PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT THE GROUP ROOM, THE REGIONAL HOSPITAL, ALBANY
THURSDAY, 22 NOVEMBER 2001

FIFTH SESSION

Members

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

ZAFIR, DR MARK,
General Practitioner,
examined:

WISNIEWSKI, MR STAN,
Urologist, College of Surgeons,
examined:

LEGGETT, DR IAN,
General Practitioner, Southern Region Medical Group,
examined:

ABAS, DR LEANNE,
General Practitioner, Albany Clinical Society,
examined:

TREANOR, DR JOHN,
Surgeon, examined:

TADJ, DR DAVID,
General Practitioner, North Road Family Practice,
examined:

SPURGEON, DR LORRAINE RAE,
General Practitioner, Visiting Medical Officer,
examined:

SMITH, DR DARCY PETER,
General Practitioner, Albany Clinical Society,
examined:

LINDSEY, DR JOHN,
Physician,
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 a contempt of Parliament. Have you completed the form entitled Details of Witness and did you understand the notes attached to it; and did you receive and have you read the briefing sheet regarding giving evidence to committees of the Parliament?

The Witnesses: Yes.

The CHAIRMAN: I will put this to witnesses collectively. Has the committee received a submission from you?

Dr Abas: Yes.

The CHAIRMAN: This is from your group; not from the other groups?

Dr Abas: Yes. All the doctors here belong to the Albany Clinical Society.

The CHAIRMAN: Do you propose any amendments to that submission?

Dr Abas: Not at this stage.

The CHAIRMAN: Is it your wish that the submission be incorporated as part of the transcript of evidence?

Dr Abas: Yes.

The CHAIRMAN: Before we ask any questions, do you wish to make an additional statement in relation to your submission?

Dr Abas: We may have some supplementary documents to follow.

The CHAIRMAN: Do you wish to make a statement in relation to your submission?

Dr Abas: Not myself at this stage.

The CHAIRMAN: Will someone explain how the VMP services work in Albany? I think that is a good starting point. We have received a number of presentations and discussions from doctors in Albany. We have received a presentation from the council. Will someone tell us how they see the VMP service working in Albany?

Dr Leggett: I think the VMP service in Albany works very efficiently. However, I have some serious concerns about a couple of aspects of the VMP service at the moment in Albany. In particular, the committee may have already been told today that as of 21 December last year, this town has not had a 24-hour, seven-day-a-week surgical on-call service. One of the surgeons withdrew his services. At that time I was the medical advisory committee chairman at this hospital. I drew this to the attention of the hospital administrator, the hospital board and the current Minister for Health, Mr Kucera, when he visited Albany following a cabinet meeting soon after he came to power. He did not seem to comprehend the problem at that meeting, so I subsequently wrote him a letter explaining that one day out of three this population of 38 000 people does not have a surgeon available for emergencies. He replied to my letter and said that he would endeavour to address this problem; however, as of today, this problem has not been addressed. This is an extremely serious situation. We are more than an hour's flying time from Perth, and as yet that has not been a serious consequence, but there is nothing more certain than the fact that that will happen. If someone ruptures a spleen in Albany on the day when there is no surgical cover, I am afraid there will be nothing we can do for that patient.

The CHAIRMAN: We asked that question of the surgeon involved. His indication was that there was cover.

Dr Leggett: There is no cover. One day out of three there is no cover. As of midday today, I saw a letter written by the other surgeon in Albany, Dr John Treanor, dated 16 November to Keith Symes. It states that he is writing to inform you that henceforth he will only be available to cover out-of-hours work on one day and one weekend out of five; so we now have less than a one in three roster. The reason for this is that the surgeons have asked that they be paid for being on call. Members are probably aware that visiting medical practitioners are paid on a fee-for-service basis. In Albany that means that if we, as general practitioners, get called to see a patient we receive a fee for the service we provide; so do the surgeons. However, Albany has a population of very experienced general practitioners and the surgeons are called only when they are really needed. For instance, on a weekend they are on call from Friday until Monday morning, and they may receive one or two calls in that period, for which they might receive remuneration of - I do not know - $100 a time, probably less if they do not do an operation on a patient. Therefore, they have been on call for an entire weekend for virtually no remuneration. Alistair Holmes, the one who withdrew his services on 21 December, has been doing that for 17 years, and he has decided he would like to be remunerated for it. That seems a pretty reasonable request to me. The Department of Health has refused to address this problem. I think it needs addressing today.

The CHAIRMAN: We will take that on board.

Dr Leggett: That is the main point I want to make.

The CHAIRMAN: What you are proposing is that he be paid an on-call rate?

Dr Leggett: I propose that, as requested, he and the hospital administration negotiate and reach an amicable agreement on some sort of remuneration.

Mr WHITELY: As I understand it, this is only an issue for the surgeon. It is rare that he is called out. It is obviously critical when he is, but it is quite rare; whereas general practitioners, even though they are not paid a retainer or an on-call allowance, if you like, are frequently called out, so they earn a reasonable income. Is that a reasonable summary?

Dr Leggett: That is correct.

Dr Zafir: It is not just surgeons; it includes anaesthetists as well. Most of the anaesthetists in town are GP anaesthetists, so that is not a problem. When you are on call for doing general practice work, you are also covered for anaesthetics. That is not a major problem. We also have a specialist anaesthetist in town who does nothing but anaesthetics, and when she is on call she can sit around all day and not get called. She needs to be included in this as well.

The CHAIRMAN: What do you do with the spare capacity of the surgeon? He has told us himself he only has three and a half days work here. What do you do with that spare capacity?

Dr Leggett: I am sorry, I do not quite understand.

The CHAIRMAN: The surgeon himself has indicated to us that he only has three and a half days work. What do you do with his spare capacity of one and a half days?

Dr Abas: It is up to him what he does with the rest of his time.

Dr Leggett: He is asking to be paid for the time that he is on call. If he is unoccupied some of the time and not on call, I do not think you could do anything with that.

Mr DEAN: Do you have a ballpark figure for this on-call rate?

Dr Leggett: Personally, no.

Mr DEAN: Does your association?

Dr Abas: Perhaps we could come back to this topic.

The CHAIRMAN: Dr Leggett, did you want to refer to the second point you raised?

Dr Leggett: I did want to raise one further point. This is of more personal importance to me. As a general practitioner in this town, I do a significant amount of obstetrics. The committee is probably aware that Albany does not have a specialist obstetrician and has not had for about four or five years. All the obstetric care is provided by the GPs of the town, including the operative obstetrics, meaning caesarean sections, and the only ones we transfer to Perth are women who are under 36 weeks gestation. We manage a significant amount of complicated and difficult obstetrics. The commonwealth medical benefits schedule contains a special item number for managing complicated obstetric deliveries, which is significantly above the item number for a normal obstetric delivery. It is about $1 100 compared with $650. The Department of Health in Western Australia has refused to pay this amount for complicated obstetric deliveries. The argument is that the amount the department currently pays is slightly above the Medicare schedule for a normal delivery, and therefore on the swings and roundabouts we should be reasonably even. Personally I do not think this argument holds water, and I think for the care and expertise we provide and in circumstances of complicated and difficult deliveries we should be remunerated appropriately.

