STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 16 FEBRUARY 2015

SESSION TWO

Members

Hon Liz Behjat (Chairman)
Hon Darren West (Deputy Chairman)
Hon Nigel Hallett
Hon Jacqui Boydell
Hon Amber-Jade Sanderson

Hearing commenced at 10.12 am

Dr MICHAEL GANNON
President, Australian Medical Association (WA), sworn and examined:

The CHAIRMAN: Dr Gannon, we have met before. I am Hon Liz Behjat, North Metropolitan Region. If I can just introduce my colleagues here: Hon Amber-Jade Sanderson from the East Metropolitan Region; Hon Darren West, our Deputy Chair, from the Agricultural Region; Felicity Mackie, who is our advisory officer; Hon Nigel Hallett from the South West Region; and Hon Jacqui Boydell from Mining and Pastoral. I understand this is the first time you have given evidence in front of a parliamentary inquiry.

Dr Gannon: Correct.

The CHAIRMAN: You are very welcome. It is not going to be a scary process. As you have just seen with Dr Moody, it is all a very relaxed atmosphere. We are just trying to do the best possible job we can in relation to this review of the PAT scheme, and we thought having you here today was going to really value-add to what we have been doing. I just have some formalities I need to run through here if we can do that before we start chatting. I have to ask you first to take an oath or an affirmation.

[Witness took the oath.]

The CHAIRMAN: You will have signed a document entitled "Information for Witnesses". Did you read and understand that document?

Dr Gannon: I did.

The CHAIRMAN: The proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphone and try to speak into it and do not cover it with papers or make too much noise near it. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

That is the formalities over and done with. Now we can relax. Is there an opening statement you would like to make to the committee or do you just want us to jump straight in and ask you some questions?

Dr Gannon: I might just make a brief opening statement.

The CHAIRMAN: Please do.

Dr Gannon: As president of the Australian Medical Association, we are interested in this for a whole variety of reasons. We are keen to support general practitioners in rural areas, we are keen to support specialists in rural areas and we are keen to support our members who are specialists in the metropolitan area in trying to have this scheme, which in many ways has served the people of Western Australia very well. The geography of our state is well known to the members in front of me. It is something that I am very conscious of. The difficulty in providing medical services to people across this vast piece of geography is fairly self-evident, so PATS is a very important part of

that. It is a great challenge for the medical profession to staff regional areas, but it is a reality that there is just not the population density to merit having specialists even in some of the bigger regional centres. Like any great institution, PATS needs to live long into the future, but it could do with a bit of tidying up. There are areas where it is perhaps not serving patients as well, and I am happy to answer your questions there. From a personal point of view, I have always had a very strong view as a medical practitioner, whether that is a junior doctor or a consultant, that the patients we talk about are from the areas that generate the great wealth of this state. I have always had a philosophical attitude when answering the phone at King Edward at three o'clock in the morning on a Thursday the answer is always yes; you always try and look after the patient and the doctors who find themselves in difficult areas. But we need to support people who have to travel long distances to access care and, wherever possible, you try and get to a point where Western Australians in rural and regional areas enjoy the care that is as good as or nearly as good as it is when you live down the road from the hospital.

The CHAIRMAN: One of the things—you heard us just speaking with Dr Moody in an earlier part of the hearing—is the use of these blue forms and the yellow forms and getting the forms back and the cumbersomeness of it. We have also heard as we have gone around that sometimes doctors themselves have put something on the form and it has not been quite clear what they are meaning and it then delays the process with PATS clerks having to go back and ask, "What does that mean?" or "You forgot to tick this part of the box" and perhaps there is the possibility of moving to an electronic form that could start to be generated at the time of the consult with the GP and then that form would move its way through the system rather than the onus being back on the doctor themselves to ensure that every box is ticked. But, obviously, a computer system is not going to let you move forward to the next screen until you have ticked the box. Do you want to speak to that as to what you might see as the advantages and disadvantages of that sort of a system?

