

Mr HOUSE: The figures for patient admissions we have been given indicate that Albany has a little more than 1 000 private patients, but Geraldton has only 240. The public patient figures are similar at 7 500 in each. You are defending the way you have decided to run your system on the basis that Albany is similar and therefore it made the same decision. I gather that that is correct. What is the difference in those figures?

Mr Snowball: The presence of St John of God Health Care causes the difference. Albany does not have a private hospital. The comparison of general practitioners is valid. Regardless of the existence of a private hospital, GPs provide general practice services to the community.

Mr HOUSE: You are still spending as much on VMPs as Albany, but you have 800 fewer patients. Is there something in that?

Mr Snowball: No. It is a comparison between accident and emergency services.

Mr HOUSE: Do you have more?

Mr Snowball: Yes.

Mr HOUSE: Why?

Mr Snowball: We are drawing on a larger catchment. Unlike Albany, the hinterland here does not have theatres or provide obstetric services. More patients come to Geraldton for those services than would go to Albany. Mt Barker and Denmark both have theatres and both provide obstetric services. Our emergency department also has many transfers. A GP at Mullewa or Northampton will send a patient to Geraldton if required.

Mr HOUSE: To get these figures in balance, we would have to add Mt Barker and Denmark to the Albany figures.

Mr Snowball: You would be getting pretty close.

Mr HOUSE: We can do that.

Mr BRADSHAW: You would include Katanning with Albany.

Mr Snowball: We are dealing with a wider catchment. General surgery is similar, because both it and obstetric work filter through to Geraldton. On the other hand, in the great southern, a component of that work is still done in the smaller centres. There is a different mix in that sense.

Mr HOUSE: Paul Flanagan indicated that some sort of tendering contractual arrangement might be worth trying. Do you agree? He is one surgeon in the system and he must be responsible for a wider range of services.

Mr Snowball: I would if there were a market, but not if there were not.

Mr HOUSE: Is there a market here?

Mr Snowball: In general surgery there is. A fine line must be followed with quality and the skills of the practitioner. We must be careful about taking the cheapest option.

Mr HOUSE: Would you be concerned as a hospital administrator that took Monty House's tender over John D'Orazio's and that he might be the better surgeon? Is that a problem?

Mr Snowball: Yes. We need to be very careful, particularly in a community like this. If a resident general surgeon does not handle a case well, it quickly becomes known in the community and his patient numbers will decline. Practitioners must be ready to practise in a place like Geraldton. They are taking on a lot of other work. They take on disciplines that are covered by specialists in Perth. They need to have the right skills. That is why I am saying that the cheapest is not necessarily the best in health care.

Mr HOUSE: How many closed beds do you have here?

Mr Snowball: We have not closed any beds.

Mr HOUSE: Are you fully operational?

Mrs Anderson: We do not turn people away. There was a point at which we were managing 60 beds. However, if there were medical patients coming in, we could not say that we were full because it would mean sending them to Perth. We just accept them.

The CHAIRMAN: How many empty beds do you have?

Mrs Anderson: None.

Mr HOUSE: What is your bypass rate into the Perth system?

Mrs Anderson: Certain people are flown out because of their acuity.

Mr HOUSE: I accept that. If we cut the allocation to a country hospital, do we then pass that problem to a Perth hospital?

Mrs Anderson: I believe so.

Mr Snowball: Over the past three years, we have made a particular effort to provide more services locally, so people are able to access services in Geraldton rather than go to Perth. At the moment, we are able to capture about 85 per cent of those needing hospital services that are available in Geraldton. In other words, only about 15 per cent of people are going to Perth for different reasons. That could be because they believe there is better backup or they have family. That is a very high percentage.

Mr HOUSE: I accept that people have a choice. I want to make something very clear. If the Government allocates a certain amount of money to a country facility and, because of that, it cannot then provide a service, we are kidding ourselves if we think we are saving money. It is bypassing your system and going into another system somewhere else.