Mr WHITELY: Would it be different if you had a specialist obstetrician in that situation, or would they simply get the same fee?

Dr Leggett: It would be no different.

The CHAIRMAN: This discussion occurred yesterday in Kalgoorlie.

Dr Leggett: I know that Barney McCallum has had exactly the same problem.

The CHAIRMAN: Some of the fees in the fee-for-service schedule are way above the commonwealth schedule fees. Do we reduce all those back to the commonwealth fee?

Dr Leggett: Which items are you talking about?

The CHAIRMAN: There is a whole pile of them. There is the $32 you get as a visiting medical officer for a general practitioner coming to the hospital. Under the Medicare-type arrangement that is much lower. Should all the adjustments and fees be at the commonwealth level; in other words, do you want the commonwealth level of fees -

Dr Leggett: No, I do not. I want the complicated obstetric item number recognised. No, I do not want the other fees reduced.

The CHAIRMAN: They are the swings and roundabouts that the Department of Health is talking about - you cannot have your cake and eat it as well.

Dr Spurgeon: I would like to try to explain two points. One of the basic points you raised was what Alistair Holmes does with his spare time. We do not cause patients to come to accident and emergency or to have babies; we respond to what is needed medically. We cannot create work if there is no work. Alistair only has three and half days work because that is all the patients that need his services, and he is not on call. He cannot fill that time in with paperwork or other things. We do not make work for ourselves.

With fee for service for the difficult obstetric cases, we should be remunerated for the service we provide. These are very difficult obstetric cases where the patient and baby could die. We have had a lot of training in that area and we do not have backup by specialists. We are not asking for backup by a specialist, but we need to be remunerated for that danger period at three o'clock in the morning when there is a risk to the mother and the child. It is not whether the commonwealth benefits schedule is higher or lower; it should be fee for service and what that service has provided. A delivery on a multiparous woman, which is very easy and anybody could deliver her, compared with a delivery for somebody who is hypertensive and could have a seizure and where the mother and baby are at risk, is a totally different service. We keep up-to-date with our training, we have huge medical indemnity, and it should be fee for the quality of service.

Mr WHITELY: Presumably that would be the case in which there were complications which could bump up the insurance premiums in the longer term -

Dr Spurgeon: Absolutely, and we are at the hospital for hours and taking huge personal risks with medico-legal situations. Although we are doing everything our peers would do, it is still a life and death situation.

The CHAIRMAN: Is that the only item in the whole VMP agreement that causes a problem?

Dr Spurgeon: No, that is not the only point that I would like to make about the VMP agreement. Patients present to A and E and we see them when needed; we do not create work. We are responding and we are general practitioners with exceptional skills; we are trained to work in rural areas, we set fractures, and we anaesthetise patients. If you replaced us with a normal resident - that is second-year trained doctor - you would have a lot of complications because there is no backup here. The people of this town get an exceptional service, and a lot of the time we do not charge for our service. We get phone calls from nurses in A and E at three o'clock in the morning and we sort things out on the telephone. We do not come to the hospital, so there is no fee, but we get woken about three or four times a night. We are not asking for an on-call fee, but we are telling you that we provide an excellent service.

The CHAIRMAN: No-one is querying that; you are providing a great service. As we have seen today, what has been presented has been fantastic.

Dr Spurgeon: We are not doing it for money; we are responding to the needs of patients.

The CHAIRMAN: We are not insinuating that it is being done for money.

Dr Abas: Some people do insinuate that doctors are making a fuss for money; that is a separate issue.

Mr WHITELY: In a number of places the committee has visited there seems to be a perception that it is doing a hatchet job on visiting medical practitioner and visiting medical officer arrangements; however, that is far from the truth. Some systematic problems have received some publicity and unfortunately a lot of people have been tarred with the same brush. Those problems may or may not need to be addressed. However, the committee's brief is to review the whole system. We have come here because we must understand the differences between the delivery of health services in the regions. Obviously, the system is very different here from other regional centres, just as there are big differences in the metropolitan area. We are here to examine the situation. I am forming the opinion that there must be individual solutions for individual regions and that there is a role for VMOs and VMPs within those systems. This committee does not have a hidden agenda. Its agenda is to get value for money and to provide the best health services. The solutions for this region might be different from the solutions needed for the metropolitan area. I hope that I have provided some reassurance.

Dr Spurgeon: Thank you, that is good to hear.

Mr DEAN: I have no reason to doubt the costs that have been outlined here today. It appears that the accident and emergency system is a cost-effective method of delivering health services. I do not know whether other members of the committee feel that there has been some scaremongering, but the committee is here to knock that notion on the head. From all appearances, regional health centres are doing a top job.

Dr Abas: I have some comments in response to the statements about the general feeling of unease between the ministry and the doctors generally in the metropolitan and rural areas throughout the State. There is a feeling of unease among the doctors about the current ministry, a lot of which has come from the media, the Department of Health and/or the minister himself. It is unfortunate that the Minister for Health perpetuates the supposed general perception in the community that doctors are out to get more money. I have an article in black and white that was written following a conversation I had with him, which refers to the health services in Albany. Members of this committee have said that the hospital and the accident and emergency department are run efficiently. In the article, the minister said that the way we run our department is an expensive way of supplying medical services. If the minister is willing to say that publicly, either he has not done his research or he is spreading disinformation. However, I agree that this is not the forum to discuss that matter because it is not relevant to this committee. I am responding to it only because members have raised the matter.

The CHAIRMAN: The committee's role is to examine the role of visiting medical practitioners, their cost and whether there is a better way of providing the service.

Dr Abas: That is correct; however, the Minister for Health's comment related to us and that is why I have responded to it.

Mr Wisniewski: I represent the specialists who visit Albany from Perth and who have made a strong commitment to provide specialist services to this area. Local practitioners invited most of us to come here and we saw the need for certain specialist areas to be given some local support. The community of GPs, who are an excellent group of clinicians, has given us its very strong support. The clinical practices and the services they provide to the town are immeasurably better than I could have expected. I say that as a practising specialist in the Royal Perth Hospital and as a member of

the Royal Australasian College of Surgeons. We are concerned that if costs are rendered to this area, those of us who have committed our time and finances to come here and provide our specialist services would be denied that opportunity. Patients would have to travel far distances - further even than Bunbury. Albany is a long way away from the resources in Perth.

Many services are provided here from which people can benefit. If I did not come here on a regular basis, about 100 people a month would travel to Perth for treatment. If funding for the patient assisted travel scheme allowances were relinquished, an opportunity to develop the health system in this town would be lost. The local GPs in Albany drive the specialist in my field to provide a service that gets people in and out of hospital quickly. In my own specialist area the hospital admission rate and length of stay is even shorter in Albany than it is in Perth, because the patients go home and their treatment is backed up by their local GPs. The patients know that they can ring those GPs if they need to. My patients in Albany spend at least 1 to 1.25 days a week fewer, or per procedure, in hospital than my patients in Perth because of the access they have to their GPs and other visiting medical specialists.