Dr Gannon: The blue form is not overly onerous for specialists in the city to complete and it might actually add to the burden further. It might be that opening up a PDF or a Word document might actually make things more complicated. So, for the specialists themselves, the completion of the blue form or us being asked to correct it or fill it out retrospectively is not a great burden. The feedback that we get is more from the GPs and from the patients themselves.

[10.20 am]

Hon AMBER-JADE SANDERSON: Can you elaborate on that feedback?

Dr Gannon: I suppose in various problems that we see with PATS—we sought feedback from doctors around the state and then got substantial feedback from people—one of the areas where there was not a complaint was the completion of paperwork. If you compare it with other areas of paperwork filling out—the amount of paperwork that the GPs need to fill out for Medicare these days is quite significantly onerous—the blue form seems to work fairly well. Often the problem seems to be that individual patients, armed with this paperwork, then have trouble with PATS clerks. Again, that is the evidence that we got, that there is significant variation in how seamless that process is for patients. Some of them report that being a particularly difficult process. For others there are PATS officers that seem to work quite seamlessly and quiet fairly.

Hon AMBER-JADE SANDERSON: We had a bit of feedback about the blue form but I think some of the issues that were raised were with the original form that comes from GPs, particularly that GPs when they say they have taxi vouchers or whether they should fly, that that sort of stuff is being challenged by the PATS clerks and people have to go back to their GPs. Have you had any feedback from your members on that particular issue?

Dr Gannon: There is no question that that is where the problem lies. The interface for the treating doctor in the larger regional centre or in Perth does not seem to be the major problem: it is not difficult to complete, it is not overly onerous. I did overhear some of Dr Moody's testimony—I have never been asked to fill out a form again, yet, as an individual practitioner, I go to it with the

ideological viewpoint that patients in regional areas need to be looked after. So I guess I would be very generous in what I wrote. One of the areas that I have a lot of personal experience in is perfectly healthy young women living in an area where there are no obstetric services that have to come to Perth, or people with relatively minor problems but they might prohibit delivery in a regional centre. We have seen a contraction of the number of obstetric services around the state over the past 20 years. That is the problem because they have to stay in Perth for sometimes a few weeks at a time, and of course the scheme is not particularly generous in terms of how long it looks after people. But that is a fairly unique situation. We might assert that it is important that someone has their accommodation et cetera subsidised for a four-week period, even though they are a relatively healthy person. There is an expense to that. But in terms of the blue form, that is not the major problem.

The CHAIRMAN: In the submission that we received from the AMA to our inquiry, you mentioned that where patients who are unaware of the PAT scheme become aware of it that there should be an allowance made for retrospective claims for those patients. Is it fairly widespread that people are unaware of the PAT scheme?

Dr Gannon: I think that overall most people are aware of the scheme. I am, for example, not familiar as to similar schemes in other states and how they work or whether they are as generous or whether they are as broad. I honestly do not know the answer to that question. It may be the case that the people who are relatively new to the state—as members of the committee well know, there is a significant proportion of the people who have lived in Pilbara for the last 10 years who have come from New Zealand or the eastern states—might be less familiar with it. I do not know that it is a problem that we need to go and advertise the existence of the scheme. Certainly, it might be the case, if someone thinks they are going to have a relatively short episode of care, they might not think that they need to claim it. Like all government programs, there are some people who have great ability to claim it in its full generosity and there are other people who choose not to or cannot avail themselves of the benefits.

The CHAIRMAN: Say it is too hard. Also, in your submission, the issue of some PATS staff refusing claims in the first instance because of their confusion with the nature of the specialty—the example of paediatrician versus paediatric urologist. Is that widespread in your experience?

Dr Gannon: It would not be widespread, but that is the cause for disquiet and grief amongst our patients. It can be very confronting—it is unseemly to be having disagreements with the PATS clerk at your local country hospital, especially if you are in a difficult situation. If it is the health of your child then you are already distressed and upset. But any system must maintain some flexibility so that those questions are less likely to come up. I think we need to give patients greater credit in what they claim as well. I think that in most instances they would claim appropriately. The other issue which is important is that perhaps there is not an individual PATS clerk—or perhaps even members of this committee, might not have the concept of subspecialisations. It is not purely the case, you might have a problem where it is not appropriate to see a specialist in Karratha; you do need subspecialist care. Or even a certain hospital, even within the metropolitan area, for example, there might be a unit at the Sir Charles Gairdner Hospital that is not replicated at Royal Perth Hospital. So even within the city, you might have special skills, special expertise where people need to travel for that. So that distinction between specialist care and subspecialist care is an important one.