Mr Snowball: That is correct, or people wait. Over the past three years, we have done a lot of work to reduce the waiting time here. For example, in orthopaedic surgery people were waiting 16 to 18 months for hip or knee replacement procedures. They are now waiting about eight weeks. We have achieved an extraordinary turnaround in that area, and also in urology and general surgery. That has occurred because we have used some of the capacity in the hospital. Some theatres and ward areas were unproductive three years ago because we capped them. The theory was that if we capped the number of beds and elective surgery, we would save money. If you cap service at an unproductive level, you will lose money. We must be able to provide enough work in those areas to deliver economies of scale. That is what we have tried to do in Geraldton. The community has benefited because we do not have those waiting times. Part of that is getting access to the specialists to provide the service.

Mr HOUSE: Obviously the committee's brief and the chairman's questions indicate that members are looking at the visiting medical practitioner service, its cost and its relationship to other things. The cost of surgeons is only part of the total delivery deal. It could look too high in some hospitals, but they would be delivering a bigger and better service. Is that true?

Mr Snowball: Yes. They are turning their hand to other things; they can do some of the neurological services and vascular work. Within that we are trying to get people with a mix of skills who are able to cover the sort of work we should be doing in a place like Geraldton. That is what we have been trying to do. It is difficult. We can roll all that up into one person and they can do all that. That is the issue with the generalist.

The CHAIRMAN: That is okay, but you can still do the same thing on a sessional basis.

Mr Snowball: Absolutely.

The CHAIRMAN: Has that equation been done? One of the Perth hospitals spoke about doctors doing sessions involving only one type of procedure. It said it did not have the ability to negotiate with the doctor. He might be doing 10 knee reconstructions in a row. Obviously there is an economy of scale. Therefore, he should not be getting 10 times the fee for service that he would get if he were doing only one procedure. The hospital representatives said they had no ability to negotiate the fee. The doctor is paid the same rate when he is doing one or 10 procedures.

Mr Snowball: Being able to negotiate a fee is a two-edged sword. If you have a market like Perth, I agree. You have enough likely takers that you can drive the price. If you are looking at a very limited market and trying to deal with it in the same way, the price might go up rather than down. Mention was made earlier of tendering for services. You must have a market to get a reasonable price.

The CHAIRMAN: It will be interesting to see what Broome does when it goes to tender next month. It is nowhere near as well positioned.

Mr Snowball: Is that for resident doctors?

The CHAIRMAN: It is for surgical procedures and specialist services.

Mr Snowball: You can do that with visiting services. You have a market and you can tender. I was suggesting it might be more difficult if you were tendering locally for a full surgical service, with all the aftercare and so on. It might cost much more than anticipated.

Mr BRADSHAW: If you had unlimited money, which service would you prefer: the current service with the visiting medical practitioners or salaried medical officers?

Mr Snowball: I like them both. I like the idea of being able to say to the community that they can have confidence when they come to the accident and emergency service. Servicing the ones and twos is our prime issue. If we had our druthers, I would like that, plus the ability to call on a range of skills that are available among the general practitioners we have here as a support.

Mr BRADSHAW: Are the ones and twos the coughs and colds and so on?

Mr Snowball: It is the other way around; the ones and twos are the high-priority cases.

Mr BRADSHAW: Has this year's budget been increased or decreased?

Mr Snowball: We received more money. However, in terms of our cost structures, we need to find $1.8 million. To deliver the same range of services, we need -

Mr BRADSHAW: Are you saying that you have to make up the $1.8 million?

Mr Snowball: We must look at areas in which we can reduce our costs.

The CHAIRMAN: Is the $1.8 million a reduction in the budget or has there been -

Mr Snowball: There has been an increase.

The CHAIRMAN: But your cost structures have increased.