The CHAIRMAN: What specialty do you provide?

Mr Wisniewski: I provide a urology service to older people. There is a lot of demand for that service in this town because of its ageing population. Many of my patients are able to stay in nursing homes because the service that we provide allows their incontinence problems to be treated in the nursing homes where they are comfortable. Some patients have been able to stay at home. We are very conscious of keeping people in their homes if we can. If my specialty were taken out of this area, I foreshadow that there would be an enormous change in the costing and structure of patients wanting to come back to Perth for the treatment that we offer. That applies to plastic surgery; ear, nose and throat specialists; visiting obstetrics; and gynaecologists. This town needs an orthopaedic surgeon or an orthopaedic service desperately. That issue must be addressed if this community is to be provided with the opportunity to keep its patients here.

This committee and the references that have been made about the change of government funding arrangements have caused great concern because of the way it could impact not only on the people who provide the services locally, but also those medical practitioners who visit these towns and provide their services. It would be detrimental if the number of hospital beds were reduced. If that happened, I could not provide my services in this town. I would have to reduce the time I spend here and find ways of supplementing my services. I am strongly committed to keeping my specialty services in this town because it benefits the town and the people. I do not provide those services for my own benefit; I must pay for my own fares and accommodation. I do get a fee for service and I could earn a lot more money in Perth if I stayed there for the weeks that I am here. Funding is not the issue. The issue is the direction in which we are taking the medical services of this town, and the impact we are making by providing the medical needs of this town locally. The dreams that we fostered to develop this town into a centre of medical excellence are being thwarted. Everyone who works here is of the opinion that our dreams and ambitions will be undermined. We are starting to feel that we do not have control of our own destinies. We feel that we have done pretty well up to now.

The CHAIRMAN: How many weeks a year do you visit Albany?

Mr Wisniewski: I am here for one week every month, which is at least 10 weeks a year, and that is a fair commitment. Medical practitioners who work in towns like Albany leave their families, their practices and patients in Perth. Medical practitioners are under a lot of pressure. Hours and hours of calls and contact with patients are required. All the specialists who do that have a strong level of commitment. To remove the present infrastructure without replacing it is worrisome and it is an issue of severe contention for us and for the future development of our town. I would like to speak on behalf of all those visiting specialists like me who enjoy coming here and who have a tremendous rapport with the clinicians who support anything we ask of them.

The CHAIRMAN: I reiterate that there is no question about removing services.

Mr Wisniewski: From the information we have been provided with, we believe that services will be cut and that people who work here are not being supplemented as they should be. We worry that if the right environment is not created here, specialists will not come and medical activity will languish. This town has the potential to be a great service centre for the southern region. If we do not approach it properly and put in the right infrastructure, we will miss a great opportunity. What has been done already is so good, that to build on that foundation can only make it better.

Mr HOUSE: It is fair to say that that story would be fairly universal in all the country towns we have visited. Country doctors and visiting specialists do a superb job, and I think everybody agrees with that. There is a consensus among the committee members after we conduct these interviews that that is the case. I told somebody in Kalgoorlie that he deserved a medal for what he did. The Public Accounts Committee has been asked to provide some information to Parliament about VMPs. The committee does not make the final decision about health issues. The minister, the Cabinet and the Government of the day will make those decisions. In that structure this committee must be provided with information from interested parties, because that information will have an influence on the eventual decision. The members of this committee will relay that information to Parliament and to the Government. As Monty, John and I have indicated, we are on your side. We want to find out what the problems are and, by that method, make some sensible recommendations that will help you, not hinder you.

Mr Wisniewski: We could offer some opinions but I would like to get others involved.

Dr Lindsey: I am the only physician down here and have worked here for the past 30 years. I have been on-call 24 hours a day, 7 days a week over that period of time. The general practitioners here do an excellent job. There is no way that an in-hospital service by registrars could provide that level of care. We also have the advantage that our general practitioners know their patients and when they come into the hospital, the practitioners are au fait with their condition. It would be impossible to replace that sort of service. It could not be replaced at cost and it would be not be effective.

The CHAIRMAN: What about the argument put by others that the hospital is not providing 24-hour coverage? It does not have a doctor present when somebody presents in an emergency. That patient is assessed by nursing staff and that in itself could create problems.

Dr Lindsey: That is not a problem because in an emergency, our nursing staff are trained for acute assessment. They can do cannulations and cardiopulmonary resuscitation, they can take blood samples and can do an acute assessment and resuscitation. They are trained at an extremely high level. Ambulances may bring someone in whom they are very concerned about. Ambulancemen will ring casualty first and say that a doctor is needed. Most of the doctors that work here live in Albany. Therefore, by the time the ambulance takes the ten minutes to get to the hospital, that doctor will already be there. It is not a major problem. Doctors are always in the hospital during the day.

Dr Abas: The theatres are running regularly. One of the two surgeons in theatre and/or one of the doctors doing the minor theatre list in the casualty department can handle the situation.

Dr Leggett: There is no doctor sitting in casualty waiting for a patient to come through the door. However, at any time our casualty department has three separate general practice rosters to call on. There is often more than that during the week. Those general practitioners who are on-call are immediately available when they are called. We all live in close proximity to the hospital. In fact, many of us are within five minutes and the rest of us would be within 10 or 15 minutes of the hospital. This hospital has done surveys of its waiting time for patients to be seen by a doctor in our emergency department. It was last done some years ago. The average waiting time - this is not the

waiting time for emergency cases - for a patient to be seen by a doctor was seven minutes. That compares quite well to most hospitals in this State.

The CHAIRMAN: That is true. If we could get some evidence to back that up -

Dr Zafir: Keith Symes can provide that evidence.

The CHAIRMAN: Can you give us some evidence to show that there is only a seven minute waiting period?

Dr Leggett: That was some years ago. However, that document exists in the hospital records. It was presented to a medical advisory committee meeting at the time.

The CHAIRMAN: Can we get this information, because we want to have the data that backs up what you are saying?

Dr Abas: I can supply that for you.

Dr Spurgeon: When patients present at big Perth hospitals, they first get assessed by a nurse anyway. The same thing happens here. The doctor that is seeing another patient in another cubicle then sees them.

The CHAIRMAN: The argument is that the doctors are there.

Dr Spurgeon: Yes. Most of the time one of us is at the hospital. At 3.00 am there is often a doctor in casualty seeing another patient.

The CHAIRMAN: This afternoon evidence was presented by an ex-nurse that a long time ago someone came to this hospital when no-one was available, and that patient then died. I understand that that was 20 years ago. However, is that of concern to any of the -

Dr Smith: I used to be a regional director of the health area from 1989 to 1994. When I first came to this region there was no nurse in casualty at all. Now we have at least two nurses on at any one time. In 1989, people had to ring a doorbell, and the doorbell could only be answered by the nurse supervisor. I do not know the time that you are talking about, but things have obviously changed. We are constantly reviewing adverse events and trying to improve practices. However, we could say categorically that now, that situation does not exist. The training that our staff and doctors undertake now, compared with 1989, is vastly different.