The CHAIRMAN: That also raises the issue that has been canvassed quite widely with us, as we have gone around, of dental care. What is your opinion in relation to that? Should that be something that we need to look at including in the PATS scheme?

Dr Gannon: I suppose—not to overly broaden the answer—but there is a cost to our community that we do not have the dental equivalent of Medicare. It means that a lot of patients end up with chronic health problems that could have been dealt with a lot more easily. All across this state there are people who go and see their GP and get a subsidised prescription for antibiotics or strong

painkillers, when more ideally they need comprehensive dental care. I have to draw on the fact that Dr Moody came in just before me, that a significant burden of chronic renal disease in our community is Aboriginal Australians who have probably contributed to or their rheumatic heart disease has been exacerbated or caused by inadequate dental care. If we can do anything to improve dental care for those who do not have the means to visit private dentists, then there would be a benefit for the community. It is not just about teeth, there are chronic health problems that come from inadequate dental care.

The CHAIRMAN: One of the other things that has been raised as an issue, for instance, is that there is more and more bariatric surgery taking place, either by gastric banding or sleeve gastrectomies. A patient in a regional area can come to Perth to have that surgery done, but then they do not get enough follow-up from that, which I understand is really quite important in that sort of surgery. Do you have issues with that also?

Dr Gannon: One of the problems we do have is that there is not a lot in the way of publicly funded bariatric surgery, but it certainly would be the case that a lot of private patients come to Perth. I think that perhaps it is important for the committee to understand the real success of bariatric surgery is not so much the operation itself, but it is the multidisciplinary teams that come with that. Although you might have a general surgeon who might visit a regional centre and follow-up their hernias and their varicose veins and other things like that, they will not take with them the psychologist, the dietitian, the nurse who has developed special expertise in this area. That is a great example of where the system has to maintain a degree of flexibility to say this fits in well within the remit of general surgery but a surgeon visiting Merredin, Narrogin, Karratha does not bring their whole team with them. It is not a quick fix, bariatric surgery; it should be regarded as an ongoing need for management. It is not just the case of inflating the balloon or deflating the balloon; a lot more goes into their care. One of the problems with this kind of surgery is the failure rate at the five to 10–year period. If they receive appropriate follow-up, they are less likely to fail.

[10.30 am]

The CHAIRMAN: Moving on to a different area now—unless other members have questions on this, particularly—in your submission to us—I will just read this from the AMA submission; we are talking about Fiona Stanley hospital in particular —

> Lack of accommodation for regional patients is expected to be a serious issue for Oncology and Haematology at Fiona Stanley Hospital … PATS and Royalties for Regions funding should be considered as possible contributors to answering how regional patients will access, with their families, appropriate care in Perth from 2015. The AMA (WA) requests urgent consideration be given to this matter and can provide further information as to the nature and ramifications of this shortfall.

Now is your opportunity to provide that further information with regard that, if you could.

Dr Gannon: Sure. I think, members from both sides the house should take great pride in the project—the enormous build and really exciting developments in the future for people in the whole state. The reconfiguration is not going to be without its challenges. It is going to be difficult and there are going to be teething problems. One of the issues is that now the two biggest hospitals in the state are in areas that are perhaps not ideally served by public transport and are also in areas where accommodation is not ideally available. Another issue, which feeds into this, is the closure of Jewell House, which was always a source of accommodation for patients attending Royal Perth Hospital. It is just a reality. I was fortunate enough to have a lovely walk to Wellington Square on Friday and see a certain famous six-metre tall young girl, but in Wellington Square the tragedy is that a lot of people are sleeping rough—Aboriginal patients or families of Aboriginal patients having long-term care at Royal Perth Hospital. That is a failure of our current system to appropriately fund accommodation for people coming from the bush to have medical care.