Mr Snowball: There has been an increase in our allocated funds because services have been transferred to us. Mental health was run by the mid west and Gascoyne, and it is now run by Geraldton. That has resulted in a transfer of almost $3 million from those services to ours. That is

a large part of the increase. Regional services are in a similar boat. We have cost escalations from the nurses' enterprise bargaining agreement, and so on. These are the cost estimates. Of course, the doctors' pay increase is another potential issue. Those things add about $1.6 million to the cost of running the service. All up, to provide what we provided last year, we need to find $1.8 million.

Mr BRADSHAW: Health services in the Geraldton area have suffered a reduction.

Mr Snowball: I cannot speak for the others.

Mr BRADSHAW: You are saying that you have had psychiatric services and regional services transferred to you.

Mr DEAN: I am not sure that that is part of the committee's brief.

Mr BRADSHAW: It is, because they cannot provide medical services if they do not have the money to do that.

Mr DEAN: If you have salaried officers, you do not have to pay VMPs. That is simple.

Mr BRADSHAW: There is a general reduction in funding for health services in Geraldton.

Mr Snowball: The board has done a great deal of work in deciding whether to use resident doctors or GPs. It was not simply a financial decision. It was also based on the services we provide. That requires a good deal of care. It relates to following through with the same practitioner whether they go to a surgery, come to the accident and emergency department or are treated as an inpatient. They lose confidence that we will have a doctor in the facility. It is a judgment call.

The CHAIRMAN: I understand. If I came here, what guarantee is there that a doctor would be waiting to treat me in the accident and emergency department?

Mr Snowball: We monitor all our ones, twos and threes.

The CHAIRMAN: If I came here at 6.00 pm, would there be a doctor sitting here waiting to treat me?

Mr Snowball: Usually there is.

The CHAIRMAN: Is there any time that a doctor would not be here to provide a service?

Mr Snowball: Most of the day and after hours there will be a GP in the accident and emergency department. I suspect that if you were to go down there now, there would be GPs.

Mr HOUSE: How many beds are there at St John of God Health Care?

Mr Snowball: There are 60.

Mr HOUSE: What about here?

Mr Snowball: There are 79 available beds, but we staff for fewer than that.

Mr HOUSE: Are the hospitals about the same size?

Mr Snowball: Yes, but occupancy is different. It is a bit over 50 per cent there and about 90 per cent here.

Mr HOUSE: Is there a clear choice for private patients in this town between that hospital and this one, which is not available at Albany?

Mr Snowball: Yes. Bunbury is the only location outside Perth that has a private hospital.

Mr HOUSE: Is that an issue? Obviously privately insured patients will go there.

Mr Snowball: No. One of the questions asked is whether we benefit from having private patients in a public hospital. Because we are deficit funded, it makes no difference to the hospital. It does not affect the system as a whole. If a private patient comes in, we get the revenue from the private health fund for that patient. However, we receive less funding from the Department of Health.

Mr HOUSE: It also follows that they have a choice. The service you are providing cannot be all bad, otherwise they would not come here. You are indicating that you have a 90 per cent bed occupancy average and they have 50 per cent.

Mr Snowball: Yes, that is correct. Part of that is driven by the decrease that was experienced in private health insurance. That has picked up since the numbers have increased.

Mr HOUSE: And the gap.

Mr Snowball: Yes, although many of the funds have negotiated no-gap arrangements with practitioners. That has also made a difference. People make a judgment. In terms of medical clinical care, it is similar. Because we draw on the same medical practitioners to provide the services, that is not where the distinction lies. Most of it lies in how long people wait, the environment and so on.

The CHAIRMAN: What sort of fee for service would a GP get and what is the cost to the system?

Mr Snowball: Coverage through the accident and emergency department is $73.

The CHAIRMAN: The doctor must come from town to see the patient here and he will be paid $73.

Mr Snowball: On average.

The CHAIRMAN: The patient would pay $46 for a consultation in his surgery.

Mr Snowball: Yes. It must be borne in mind that the service is provided here at any time of the day or night. That is an all up, 24-hour-a-day service cost.