The CHAIRMAN: We made the same comment; that evidence from 20 years ago seemed to be totally irrelevant. However, I just made the comment to highlight the point put to us earlier.

Mr WHITELY: The argument that when someone rolls up to an emergency department when there is no doctor there comes up often and is superficial.

Dr Smith: A lot of us also deliver babies. We are here within three to five minutes and we purposely live in a particular area to service the hospital. There are no current examples showing that the lack of having a doctor standing in casualty and waiting has caused an adverse outcome.

Mr HOUSE: I refer to the Alistair Holmes issue regarding the on-call position. He give evidence this morning, so it is on the record and available for people to look at in good time. Has he ever refused to come in? If he is needed and called, does he come in despite the fact that he is not on-call?

Dr Leggett: We do not ring him because he is not on-call. On one occasion, he was rung when a patient had appendicitis. He did not come in and that patient went to Perth for an appendicectomy. However, he had made it very clear to the hospital that he was not on-call and not available. Keith Symes and the administrators of the hospital dropped a letter on my desk the Monday morning after the event saying that while they were prepared to go along with Alistair in this negotiation, to refuse to treat a patient was a completely different matter. I replied immediately in writing saying that it

was total hypocrisy and that he was not refusing to treat a patient. He categorically stated that until a satisfactory agreement was reached, he was not available.

Mr HOUSE: If somebody presented with a "spleen" now, would you ring Alistair Holmes?

Dr Leggett: Yes, I would have to ring him.

Mr HOUSE: Would he come?

Dr Leggett: I think he would. However, that is not the point. Our administrator at MAC meeting is saying that we should not have an availability roster, meaning that no-one is formally on-call, but if he is needed that we call him. The consequence of that is that the most amenable surgeon over the telephone will always be called and the most difficult person will never be called. Having an availability roster does not work. This town has a large population and services a region of 28 000 people. It should have someone on-call around the clock.

Mr HOUSE: I just want the facts.

The CHAIRMAN: Can I ask the other surgeon, Dr John Treanor, how this problem affects him.

Dr Treanor: It is a complex problem.

The CHAIRMAN: Does it mean that you are on-call all the time?

Dr Treanor: Yes, quite often. We have a roster now that the Australian Competition and Consumer Commission has decided it is not illegal to roster on-call weekends and days. A lot of it is virtually pro bono work. One can be on-call for a whole weekend and may get a few calls. They may come in on a Sunday night for an hour. However, as it is fee-for-service, it is not something that is done for money. It is pro bono work and it is very tiring and demanding. All things being equal, it has always been the way the system has run. In recent years other factors have come in to play, for example, pay rises, the cost of living and the cost of insurance. It is now becoming borderline to practice in this way. Reference was made to Alistair Holmes working three and a half days a week. That is not because he is lazy. It is because all the work -

The CHAIRMAN: That is what he said; he made that point. The point that I made was whether there was some way that we could use him more productively in the region?

Dr Treanor: I would possibly do more hours except for the monopoly employer who will only provide a certain amount of operating time. If we had private hospitals in the region, we would certainly be happy to do a half day or full day operating.

The CHAIRMAN: Are there any facilities elsewhere that can be utilised?

Dr Treanor: No.

Mr HOUSE: Are you saying that part of his issue about working three and a half days a week is because there is not enough operating time provided by the hospital?

Dr Treanor: That is one of the reasons, yes.

The CHAIRMAN: He said the reverse, that he did not have any work to do.

Dr Treanor: To be fair, the population is only so large, but there are times when we are operating on a fewer number of patients than we could normally put through. That is determined by the hospital etc. For instance, over Christmas, it shuts the operating theatres for two weeks to save money on the budget. However, they still expect us to hang around for virtually nothing. We still pay the overheads,which are very expensive, and we are supposed to hang around to cover the patients that come in on midnight on Saturday. It has always been part of our professional commitment. We have all done this for 25 or 30 years. However, it is becoming much more of a strain when the salary is not forthcoming. The value is going down every year because the amount has stayed the same for five years. It is making the practice barely viable.

Mr DEAN: Are any of you aware from associations and so forth, of any on-call rate that is struck within Western Australia - something that adds a bit of gloss to the weekends and after hours work?

Dr Treanor: It happens in some places such as Canada and the United Kingdom, where a standard rate has been fixed for a doctor being available.

Mr DEAN: If a doctor was called to the unit on the weekend, did a mainstream procedure and was paid $600 or $700, what percentage of that would you recommend as a stand-by rate - five per cent, 10 per cent?

Dr Treanor: The rate would be only for the time spent hanging around and being available. If you are on-call for the whole weekend, you may get a few calls at night and you may go in to the hospital a few times. The money that you earn on the weekend would not allow you to have one day off the following week. It would not be enough for you to take a day off just to get a bit of rest from the system. The overheads and so on make the cost of running a practice so great that you would not earn enough to take one or half a day off.

Mr DEAN: Therefore, your clinic group has not thought through the nuts and bolts of the process. What would be a fair amount? If you cannot think of it, how can we?

Dr Smith: My personal feeling is that it should be negotiated on an individual basis. That is not a cop-out, but job satisfaction is something that has many variables, such as the culture, the climate, the rapport within the system, the set up, and the individual. Everyone is a little different. I support Ian Leggett when he said that the administration of this hospital should be fully able to negotiate with the surgeons and work out a reasonable figure. It seemed to me, from afar, that when Alistair Holmes tried to do that, the bureaucrats in the health department interfered with the process by saying what he could and could not do.

Mr DEAN: Is that because they were afraid it might set a precedent?

Dr Smith: Yes, most certainly. I go further and say that my general feeling is that if anyone is expected to be on call anywhere, they deserve some payment. I do not know how many other professions in Australia -

Mr BRADSHAW: As well as non-professions.

Dr Smith: - are expected to be on call without something. The fear is that it will escalate. I mentioned before that I was previously a regional director of health. I was working for the Department of Health when we prepared the VMO agreement. It was around 1993. I was very involved with negotiations at the time. We were on the verge of conceding to the AMA that some form of on-call allowance should be paid, but that there needed to be trade-offs.

The CHAIRMAN: Was one of the trade-offs that fees and call-out fees were higher?

Dr Smith: One trade-off was in obstetrics. At that stage most general practitioners were pulling out of obstetrics for obvious reasons. In recent weeks a doctor in Sydney had costs of about $13 million awarded against him. Another doctor in Perth at $5 million awarded against him. There was a deliberate policy on the part of the Department of Health to positively weight obstetrics. That was part of the trade-off. That same principle applies in obstetrics. In this day and age it is really too much to expect anyone to be on call without receiving something, however little it may be. General surgeons deserve a hell of a lot more than anybody else. The fear is that costs will escalate, and that will cost the Government. There needs to be a reasonable approach by all parties.