Fiona Stanley Hospital is a great greenfields build, but there is a dearth of accommodation options in the immediate area. You could say it was perhaps in many ways a visionary place to build a hospital, next to Murdoch University, and having it next to St John of God, Murdoch, but the reality is that the accommodation just does not exist in that area, so people are going to have to travel further to where they staying. The reality is that in the Murdoch area and in the Nedlands area there is not much in the way of affordable accommodation often for people of limited means, so that needs to be looked at. We either need to look at building new accommodation in those areas or, in terms of your deliberations, we might look at the generosity of the scheme in terms of: is there now disconnect between the accommodation payments and the reality of motel rooms in Perth?

The CHAIRMAN: Do you think there is a case to be put that perhaps we need to look at clipping it a bit and getting more doctors out into the regions either on a more permanent basis, but certainly on a larger visiting scale, so more specialists travelling out to try to alleviate the issue of people having to come to Perth? Do you think that is feasible?

Dr Gannon: I think it is definitely feasible and I think that that is something that you will look at. You will look at the cost of the scheme, the cost of improving the scheme, the significant cost of making it more workable and then you might find that there are better ways to fund this care. It is a great challenge for the medical profession to get people closer to where they live. That is something that we are conscious of and in an intergenerational way there have been moves over the past 20 years to, for example, increase the amount of time that medical students spend in country terms during their training. There is good evidence to suggest that if you have had a positive experience working in the country, you are more likely to return to the country. There is a greater level of recruitment of medical students coming from country high schools et cetera, so that is part of the solution. But the other reality is that there are just not the population densities to justify having a specialist in a lot of areas, and certainly when it comes to some specialists, there is one subspecialty area that I work closely with where it is thought that you need one subspecialist per half a million population, so we only need four or five for the entire state. Therefore, it just does not make sense to have one in Karratha or Geraldton. But in looking at that, there are different ways of getting doctors to work in the bush. You could look at various incentives to get people to work there in the long term—various incentives in terms of locum cover to make it more attractive for people. And, of course, through the WA Country Health Service et cetera, their payments to GPs. I am aware of the existence of a scheme where GPs are actually supported to provide those services in country areas, so for visiting specialists to go out, but again, perhaps making the point that sometimes the specialist medical practitioner is just part of the team and you might need nurses, midwives, physiotherapists, dieticians et cetera that are an important part of the episode of care. It is more than just the doctor visiting. But that is something that should definitely be looked at.

Hon JACQUI BOYDELL: Can I just ask you, Dr Gannon, do you see telehealth filling a bit of a gap? I take your point about the subspecialist and ultimately you will have some patients who will require that due to their clinical condition, let alone their mental health. Do you see that as working at the moment in some areas with some patients? Is that making a difference in terms of referring people to the metro area?

Dr Gannon: I believe that telehealth lends itself to some specialties more than others and I also believe that it is underutilised. It is perhaps one of those areas where I would have guessed the technology would have moved a lot more quickly than it has, and it is not always attractive to the specialists involved. Some of the hardware is particularly burdensome. A fairly poorly targeted commonwealth government program that existed about five or six years ago paid individual doctors quite substantial incentives to set up telehealth and then required them—there was a number of patients you had to seek to gain the payment, unfortunately it was one. That is a poorly targeted bit of money. Especially now, a lot of specialist medical care involves having a look, I suppose, and for example, there are some areas of ophthalmology and some areas of gynaecology where we could have a nurse who could set the patient up and the whole thing is done over a broadband connection.

Those areas of medical care where you are looking at something with the camera or a microscope lend themselves very nicely. In terms of putting your hands on the patient, it is less helpful. But again, looking at the cost of the whole scheme et cetera, if it starts to become prohibitively expensive to have people in new-built motel units in Murdoch or Winthrop, the government might make a judgement that it is a more cost-effective way to pay for telehealth initiatives and to improve the quality of the feeder at the two ends. I think it is an underutilised area.