Mr HOUSE: If I present with a cough -

The CHAIRMAN: I will take this one step further. I am a busy GP. If you want to see me in my surgery, you will have to wait six weeks. However, if a patient sees me at the hospital, I will get $73 for seeing him. What safeguard is there that I will not send three or four patients here so that I can double my fee?

Mr Snowball: The triage nurse will say that the patient should see his or her GP. That is about the only safeguard. Yes, it happens.

The CHAIRMAN: There is an incentive for me as a doctor to see these people at the hospital, especially just after my surgery finishes at 6.00 pm. I will get $73 rather than $46. That would be a nice earner on top of my private practice earnings.

Mr HOUSE: It can work in reverse, too. There is also an incentive for the patient who walks through the surgery door and sees 15 or 20 people waiting to turn around, walk out the door and go to the hospital.

Mr Snowball: That is why we have so many fours and fives coming into the accident and emergency department.

Mr HOUSE: Is that because it is free?

The CHAIRMAN: Yes, it worries me that it is costing so much to see the same GP.

Mr HOUSE: You cannot blame the doctor.

The CHAIRMAN: I am not. The idea of ringing the doctor because it is his patient provides an incentive to have this system in place. If one doctor had to come, whether or not it was his patient, it would work as a disincentive. It is better for the doctor to send his patients here.

Mr Snowball: The test is the triage nurse.

The CHAIRMAN: That is putting a great responsibility on the nurse.

Mr Snowball: That is what they have been trained to do. If the triage nurse believes that the patient needs to see a doctor, we have an obligation under our Medicare agreement to provide that service at no cost.

Mr WHITELY: In other words, if they come in with a cough or cold, they might have to wait six hours for treatment. The triage nurse would say that there were other priorities and that the patient would be treated eventually. Is that the in-built disincentive?

Mr Snowball: I guess so. In that case, the triage nurse would tell the person to see a GP.

The CHAIRMAN: Presumably the patient would wait a long time.

Mr Snowball: That is correct.

The CHAIRMAN: He would not wait six hours, because if I were his doctor I would come down to see my patient. If I had four of them, I would see them one after another. They would not be waiting six hours. The incentive is there for me.

Mr Snowball: We pay better and more quickly than Medicare.

Mr HOUSE: Do you have an internal checking system? Do you watch? If I were the local doctor and all of a sudden 10 of my patients started appearing here every day, would you wag your finger at me?

Mr Snowball: Yes.

The CHAIRMAN: Have you had situations like that?

Mr Snowball: Yes. We have had different circumstances. For example, not long ago, someone who would not pay his bills was sent here. That was inappropriate and we followed that through with the practice. It has now ceased. That patient is referred to other practices.

Mr HOUSE: If a person continually presents here, do you tell that patient that he should be going to a surgery?

The CHAIRMAN: You cannot.

Mr Snowball: No, we do not, but the assessment is, on each occasion, a service. Each attendance is assessed by the triage nurse.

Mrs Anderson: Exactly. There are five categories. We keep talking about triage. The first category is for patients who need to be seen immediately, the second is for those who can be seen within 10 and 20 minutes, and the others are for patients who can be seen within a longer period, such as 60 minutes. Category 4 and 5 patients are those who in the main can be seen in procedural priority, which is triaged. The patients are observed and assessed, and a decision is made about the category they go into. Some consultations in accident and emergency are with a nurse only. We can tell people who have had a bad cough all day that the surgery will be open the next morning and ask them whether they would like to go. Some of them will categorically say that they will not go and we cannot tell them that we will not treat them. We let the doctor know and the patients will sit in the waiting room. Sometimes they sit longer than at other times. That can turn into three to four hours.

Mr DEAN: What percentage of those patients would come under categories 4 and 5?

Mrs Anderson: I presented that to the board just last month. Category 1 patients were all seen within the Western Australian benchmark time. In category 2, one patient was not seen in that time limit.