Mr WHITELY: I proposed earlier that general practitioners on call are effectively remunerated because they get a lot of call-outs. I have spoken to other people throughout the State, and it seems that they are relatively happy with the current arrangements. There is a problem with general surgeons in Albany because they have to be on call in the event that they must deal with life-and-death situations, but they do not earn enough because the number of call-outs is not high. Would

you accept a situation in which they received an on-call rate but general practitioners are paid on a fee-for-service basis? Rural general practitioners throughout the State who are not on call say that they do not have a problem with that.

Dr Smith: If we looked at a place like Gnowangerup, which Mr House knows very well, I think it is unreasonable to expect a doctor to be on call seven days a week. That doctor, regardless of his or her call-outs, deserves some remuneration for being available all the time. It is unreasonable to expect a general physician to be on call all the time. At the same time, I need him and want him, although it may be once only every few weeks. For that doctor to be available at the end of a phone warrants some consideration.

Mr WHITELY: Let me put another suggestion: what about a doctor on call but whose income does not meet a certain level? That doctor could then be given an on-call allowance.

Dr Smith: I would accept that, but there needs to be negotiation. I am a one-doctor practice, although I have a registrar. For a variety of reasons I am not part of any other roster during the week. As well as the three doctors on call, my practice must also provide an on-call service. For instance, I was on call last night. I had four telephone calls: one was at three o'clock in the morning, one was after I went to bed - I do not know what time that was - and two calls were before I went to bed. I attended the hospital at 11 o'clock. I will receive remuneration for one visit to the hospital, but I was on call all night. I am a single parent; I have a 14-year-old child whom I do not like leaving home alone. When I am on call I must make provision for my child to be fed. At the age of 14 he can prepare some meals but not other meals. There are other issues of getting him to tennis and cross-country runs. I know that is not everyone's problem, but it is my problem when I am on call. Some of those factors warrant some consideration. The on-call arrangements should possibly be improved but, for a variety of reasons, they sometimes cannot be changed, even with the best will in the world.

The CHAIRMAN: Let us return to the issue of general surgeons. I made a comment to Mr House when we were in the Geraldton and noticed that the highest VMO payment was to a general surgeon. His payments for VMO services were astronomical. As I said to someone else this afternoon, his salary appears to be very low in comparison with the on-call costs. That is not the problem of the system, that is the problem of Albany because there is not enough work. How is it solved? It is a question of capacity.

Dr Smith: It is horses for courses.

The CHAIRMAN: If we recommend that you have the on-call hours for Albany, the doctor in Albany will say that he is on call all the time and that he works 80 hours a week.

Dr Smith: The system's difficulty is drawing up guidelines for special circumstances. I have had to send two patients with acute abdominal problems to Perth through the Royal Flying Doctor Service in the past six months. I do not enjoy that, and I would like to know that, for the safety of my own patients, family and friends, someone is on call. There is a problem in this town that needs to be addressed. If Geraldton does not have a problem, then do not fix it there.

Mr DEAN: One of the suggestions was that surgeons forfeit their on-call rates if they are called out. What do you think about that?

Dr Smith: I am sorry to personalise my answer but I think the administration should ask the surgeons whether they agree. It is an acceptable proposal to me.

Dr Spurgeon: What if we received a fee for every phone call we took? We often get phone calls at three or four o'clock in the morning. We may not need an on-call rate for them but we often give good advice over the phone and we take responsibility for that advice.

Dr Smith: When hospitals go over budget, the administrations of hospitals seem to reduce services to patients. They do not look at what patients need; they look at cutting costs. They cut costs by

reducing the activity of doctors. That creates a lot of uncertainty with patients about bed availability. We do not have the luxury of sending people anywhere else. To keep reducing bed numbers because there is not enough money is not the best situation for our community. It is a most unhappy situation for a doctor to be in. It has happened to me twice in the past few months.

The CHAIRMAN: Are you saying that bed numbers are being cut back here?

Dr Smith: Yes.

The CHAIRMAN: We have been told that there is no such problem.

Dr Abas: Four beds were closed in the last two weeks of October.

Mr DEAN: That was explained to us this morning.

The CHAIRMAN: According to the evidence the capacity to admit patients still exists. The hospital has 120 beds but most nights only 105 would be needed.

Dr Abas: There are 120 beds at the community out-based surgery level. That is the category in which beds are closed. The acute care beds are monitored 24 hours a day.

Mr HOUSE: It is a case of asking the right question to get the answer.

Dr Abas: We have already had four beds closed.

Mr DEAN: Were they in general medical wards or surgery wards?

Dr Abas: In a general surgical ward.

Dr Tadj: I agree with Mr Whitely's comment that it has become clear that we should look at health services on a case-by-case scenario. What is happening in Albany is not the same as the rest of the State. We are providing health services in a fairly unique way. Much of the Department of Health's difficulty or reluctance in addressing remuneration issues pertains to setting precedents. If they give surgeons an on-call allowance or something like that, it may have to be done statewide. The department may not be able to afford that. The logical thing is to negotiate on a case-by-case basis. What is happening here is probably a good thing for our health service. I met Bob Kucera a few weeks ago when he visited and I made the point that Albany presents a model of best practice in many ways. We do things differently here. I worked in a number of country hospitals of this size and smaller in country Queensland. Hospitals of this size would be staffed by salaried doctors. One of the undercurrents of this inquiry is whether there is a better way: could we staff the hospital with salaried doctors? I have been working here for four years. I was previously in rural general practice in Queensland. The system here is far superior to that in Queensland. Their policy is that every hospital, no matter how small, will have its own salaried government doctor. Even a town the size of Mt Barker would have one, as well as a private general practitioner. It creates a divide; it is almost a mini-city situation in which a general practitioner does all the general practice work and the hospital doctors do all the hospital work. That creates all sorts of problems.

We have amazing continuity of care. If I see a patient who has chest pains in my rooms, I refer him to the hospital. I follow the progress of his case in hospital and see him afterwards in my rooms. That is miles ahead of what happens in even some of the tertiary hospitals in which such a patient would go to the hospital, but the general practitioner would not know what happens. The discharge summaries to the general practitioner might be late or not even arrive. It is a continuity of care issue.

There is difficulty staffing a place of this size. First, we have great difficulty in getting people to come down here to work. Secondly, those doctors tend to be quite junior and are often not very experienced. Thirdly, the hospital salaried officer position tends to have a high turnover, because it is not very satisfying. The position tends to be underpaid. People usually burn out within a year or two and move on. It is not a very happy atmosphere. What we have here is streets ahead. As Stan was saying, this is really showing the way in the level of service that can be provided to the

community and in the efficiencies that we can demonstrate. I suggest that the committee might want to look at our service and consider how it can support the system and build on its strength. The way to do that is to recognise some of the things that are already in place. Specialists have a significant on-call commitment. For a specialist surgeon to be on call one in three or a physician to be on call 24 hours a day for years and years is unheard of in the city. That is a fairyland to our city colleagues. That needs to be recognised and I think payment and item numbers are small ways to do that.