The CHAIRMAN: An issue that I know is very close to your heart is obstetrics. For obstetrics patients in rural areas are there particular issues there with PATS, how they access the scheme, the care afterwards and getting them back to where they come from? Do you have evidence with regard to that?

Dr Gannon: This is a major problem. We have seen so many of the smaller rural obstetric units close over the years. In many ways that was a necessity and possibly even a good thing, and yet what it does is create this huge disconnect for people—often women who are perfectly healthy and often women who have other children at home. Although from an obstetrician's point of view is probably appropriate to have them all parked close by from 36 weeks onwards, that then introduces the idea of having someone for over a month separated from their other children, their family, from the communities and from other support. So, even if we had the perfect scheme in terms of its generosity, it is a problem. So there has been a real move over the past 10 years or so to try to reinvigorate GP obstetrics in larger regional towns, and there are some real success stories; Esperance, Geraldton are real success stories in terms of making those kind of improvements.

[10.40 am]

The CHAIRMAN: Esperance and Geraldton?

Dr Gannon: Yes.

The CHAIRMAN: Do you want to elaborate as to what they have done there?

Dr Gannon: Probably just attract and retain GPs who have had extra training, so, in simple terms, probably the ability to do a caesarean section, to get them or the mother out of trouble in a hurry. There are more and more GPs being trained to deliver babies by caesarean section, bearing in mind that it is too late to transfer the patient if there is an emergency. There are a lot of circumstances where you have got 30 minutes or 60 minutes to get a baby out, so the Esperance to Kalgoorlie shuffle is just not going to work. That, again, has been a real success story, and that is an ongoing project.

The CHAIRMAN: From my recollection of it—and this goes back, I think, quite a number of years—one of the big issues about GPs and obstetrics was that there was a massive increase in the insurance premiums for GPs and that they then found that they were not delivering enough babies in one year to actually even cover the increase in premiums. Has that since been addressed to then allow this to happen where we can get back to that situation where we have got more GPs doing more deliveries?

Dr Gannon: It remains a problem. The medical indemnity fees paid by private obstetricians are now of the order of $80 000 to $90 000 a year, and if you have got a large practice where you are delivering 200 women, 300 women, per year, then you will comfortably fund that as a business expense; but that is a problem for a GP obstetrician who might historically have done 10 or 15 deliveries per year. It is a reality that GP obstetrics is not a low-cost area when it comes to medical indemnity claims. In fact, the story of the past 10 years is a success story for private specialist obstetrics in terms of a significant reduction in claims et cetera. Most of the massive claims that still happen in different parts of Australia relate to the inability to deliver a baby on time by caesarean section, so, again, this is just a wonderful example of how the whole system knits together, and you cannot fix one problem at a time. There will always be a proportion of patients who need to come to Perth for specialist or subspecialist care, and yet the more we improve

services, the less we dislocate patients from their communities—bearing in mind we are often talking about perfectly healthy women.

Again, another part of the submission is as an individual obstetrician you make decisions every day of the week about the pros and cons of induction of labour—and induction of labour, many women will often regard as a merciful obstetric intervention, but, at the same time, you would never want to feel people are forced into doing that. You would never want a situation where you know PATS pays for two weeks, two days in Perth and that is the only indication for induction of labour. The pros and cons should be a clinical decision between midwife or doctor and the patient.

Hon DARREN WEST: Thanks, Dr Gannon. Most of the questions I had for you have already been canvassed. If I could, I was a little bit unclear when we mentioned the form that perhaps moving from the old blue bits of paper—which I personally find quite quaint in the year 2015, that we have to carry little pieces of paper around with us—but should an outcome be that perhaps this might be something worth further investigating? Do you think that would be something that would be embraced or perhaps resisted by your members—sorry—if we go to an electronic form that needs to be populated at the surgery and all the details transferred up the chain?

Dr Gannon: I think a paperless electronic system is the way of the future. Personally, I am a dinosaur—I do not know if that requires interpretation for the committee—but perhaps just the point I was making is that the blue form for specialists to complete is not overly onerous.