Mr DEAN: No, I am asking what percentage of those patients were in categories 4 and 5? Was it 20 per cent, 40 per cent or 50 per cent?

Mrs Anderson: It was 50 per cent or higher.

Mr Snowball: Higher. I have figures for a three-month sample from July to September this year. Of the 4 500 attendances, 3 500 were category 4 and 5 patients.

Mr HOUSE: Just at this hospital?

Mr Snowball: Yes, just at this hospital. I will clarify that point. Of those category 5 patients, more than half were seen only by a nurse, so a lot of those cases can be handled without calling a doctor in. Twenty five per cent of category 4 patients were seen by a nurse only. That gives you a bit of a feel for it.

The CHAIRMAN: What was the initial percentage again?

Mr Snowball: Of nurses only?

The CHAIRMAN: No, of the whole lot.

Mr Snowball: We are looking at 3 500 attendances out of a total of 4 500. Of the total attendances, 3 500 patients came under category 4 and 5.

Mr DEAN: That is seventy-five per cent.

The CHAIRMAN: What is the percentage at Bunbury?

Mr DEAN: It is 54 per cent. Even that is too high. I suggest that there is a major problem here.

Mr HOUSE: Is there a pattern with any group in the structure of this region?

Mr BRADSHAW: You do not have to answer that.

Mr HOUSE: Are you able to answer that question?

Mrs Anderson: No, I would not like to answer that question. I do not have the facts and figures.

Mr BRADSHAW: Do the surgeries have after-hours services or do they just knock off at five or six o'clock?

Mr Snowball: Usually at six o'clock. When the new practice started it was also open on Saturdays. There is some after-hours coverage. That is an issue we have been talking -

The CHAIRMAN: There are 27 doctors and not one will stay open until at least 10 o'clock?

Mr Snowball: No.

The CHAIRMAN: What incentive is there? They get $70 to come in.

Mr Snowball: The service is already here, so why would one?

The CHAIRMAN: Another comment made by the consumer advocate was that nurses are having grave problems getting doctors to come in, especially after hours. Is that true?

Mr DEAN: Some problems.

The CHAIRMAN: Some problems.

Mrs Anderson: It is hearsay. We have not done questionnaires on it. Triage indicates that doctors are seeing the patients.

The CHAIRMAN: You obviously have nurses working in the system. I have heard that that happens from nurses' representatives.

Mrs Anderson: Yes, there are some doctors who are -

The CHAIRMAN: The nurses have problems getting the doctors to come in to provide after-hours services. Is that true? I do not want you to give me a diplomatic answer. Tell me the truth. Is it true or is it not true?

Mrs Anderson: It depends how true you want one to be. There can be one bad apple in a case. The nurses can say that they cannot get doctors to come in, but I am not prepared to generalise. I

am not prepared to go on record to say that a certain doctor is really bad because he has X number of patients and never comes in.

Mr Snowball: There are mechanisms. In fact not long ago -

Mrs Anderson: I am referring to that.

Mr Snowball: Yes, it was also raised through the media. A health consumers' council raised the issue. As soon as any evidence along those lines is put before me, or before the chairman of the Medical Advisory Committee, that issue can be dealt with, but I have not received any documented evidence. I have asked for it. In fact, since that letter came out I have asked for that situation to be monitored through the accident and emergency department. If there are any circumstances in which doctors refuse to come in when they have been asked to, that needs to be followed through with that doctor. We need a response about why he would not come in. If it is not considered to be a legitimate reason, there is an agreement with the Medical Advisory Committee that after two strikes the doctor is out.

The CHAIRMAN: What about control of the services that the doctors claim have been delivered. Is that monitored?

Mr Snowball: Yes.

Mr DEAN: Have you stopped any payment vouchers in the past 12 months?

Mr Snowball: Yes, we have. For a number of reasons.

Mr DEAN: Non-attendance?