The CHAIRMAN: Evidence given by one of the administrators at a previous hearing in Perth indicated that they wanted flexibility in the system in relation to the agreement. The agreement is binding across the State; everybody gets paid the same fee. There might be six or seven hip replacements in a row to be done. A surgeon could strike his own deal with the hospital by saying that he did not specialise in that procedure, the schedule fee was not that, and it could be done cheaper if the whole pile was done together. That would reduce the costs of the surgeon and the hospital. Are you in favour of individual agreements between hospitals rather than having one agreement across-the-board?

Dr Leggett: Personally, I think it would be extremely messy and unworkable. An across the-board-agreement would be preferable.

The CHAIRMAN: When you have across-the-board agreements you do not have flexibility to have special arrangements. That is the problem.

Dr Leggett: No, you do not have the flexibility.

Mr DEAN: Are we not against workplace agreements?

Mr HOUSE: You blokes have not decided yet. You are still messing around.

The CHAIRMAN: Guys, let us get a principle here. Flexibility goes out the window with across-the-board agreements. That is the nature of the beast.

Mr WHITELY: The problem with precedence is that it then becomes -

The CHAIRMAN: You cannot have your cake and eat it too.

Dr Abas: Why not?

Mr Wisniewski: One of the things you would be starting to hear about the town is that we have one hospital, two theatres and nowhere else to send patients. There is no flexibility. Clearly, that is another issue that we are looking at locally. We are hoping to expand and to perhaps develop some private facilities. One of the things I put to this committee is that in the absence of any other flexibility for the people in this town, the agreements struck for a tenuous two-year term or whatever should be reviewed again and take special circumstances into account. There is an understanding that other facilities might be introduced into the town in the future, which might take some of the pressure off the hospital and other services. The committee might well say that things should be put on hold. Albany is expanding its resources; we are looking at developing private facilities in the next few years. The people who work here should be given support to stay. The town is looking for a resolution to its problems by trying to provide its own private practice in the future. If you provide an infrastructure, which is already here, to be able to cope with the changes that are being implemented, you may well resuscitate a situation that we need to keep. Perhaps in two years this discussion will be redundant, because the people who work here will have private resources, private hospital facilities and the ability to generate some further income. They will not then be tied to one infrastructure, which is creaking and which is obviously not able to cope with it all. That is what we are trying to address. This committee might be able to consider other avenues. It might be able to provide some on-call payment to certain individuals to keep them here, because it is necessary to do so. That might be the way to go for two or three years, with the option to have it reviewed in the future. I put that to the committee as one solution.

Dr Zafir: I would like to make three quick points. I am a GP and have been here for 18 years. When the operating theatres are running morning and afternoon, two doctors - usually specialist doctors - work to maintain the core service throughout the hospital for any emergency that shows up. Our surgery is also quite close to the hospital. We will always respond to an emergency. The hospital can call us first and we will rapidly attend to any emergency. We are no more than a five-minute walk away and we are a lot faster when we drive. That is a pretty good service. During the day, the doctors will generally attend to emergencies. If any emergency call comes in, the call comes over the loud speaker and whoever is around - if they are in the wards or around the area at all - will usually show up. That is during the daytime when there are doctors around the place. That is particularly the case when the operating theatres are running. We have sessions during the week at the hospital at which doctors operate in the casualty department on lumps, bumps and bits and pieces. Our week is broken up and doctors go there at varying times. A general practitioner or specialist presence is maintained at the casualty department at no cost to the hospital, apart from the fact that the doctors use hospital disposables to deal with the lumps and bumps. That service is there at no cost to the hospital. After hours, we often intermingle and look after each other's patients, should there be an emergency. If not, we will handle the situation as it comes up. In my 18 years here I have never seen a problem. The other point is that we have not had our contracts renewed since 1998. We have tried to renew our contracts since then. The contracts started in 1995 and were supposed to terminate in 1998. Because we have not been able to get any consistency with the Australian Medical Association and the Health Department, the contracts have been carried on and on through a lack of goodwill for local GPs. This is why we are ending up in a situation in which the monetary values put on our contracts in 1995 are no longer applicable in 2001. They are six years out of date.

The CHAIRMAN: The contracts would have an escalation clause.

Dr Zafir: They are fairly minimal compared with what is happening. The commonwealth Medicare Benefits Schedule is going up a lot more than the hospital contracts.

The CHAIRMAN: We have asked for those lists - the private, commonwealth and agreement lists - so that we can compare those fees.

Dr Zafir: If you are going to do that, please also pull up the Medicare private fee schedule and have a look at what is really applicable and assessed as doctors fees.

The CHAIRMAN: Is that from Medibank Private?

Dr Zafir: Medibank Private would probably provide the best idea about how doctors' fees and services are valued; not the local health or the CMBS lists. Medibank Private probably provides the best idea about what is going on. The third point I would like to make, and this is a reversal -

The CHAIRMAN: How does that compare with HBF's private medical -

Dr Zafir: They are all about the same. Only a few dollars separate them, but they are miles up from what we currently have. The third point is that doctors here have been pushing private health insurance within the hospital. A reasonable number of private patients come through the hospital. These people are supporting the hospital; they are paying their way. The hospital administration has cut down the operating list. We have the capacity to do 20 lists a week. In general, we are doing 14 lists a week. At present, we are down to 10 lists a week because one of the theatres has closed. As a direct result, the situation we have -

The CHAIRMAN: Who is losing out because the lists have gone down to 10?

Dr Zafir: We are all losing lists at present.

The CHAIRMAN: We asked the surgeon and he said that it did not affect him very much.

Dr Zafir: I cannot speak for him, but I know that it is affecting a lot of others. One of the dentists in town now has an appointment at Fremantle Kaleeya Hospital and is taking private patients from

the Albany Regional Hospital to Kaleeya. He starts on the fourth of January next year. He is taking about eight private paying patients out of Albany to be operated on in Perth. That is a disgusting state of affairs. Not only are we losing money -

The CHAIRMAN: Who is doing that?

Dr Zafir: One of our private dentists. Do you want me to mention his name?

The CHAIRMAN: Is it Rosenberg?

Dr Zafir: No, he is a private, local dentist. He is taking the cream out of Albany and taking it to Perth. It is costing him and his patients more money and it is generally disruptive. He has no other option but to take those patients to Perth and to establish himself at Kaleeya Hospital. He is taking Albany people to Perth. All he wanted was two extra lists, but the hospital refused to give them to him. He has a waiting list of 30 people. He told the hospital that he could identify the people for private operating lists and could bring them into certain lists if the hospital gave him extra time, but the hospital refused him point-blank. I mentioned this to Keith Symes on Monday and Keith was a bit upset about it. He said he would talk to the local dentist to find out what he could do to try to reverse the trend. I spoke to the dentist yesterday and at that stage Keith had not contacted him, so I am not sure what has happened. I know this list will occur. We are doing the reverse. We are taking our private patients to Perth and operating on them there.