Hon DARREN WEST: Yes; sure.

Dr Gannon: The major complaints we have had about the PATS system, about individual patients having disagreements, arguments, with PATS clerks—and, again, so much medical care falls on the poor old GP. The specialist waltzes in and waltzes out of the health care arrangement; it is the GP who is expected to tidy up the paperwork, sometimes retrospectively or sometimes contemporaneously. But the point I was making is that it is not onerous for the specialist.

Hon DARREN WEST: I am certainly conscious of the GP's time—they are incredibly busy people—but perhaps it is something that could even be filled out by a practice clerk, or something like that, might be possible to investigate.

Secondly, just on the numbers of doctors we have in regional areas—it is a fairly age-old chestnut—where are we at? Clearly, this does have an effect on the number of people who need to travel, as you touched on with obstetric services. But if we have got a shortage of doctors, we are going to have a greater demand on the scheme. In terms of the AMA's view and your view, where are we at with required versus numbers of doctors in regional areas?

Dr Gannon: There is no question we did have a shortage of doctors and there was no question in my mind there was a failure of commonwealth government policy in terms of medical student numbers going back. There was one particular bad decision in the early days of the Howard government that basically left us underdone in terms of medical student numbers, and, if anything, we possibly have had an overshoot, so we have gone from having basically 1 200 medical students in Australia to closer to 3 400. So there is a massive number. In the state of Western Australia we now have two medical schools. The year I graduated there were 108 doctors that came out, and we are now talking about 340 doctors per year. So, the problem we do not have is with the number of medical students. AMA policy is that we do not need a third medical school in this state. The challenge is to ensure the training pipeline for those people who are coming out year by year now. Most specialist medical training is undertaken within public hospitals. There is an increasing amount of training that is undertaken in private hospitals. Most GP training is done by GPs in community practices, in their practices—at least half their training. So what we do not have in this state is an undersupply of doctors, but we clearly have a maldistribution of doctors. Now even within the metropolitan area, you will be aware there are significantly more general practitioners practising in leafier, well-heeled suburbs than there are in less attractive areas. The amount of

money that GPs accept if they choose to bulk-bill patients is completely out of step with the cost of providing high-quality general practice. That is something that is a story of ongoing discussion with your federal colleagues. But whatever we can do to make it more attractive for doctors to go and practise in less wealthy areas of the metropolitan area and into the regions will be worthwhile. It is against the constitution to send medical practitioners where they do not want to go in the bush, and it does no-one a great service to force people who do not want to be there. But as a community, and as a profession, we are interested in doing anything we can to maintain the educational opportunities for doctors who work in the regions, to make sure they have safe and workable locum arrangements—and everything we can do to make life vibrant and enjoyable for their spouses and children, anything we can do to improve the educational opportunities for their kids. If we get there, then you have got doctors in regional areas. But for some specialist areas, you will never reach the population density to justify having someone. You cannot have a psychiatrist in a town of 9 000 people; it just does not work.

[10.50 am]

Hon JACQUI BOYDELL: I just want to touch on the position of regional areas and overseas-trained doctors coming to their communities and, just going back to PATS, whether you can see sometimes a high rotation of overseas doctors, who are all very welcomed by the communities, of course. How are they being made aware of things like PATS for patients they are seeing and may never come across again? Does the AMA play a role in that? I think we have heard some evidence that locally, on the ground, they do not seem to receive any sort of training. I think it is left to maybe the hospital they are going to, or the practice they are going to.

Dr Gannon: Historically, a lot of the doctors who ended up in country towns were recruited by the AMA; they had a role in that, and it is more the Department of Health that seems to do that these days. I think it would be fair to say that those colleagues of mine who go and work in rural areas will have to become fairly familiar with PATS fairly quickly, because their patients will have the expectation that they —

Hon JACQUI BOYDELL: How, in your experience, are they getting that awareness?