Mr Snowball: Yes, for non-completion of discharge summaries, which is basically the final document that summarises the condition that was treated and the way in which it was treated. We have traditionally had problems in getting responses to that. The response was as low as 30-odd per cent when I first came here. We are now up around 90 per cent, which is quite a good rate.

The CHAIRMAN: How do you verify that Dr J, B or D arrived, performed the service and got paid, because the nurse will not be there? Who will know that they have done the work?

Mr Snowball: A set of accountability mechanisms is in place, which I am happy to table.

Mr Snowball: That basically goes through the outpatients. One hundred per cent of all claims are checked, as is the documentation associated with the activity, which is validated and signed by the nurse in attendance.

The CHAIRMAN: A doctor must physically do the paperwork?

Mr Snowball: Yes, that is right. It is documented and signed by the nurse. It is usually a triage nurse in the case of a medical record 1, so it has a collaborating signature. We check 50 to 60 per cent of inpatient claims; that is, claims by surgeons and anaesthetists. We check them on the computer against theatre procedure lists to validate that a patient who was on the theatre list was attended to and so on. General practitioners are checked manually by looking through patient files. The documentation is checked and crosschecked with H-Care System to make sure that the date of the service matches. If they are inconsistent, it is rejected. If there are any errors in the documentation, it is returned to the doctor as an invalid claim or one in which they need to clarify a date or so on. Audits are also carried out, which automatically adjust the payment amount for the item if the doctors claim something different. It also goes through to the Health Insurance Commission system to validate the claims. That makes sure that there is no double-dipping. A doctor cannot claim Medicare in his rooms as well as in the hospital. That is essentially the process that we have designed.

The CHAIRMAN: How do you stop the Health Insurance Commission problem of double-dipping?

Mr Snowball: The HIC basically runs the claims against its database, so there is a check against whether there has also been a claim through Medicare. That checks that doctors do not charge at both ends. A doctor cannot charge for a certain procedure done in his rooms and in the hospital.

The CHAIRMAN: How would that happen? Do you send your data to the HIC?

Mr Snowball: Yes, it makes up the payment schedule for us. Basically, it is a service provided to each health service by the Department of Health. We transmit data down the line to the HIC mainframe in Canberra. It is then validated against the fee schedule and the Medicare database and is returned either verified or not verified. That is a double-check process. Claims can be made not only at the hospital, but also in the community, through surgeries.

Mr DEAN: How do you feel about the degree of control you have over visiting medical practitioners as opposed to paid residential staff? A lot of extra paperwork validation seems to be involved with VMPs, which you would not have to do for paid residential staff.

Mr Snowball: Management of employed doctors is much easier. That is the simple answer.

Mr DEAN: We have not factored the cost of auditing into the calculations for employing paid staff.

Mr Snowball: I guess you could include that payment as a reasonable assessment of cost.

Mr DEAN: It seems that for accounting and accountability purposes it would be a lot easier to have paid staff.

Mr Snowball: Yes. That is one of the offsets too. If that were the only difference between the two, from a management point of view, it would be much easier. In our case, we are dealing only with four and a half employed doctors, so there is a much clearer master-servant relationship in that respect.

The CHAIRMAN: You have given us 65 names. Could you identify which of those are the local GPs and which are not? There are only 27 doctors here and some of us have no idea whether the doctors on the list are local or not.

Mr Snowball: Yes, I am happy to do that. There also needs to be a distinction when they are procedural GPs. Those GPs provide anaesthetics as well as inpatient medical services.

The CHAIRMAN: Yes. That happens with them all.

Mr Snowball: You will see a big variation. Some GPs are drawing in the teens and others are drawing in the 60s and 70s. That is usually the reason; they are procedural.

The CHAIRMAN: We heard about one doctor today who works heaps of hours but who only seemed to be getting $40 000. It seemed funny. At the other end, doctors are earning $230 000 in the other system. That is not exactly high compared with some of the numbers we have seen.

Mr HOUSE: I think the feds run an overservicing check. They have a system in which they double-check individual doctors to see whether they are overservicing.