Mr HOUSE: So that is actually happening?

Dr Zafir: It will happen from 4 January.

Mr HOUSE: I asked that very question twice this morning.

Dr Zafir: Keith was aware of this situation on Monday or Tuesday. I told him about it.

Mr HOUSE: I thought I was skilled at asking questions, but I obviously am not.

Mr DEAN: Part of our discussion here is to work out how to remove private patients from the public system. This person is doing it for us.

The CHAIRMAN: We want to get the private money in to help the state system.

Mr DEAN: Will those people be declared as private when they come into the state system? You know that John.

Dr Zafir: These people are being declared. We can identify and bring them in as private patients. There is no problem; there is no charge to the hospital. The hospital makes a big whack out of government funding for that. You guys are just losing money. We could run this system really well for you if you just let us have the operating lists. We can make money for this hospital, but we are being squeezed. The whole lot is being squeezed down because the Government will not differentiate between private and public. In the end you will lose the private patients.

Mr HOUSE: You are talking about a federal problem now Mark.

Dr Zafir: I am just telling you the situation from my point of view. When you start squeezing us all down equally, you start losing money. You guys will be the losers.

The CHAIRMAN: We have been trying to advocate this private arrangement.

Dr Zafir: If you gave us a free run and enough operators and nurses, we could make you money in this hospital. If you gave us a private wing, we could make you money. You do not have to worry about your beds. The same hospital and the same service could be provided. We could rent out a wing and run the service as a private wing. You could make your money without any worry.

Mr HOUSE: Where is the bottleneck that you are talking about? Is it with operations?

Dr Zafir: In theatre. We cannot get into theatre.

Mr WHITELY: Is that a temporary problem? Is one of the theatres temporarily closed? Is it about to reopen?

Dr Zafir: No, the bottleneck has been created over a long period. We also have a problem with losing surgery. We need more orthopaedic surgery down here. There is a major problem with dental work. These people are prepared to pay and be mobile. They will be lost out of Albany. Albany has more dental work than any other regional hospital in the State. That is because we have three really good operators down here - two locals and one visiting dentist. These guys do a helluva lot of work. A lot of their stuff is private compared with a lot of the other work we do in the hospital. As I said, if you start squeezing these people, you will lose out and you will be in a worse situation. You have to free up our list, give us our beds and let us work this hospital so that we can push through more private patients.

The CHAIRMAN: Is anybody from your group on the administration board at the hospital?

Dr Zafir: The Australian Competition and Consumer Commission has gagged us. We cannot talk as a group. As individuals, we are just too busy to talk or correspond. The administrator has total power, so if an individual tries to negotiate with him, he says no. We have nowhere to go. I addressed the board on this situation because I felt it was incorrect. Despite what the hospital board has said - if it agrees with me or not - we must go through the administrator and the Department of Health before it can go anywhere. Once the administrator says no, nothing happens. This is one of the problems. Keith is a very nice guy, but unfortunately he is led by the people above him. He is directed from above. He is our only bottleneck.

Mr BRADSHAW: You indicated that 20 sessions a week could be available. How many have been available?

Dr Zafir: We have been using 14 sessions a week.

Mr BRADSHAW: Okay. Has this dentist also had sessions here or is he -

Dr Zafir: Yes, he has sessions here, but they have been squeezed down quite dramatically.

The CHAIRMAN: Is the temporary dentist extra?

Dr Zafir: No. They have been saying to him for a couple of years that they do not like the amount of dentistry work that goes through the hospital. The administration is trying to reduce the amount of dentistry work because they are being pressured from above to do so, because we are doing more than anybody else. These patients have to be seen. Public patients will have to go to Perth Dental Hospital. Perth Dental Hospital is already screaming; it is already overloaded. The private patients will be lost. They will go as private patients to another hospital, so that source of income will be lost. We will be left with patients who will cost us money.

Mr BRADSHAW: If you had 20 sessions a week, from the number of beds occupied, I doubt whether you would have the capacity to handle that at the hospital.

Dr Spurgeon: Not with the bed closures.

Dr Zafir: You would need more beds. It is not a matter of beds or space; we have the space. They have two-bed wards and have taken one bed out, leaving us with a one-bed ward. The beds are in the corridor down the back; they are physically in the hospital and they are brought in if there is a major drama or a disaster. We have the operating theatres. What we do not have is the funding to supply the nurses for those beds. More and more beautiful buildings and magnificent structures are being built, but the hospital is not being run efficiently. We have everything we need to increase the output of this hospital dramatically; we just have to fund the nurses.

Mr HOUSE: Apart from the dental example - and I do not want details - is there a percentage of other medical procedures bypassing this hospital because of operating theatre time or lack of beds? Would it be 10 percent or 15 per cent?

Dr Zafir: Orthopaedics is one.

The CHAIRMAN: Orthopaedics is a problem because there is no orthopaedic surgeon.

Dr Abas: Yes, and gynaecology. Michael Price is one of our visiting specialists.

Dr Smith: In opthalmology.

Dr Abas: He gets referrals from us.

Mr HOUSE: Out of the total health needs of this region - I will pluck out a figure and you can respond - would 20 per cent be bypassing this hospital?

Dr Spurgeon: Of private patients?

The CHAIRMAN: Of all patients.

Dr Abas: If they were given the choice of waiting here for three months for a specialist appointment, or going to Perth and getting one within the next week, yes, it would probably be about 20 per cent.

Dr Spurgeon: And they would be private patients, because they would not get on a public waiting list.

The CHAIRMAN: There is a dental inquiry under way now; it the committee is in Kalgoorlie at the moment. You should forward a submission to that committee.

Is it feasible to set up some sort of clinic, staffed by the doctors - separate from this hospital and on a private basis - to try to transfer some of the costs to the Medicare rate?

Dr Spurgeon: Cost shifting?

The CHAIRMAN: Yes.

Dr Spurgeon: We have GP surgeries very close after hours.

The CHAIRMAN: They are manned by the doctors themselves on a voluntary basis and they can transfer acute cases to the hospital.

Dr Spurgeon: We do so many hours on call, we are all really tired. We are probably not going to open our surgeries after hours because we are on call here anyway The nurses say that many of the patients who present in the accident and emergency department do not need to see doctors, and they are seen the next day. The category 4s and 5s that you are talking about - the triage patients - are often not being seen by a doctor at night or after hours. They get fixed up by the nurse following a phone order from us and they see the doctor the next day. That is already happening. Only the triage 3s, 2s and 1s get seen by a doctor out of hours. They would be the ones we would transfer.

I want to say one more thing. I think Dr Lindsey, who is on call 24 hours a day, seven days a week, and who provides us with a fantastic service, has to be taken into consideration for this on-call situation. I do not know if he wants to say anything. He has not really said anything to date. He is on call all the time. We ring him for help, and it is not about operating -

The CHAIRMAN: Dr Lindsey, are you happy with your fees?