Dr Gannon: I do not really know how we get them to that point. There is a lot for people to learn. If you arrive in Australia from India, Britain or South Africa, your medical training is, in many circumstances, comparable. The things that you see day by day are comparable. There are things that are fairly unique about Aboriginal Australians that they need to come to an understanding of, but a lot of them have worked in underprivileged communities where they come from, so those issues are not completely new to them. But as to how they achieve the professional literacy in Medicare—writing referrals, different schemes and authority prescriptions et cetera—there is a responsibility that partly lies with the profession and a responsibility that lies with the people who employ them, for them to come to understand the complexity of the bureaucracy of medical practice. Again, we see this all the time, where health services being partly the responsibility of the commonwealth and partly the responsibility of state governments makes it even more complex. There are things that are the commonwealth's responsibility, like the pharmaceutical benefits scheme—so writing scripts and writing authority scripts—and then there are things like PATS, which comes under the remit of the state government. I think we have a responsibility that when people land, they are given that education. Certainly, members of the AMA are given that kind of support when they ask for it. There are very high levels of membership amongst doctors who arrive from overseas, because they are clever enough to realise that they need every bit of support they can get, whether that is industrial or professional, or just to make sense out of the system. There is no formal orientation program that is owned by the AMA. It is something that would vary from town to town. If they are arriving in a one-horse town, they might have to try to learn very quickly on their feet.

Hon JACQUI BOYDELL: I think it is just a bit of a concerning gap that does not seem to have much transparency around how that process is undertaken, from evidence that we have received previously. One concern is that the doctor is arriving and not getting the right support—invariably that means that they may leave a community—and the second is the patients, at the end of the day. It is interesting to hear the AMA's role in that. Thank you.

One more question I have revolves around the committee's consideration of potentially expanding the scheme to other allied health services. You have touched on that with some specialties being provided to the patient around their immediate clinical emergency or ongoing treatment. Can you give any indication of what the AMA would consider, through allied health, would be an area where we should expand the scheme? I mean things like mental health, and I know other members touched on dental health.

Dr Gannon: Doctors are very good at working in teams. That is not foreign to them. In many areas of practice, they would be at the head of that team, and in other areas that is not necessarily the case. There is very good evidence in certain areas that people will benefit from seeing people other than doctors. You mentioned mental health, and there are some people who do not need to see a psychiatrist; they need to see psychologists or counsellors. That is a good example, where sometimes the system is fairly seamless in working out who needs to see the right person. One thing that the AMA seems to be constantly speaking to the government about, or in some cases fighting about, is task substitution agendas. They are a real concern to us. There seems to be a near constant desire perhaps for pharmacists or midwives or podiatrists to steer into an area that has traditionally been an area provided by medical practitioners. Sometimes it looks as if there are savings there for the entire health system, but in most areas it adds to the expense. I think it would be very easy to make a case for expansion of the scheme to look at psychological care, but there are not too many other areas where there would be a long-term saving for the community and the precious health dollar in farming people out to allied health practitioners, if you like. Again, speaking from personal experience, in what I do day by day, midwives and obstetricians work in teams in public hospitals, so it is something that works very well, but it would not be a cost-effective expansion of the scheme to be sending patients to see private midwives in regional towns or in the city. In areas like mental health, where the services really are failing, supporting the capacity for people to see a psychologist would be worthwhile.

Hon JACQUI BOYDELL: Thank you.

Hon AMBER-JADE SANDERSON: But you would support it where it was supporting the surgery, for example, around bariatric surgery?

Dr Gannon: I think that is what I was talking about, like teams and multidisciplinary options. Just using that example of bariatric surgery, it is not just the case that the surgeon can come to town and look at your wound and take five mils out or put five mils into your laparoscopic band bubble. It is an important part of the success of so many of these operations if you are seen. That is just one example of how the surgeon visiting town does not constitute the full episode of care.

The CHAIRMAN: There are no further questions. Dr Gannon, thank you very much for coming and spending time with us today. It has certainly been a really good way of rounding out the medical evidence, as it were, that we have been taking in the inquiry, so I really appreciate you taking the time. Thank you.

Dr Gannon: Thank you.

Hearing concluded at 10.58 am

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