PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN AT THE OFFICES OF THE NORTHERN GOLDFIELDS HEALTH SERVICES, KALGOORLIE, WEDNESDAY, 21 NOVEMBER 2001

FIRST SESSION

Members

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

Committee met at 9.00 am

CANNING, MR TREVOR,
General Manager, Northern Goldfields Health Service,
PO Box 716,
Kalgoorlie, examined:

The CHAIRMAN: Have you completed the witness form, and did you read the note at the foot of the form?

Mr Canning: Yes.

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

Mr Canning: No, I have not.

The CHAIRMAN: Will you now give the committee some background about how the Northern Goldfield Health Service operates, and how it is controlled?

Mr Canning: The Northern Goldfields Health Service is made up of two health service boards. The Kalgoorlie-Boulder Health Service Board covers the city of Kalgoorlie-Boulder and the shires of Menzies and Coolgardie; and the Laverton-Leonora Health Service Board covers Laverton and Leonora. There are two independent health service boards. As general manager, I am employed by the Kalgoorlie-Boulder Health Service, because the Northern Goldfields Health Service has no legal entity. I provide the services to Laverton and Leonora as part of that role.

The CHAIRMAN: Does that include the hospitals?

Mr Canning: Yes, it encompasses all public sector health services, which includes mental health, public health, community health, and the hospitals across this area.

The CHAIRMAN: What is the total budget for the area?

Mr Canning: It is $35 million.

The CHAIRMAN: As you are aware, our inquiry is about visiting medical practitioners at the Kalgoorlie Regional Hospital. Will you provide the committee with some background information about how the system works, and how the VMPs work, particularly in the emergency department? The committee has just had a look at that, and it seems to be fairly bustling.

Mr Canning: Yes, it does at times. Overall, we are a visiting medical practitioner hospital. All the private practitioners living in the town service the hospital on a VMP basis. It has been like that for many years. The only exception to that is the emergency department, which is run by resident medical officers from Royal Perth Hospital and Fremantle Hospital. We do have some other residents, four interns - two medical and two surgical - and a registrar provided by the teaching hospitals. We did have three physicians in the city, but we have been reduced to only one, and he basically withdrew his services from the hospital. We have been trying to get a position in the city, which is an area of unmet need, and have ended up having to take one who was not fully qualified. He is still on our staff as a physician. He is the only staff medical practitioner.

The CHAIRMAN: Why did the previous doctor withdraw his services? Was he not being paid enough?

Mr Canning: The area was being serviced by three practitioners, and when the number reduced to one, he was thinking of himself and his family. He still had a fairly vibrant private practice. He still does chemotherapy for us. We have been sending patients to Perth for that, but he has come back to doing it for us Kalgoorlie-Boulder.

The CHAIRMAN: How many staff does your emergency department have? How is it run? Does it provide 24-hour cover?

Mr Canning: Yes, 24 hours, seven days a week. A resident is on at all times. The residents are covered by the visiting practitioners; there is a general practitioner on-call roster, and a specialist and an anaesthetist are on call. If they are needed they can be called in.

The CHAIRMAN: Are they all VMPs?

Mr Canning: The external ones are. The residents, of course, are on the payroll.

The CHAIRMAN: How many patients would go through the outpatients or the emergency department?

Mr Canning: For Kalgoorlie, the figure is about 19 000 a year. As well as that, there are all the other hospitals, so the total for the health service is about 28 000.

The CHAIRMAN: What is the population covered by the health service?

Mr Canning: About 54 000, but another 15 000 to 16 000 could be added to that figure for fly in, fly out workers.

Mr HOUSE: Are there any outlying hospitals that pick up any of your area? Can you walk us through that?

Mr Canning: There are hospitals at Laverton and Leonora, and nursing posts at Coolgardie, Kambalda and Menzies. We provide emergency care at those places, and the patients are transferred to Kalgoorlie, if necessary.

Mr HOUSE: Are there doctors in any of those places?

Mr Canning: Laverton and Leonora both have general practitioners; Kambalda and Coolgardie have visiting services from Kalgoorlie. There is no doctor in Menzies.

The CHAIRMAN: At present, 32 people are waiting in the outpatient department. How many doctors are available to service those patients?

Mr Canning: It depends on what is on today. I have a feeling the orthopaedic clinic is operating today. After his surgery, the surgeon sees all the referred patients in the rooms at the hospital.

The CHAIRMAN: Does he have rooms at the hospital?

Mr Canning: He uses our rooms.

The CHAIRMAN: Is that on a VMP basis, or a private basis?

Mr Canning: Because they are our patients, they are public patients who have been operated on in the hospital, and their follow-up is done here. The surgeon has his own rooms at the Goldfields Medical Fund building downtown. His private practice is run off-site, but this clinic is run at the hospital.

The CHAIRMAN: Is he paid as a VMP or on a sessional basis?

Mr Canning: He is paid as a VMP.

The CHAIRMAN: Why would he not do it on a sessional basis?