Dr Lindsey: I am happy with my fees. I do not need to be on call fee.

Dr Spurgeon: This is not just about fees. He is the only physician here and he works 24 hours a day, seven days a week. That is fantastic, and if we lose him it is not about money. He needs to have services here; he needs to be able to do colonoscopies and endoscopies and things that we refer to him. So beds are shut and he needs patients admitted. That is very difficult.

Dr Lindsey: I would like to say one thing regarding procedures. I have actually done two free procedures every week for the past two years, that is, either endoscopies or colonoscopies -

The CHAIRMAN: Two free procedures?

Dr Lindsey: Two free services every week. I have the documents if you would like to see them. I do not think you will find that anywhere else in Australia.

Mr HOUSE: I do not think that is correct. You will certainly find it elsewhere in Australia. I commend you for doing it, but I know of other doctors who do that.

Dr Lindsey: I am talking about procedures. I also see patients in the wards. I am talking about putting a telescope down into someone's stomach - you find me someone who does not charge for that. I do not know of anyone who does not charge for that. I see patients in the wards. If I do not think it is serious, I do not charge them. I am talking about doing a procedure on a patient. I do not charge for two procedures per week. You will not find that anywhere else.

The CHAIRMAN: And I am glad you are happy doing that.

Dr Lindsey: I am not happy with this.

Dr Smith: You asked a question about flexibility versus uniformity. In my opinion you need uniformity with a little bit of flexibility around the edges. Things like the cost of GP attendances at a casualty should be uniform, and doctors and administrators around the State should not be running around arguing about that. I think flexibility is needed in the on-call area for specialists. Guidelines can be drawn up to protect the State from incredible costs in that regard.

The CHAIRMAN: Do you mean over-servicing?

Dr Smith: Yes. I would like to make a small comment about locum services. As I indicated earlier, I have a very small practice. Locum services in this State are still grossly inadequate and in my opinion significantly affect the quality of life for country general practitioners. I just make that statement because time is running out.

Dr Mildenhall of the Rural Doctors Association of Western Australia asked me to submit a document on its behalf, which should be an attachment to the rural doctors' submission. He has just handed it to me because he had to go to casualty. It indicates that in Western Australia there are some 178 doctor vacancies based on certain predetermined estimations.

Mr HOUSE: If you table that document we will incorporate it with the evidence.

Dr Smith: Yes. I table the document.

Dr Abas: I would like to raise a few points. First, I raise the point about Alistair Holmes and surgeons having extra capacity and free time to not do anything. That perhaps accentuates the supply and demand equation that is quite different in rural areas. It accentuates the issue of financial viability of practices for doctors in rural areas, whether they be rural specialists, such as in Albany, or rural general practitioners in towns smaller than Albany. In Albany, at the moment most general practitioners are quite financially viable and therefore we are happy to maintain the VMP service to the hospital. Our income from the VMP service that we provide to the hospital is not our major source of income.

The CHAIRMAN: That is obvious.

Dr Abas: That point needs to be made. The other issue relates to money and financial viability. Money is important, but it is a means to an end. We were talking about the supply and demand equation; we are trying to supply a medical service to our community. Demand is flexible; it changes with the age of the population etc. Other methods of remuneration for doctors, such as non-fiscal remuneration for staying in the community, are all part of what we are about here. Money is the means to an end in maintaining supply to the rural areas and, as we know, because fringe benefits have gone out the window again, it does come back to money.

The next issue relates to VMP arrangements and whether we should have them. This is difficult because everyone is different. David Tadj outlined that as well. I will go back to the RDAWA submission, section 9, point 6, where it is noted that the strength in the current VMP arrangements

in rural Western Australia perhaps introduces a collective agreement with variations to suit the TPA/ACCC, and perhaps loadings for the degree of rurality. That may be one way of using the classifications to provide that difference in loading. Various things certainly can be looked at and worked on, but we need to stress that we have not been able to come to a new agreement. We are all busy people, we cannot get into individual bargaining. I cannot say how much I will be on call for the next school holidays, because I do not know how many kids are going to fall out of trees and break their arms. I cannot tell you how much I want to be paid for that service and I do not know how much the service will be. That is one of the problems with the job that we do; it fluctuates enormously. We cannot budget for how many kids are going to break their arms falling out of trees. That is the issue: flexibility is one of the main things we need in the document.

I would like to pick up one point from the current VMP agreement, or the current revised VMP agreement. One of the main things about having a job is job security. Clause 7.5 in the revised VMP agreement states that the board may terminate the agreement - which is the contract with the medical practitioner - if the hospital can no longer provide its role in staffing facilities or funding for the range of services purchased by the Department of Health. That is basically saying to me, yes, we would like you to be a doctor to the hospital, but if suddenly there are 10 fewer beds, that is too bad. If you want a good group of doctors to give a good service and to continue doing that, you must provide some consistency in the workplace. That is not what this agreement provides, and that is just one point I have picked out.

Mr HOUSE: That is a fair comment, too.

Dr Abas: The agreement is an insult to our intelligence.

The CHAIRMAN: That agreement has not been agreed to yet -

Dr Abas: I wonder why?

The CHAIRMAN: That will be part of the committee's inquiry.

Dr Abas: I can table that document here if you like.

The CHAIRMAN: Okay, that will be tabled.

Mr HOUSE: I would like to follow up that point. Taking that agreement is fine, but I would like you as a group - or somebody else - to take responsibility for providing the committee with the amendments that you think need to be made to the agreement that would be fair and acceptable. What would be a fair deal from your perspective? Can somebody do that?

Dr Abas: I have a list of my amendments.

Mr HOUSE: It may be better done as a group.

The CHAIRMAN: You could sit down and say that these are the things we would like to see in the agreement. The Department of Health will be appearing before the committee.

Dr Abas: The Rural Doctors Association of Western Australia is working on that.

The CHAIRMAN: Will that be presented to the committee before we present a report?

Dr Abas: Has the committee agreed to meet us on 26 November?

The CHAIRMAN: No, we cannot meet you on Monday, but we will meet you at some other appropriate time.

Dr Abas: Do you know when?

The CHAIRMAN: We have been sitting for the whole week, and we have electorates, like some of you have patients.

Dr Abas: Perhaps I could discuss this with Kim Padlow.

I have a final point to make regarding the issue raised by Lorraine Spurgeon about whether an after-hours clinic separate from the accident and emergency department would be a viable option. At this stage, with our current workforce scenario, it is not a viable option; there are just not enough bodies to go around. I cannot be in two places at one time. It is actually beneficial for me to see the non-trauma patients in the casualty department at the moment, because if a trauma patient does come in I am already there. If I were at a separate clinic in a separate physical environment, I would have to travel to the emergency department. The second point is the safety issue for an after-hours clinic. I stopped opening after dark in a private clinic many years ago; it is not safe for us to do that any more.

The CHAIRMAN: That is understood. Thank you all for your evidence and for taking time out to attend the hearing. If any of you want to present any further information, please feel free to do so.

Committee adjourned at 7.30 pm