Mr Snowball: They do.

The CHAIRMAN: They would not in this system because they do not charge them anything.

Mr Snowball: That is what we do. Pathology is one area, and X-rays less so. If one doctor had a stand-out level of activity, it would be followed through. Similarly, if one doctor referred his patients to accident and emergency at six o'clock in the evening, we would identify that problem and talk to the doctor. A level of monitoring occurs in a similar way to the HIC. It is not quite so up-front, which I guess the HIC system is.

Mr WHITELY: Earlier on you talked about various costings for different scenarios and having part-time staff or part-time coverage. Do you have documents like this for that situation?

Mr Snowball: Yes. The work that we have been doing, particularly with John Pollard, has been to look at a balance, so we have a guaranteed doctor in the area who also has the ability to provide a private clinic.

Mr WHITELY: Is it possible for us to get a copy of that?

Mr Snowball: Yes. They are still being worked through. It is work in process. I ask that it be accepted on that basis.

Mr DEAN: Just going back a step, you talked about discharge documentation and that you had experienced an increase in compliance from 30 per cent to 90 per cent. Was that done with a carrot or a stick?

Mr Snowball: Both. We started with a carrot and ended with a stick. The carrot brought it up to about 70 per cent compliance and the stick brought it up to 90 per cent. The stick was that they would not be paid unless they had the discharge summary.

The CHAIRMAN: Kim, is there anything else you want to tell us?

Mrs Anderson: We only have one practitioner in certain areas.

The CHAIRMAN: Tell us about it.

Mrs Anderson: Kim was asked what he would like to have in Geraldton in an ideal situation and we talked about tendering out surgeons etc and what work the general surgeons do. In a town this size, we have single practitioners in obstetrics and orthopaedics. It would be great to have two such people in this town to provide support, as opposed to the general surgeons who provide that back-up. When they go, if they do not have a locum, everything must go to Perth.

Mr DEAN: Obstetrics?

Mrs Anderson: Obstetrics, orthopaedics and the physician.

The CHAIRMAN: Do the general surgeon not provide a locum when he goes?

Mrs Anderson: They do, but those locums cannot deal with complicated gynaecological or orthopaedic cases. They provide a certain amount of cover but not total cover. Single practitioners burn out very quickly. They cannot work 24 hours a day, seven days a week. In an ideal world, it would be great to have two people practising in those areas.

The CHAIRMAN: I am not sure if we can influence that too much. How many nurses do you employ?

Mrs Anderson: One hundred and thirty-four full-time equivalents.

The CHAIRMAN: How many agency nurses do you employ?

Mrs Anderson: It varies. Currently we have three, but it has been 10 at times.

Mr Snowball: We are trying to address that by encouraging enrolled nurses to achieve registered nursing qualifications through a distance learning program.

Mr DEAN: Is that done through the university?

Mr Snowball: Yes.

Mr DEAN: That is a good idea.

Mr Snowball: In 12 months time we will have 12 new registered nurses, and hopefully agency nurses will not be needed.

The CHAIRMAN: For the purposes of this hearing, do you have a breakdown of the schedule fees you pay for the services of surgeons and doctors?

Mr Snowball: I can provide that.

Mr DEAN: Is that the standard Western Australian fee?

Mr Snowball: Yes - the schedule fee.

The CHAIRMAN: We need that to make comparisons. Do you have the fee that Medicare pays as well?

Mr Snowball: Yes, I can provide that.

The CHAIRMAN: Thank you for your presentation. Can you think of anything else you wish to tell us?

Mr Snowball: My only observation is that there is no one system, that will fix the problem uniformly across Western Australia. I am sure you are experiencing that as you move around. It is important that a level of local involvement remain in the search for the best solution for the circumstances in a particular community. From my point of view, there must be a balance between financial considerations and the quality of care. Quality of care must be the bottom line.

The CHAIRMAN: Thank you very much.