Mr Canning: Ian Skinner is a VMP. It is one of the areas we are reviewing. It is the same with the VMPs who come from the city. Over 20 VMPs come from Perth to provide services that cannot

be provided here. They hire a room from us at $20 a clinic day, which is minimal. They bill all their patients through Medicare.

The CHAIRMAN: Does Mr Skinner do that as well?

Mr Canning: Because the patients received surgery as our patients - this is the fine line, determining whose patients they are - and have been treated in our hospital, the follow-up is part of the procedure. He would have been paid for that procedure under his VMP arrangement. I think he also occasionally adds some of his other patients to the list, but mostly these are his follow-up patients.

The CHAIRMAN: The only problem with that is that under the VMP schedule they get paid a lot more than they would normally get if it were a normal consultation. I am not sure what you actually pay Mr Skinner, because he is a specialist and his VMP fee is probably even higher. What would his VMP fee be for a visit?

Mr Canning: I could not answer that off the top of my head, but I think he does have a higher rate as a specialist. The first visit will determine the cost of the follow-up visit.

The CHAIRMAN: If he does a whole session like that, and he has 30 patients waiting -

Mr Canning: Most of those patients would be his follow-up patients, so the cost should be included in the fee he gets from us for the procedure.

Mr DEAN: Those follow-up patients are walk-up patients, are they not?

Mr Canning: That is right. They may need their plaster changed, or a similar service.

Mr DEAN: In fact, they are not hospital patients as such; they are private patients.

The CHAIRMAN: I am trying to establish who is paying for the service.

Mr DEAN: Is the State paying for it?

Mr Canning: For those hospital patients who have been operated on in the previous few days, he must do the follow-up at no extra cost; it is part of the fee he receives for doing the procedure. However, he does add in a few other patients. That is why it is so busy down there.

Mr HOUSE: When you say "at no extra cost", I am struggling to understand. He does the initial procedure. If the patient needs a plaster changed - to use your example - does he receive a further fee?

Mr Canning: The initial fee covers the follow-up.

The CHAIRMAN: So he does not actually get paid if people come and visit him in the hospital. One lady we were talking to said she came in hoping to see Mr Skinner today, and was told to be here at 8.30 am, and she might see him.

Mr Canning: I think Mr Skinner loads that clinic with some of his own private patients, as well as our public patients, and he would charge them. It depends on whether he is seeing them as public or private patients.

The CHAIRMAN: Would he bulk bill them?

Mr Canning: I do not think Mr Skinner bulk bills.

The CHAIRMAN: How do you, as the administrator of the hospital, keep a check on things, to ensure that the hospital is paying only for legitimate public patients?

Mr Canning: Records are kept of the patients going through the clinic. We check that to find out what he is actually billing us for when we receive his monthly accounts. We ensure that we are making the correct payments.

The CHAIRMAN: What is his salary from this hospital?

Mr Canning: It would be more than $200 000.

The CHAIRMAN: The northern goldfields list shows that one doctor receives $329 000, one receives $313 000, and another receives $312 000. Have you been able to provide the committee with decoded numbers? This list shows numbers, but the doctors are not actually named. Do you have that available?

Mr Canning: I have it at present, only as named data. I am presently having it brought over de-named. That should be on my computer now, and will be available to you.

The CHAIRMAN: Are any of the specialists used by other health services?

Mr Canning: The obstetrician/gynaecologist used to go to Esperance, but he does not now. Mr Skinner does not go outside of here, nor does Mr McGushin. None of the specialist goes outside of Kalgoorlie now.

The CHAIRMAN: How many specialists are there?

Mr Canning: We have two general surgeons, an orthopaedic surgeon, one physician, one anaesthetist, an obstetrician and a gynaecologist. That is the range of specialists.

The CHAIRMAN: That is five. Do they all live in Kalgoorlie?

Mr Canning: Yes. The anaesthetist is one of the higher income earners, and there is also a general practitioner anaesthetist, who does pretty well full-time general practitioner anaesthetist work.

The CHAIRMAN: Some of the people are receiving big salaries. Would it not be more feasible to have them employed as salaried staff? In other words, if general surgery were required, could not a general surgeon be hired? Some of these salaries are over $300 000, just for the services provided here. The comment made is that a brain surgeon at Royal Perth Hospital gets $130 000 plus on-costs. Have you done a feasibility study of whether it would be possible to bring these services in house?

Mr Canning: The physician, who has been with us for 12 months, is costing us in excess of $350 000. The costs incurred are not just straight salary. They include his availability and the provision of rooms, which we have never had to provide in the past. We provide him with a car and housing. We have to provide relief coverage, which we buy from Perth. We bring someone up here for four days every month, paying airfares plus $1 000 a day. That is costing us another $100 000 a year above his salary. This is to give him a break. If we did not, we would end up losing him because the pressure on him is terrific. We are paying $350 000 for that position. We provide medical records and secretarial support for his clinics. Medical records now spends three days a week pulling charts for him, which we never had to do, because it was always done in private practice rooms. On that estimation, I do not think it would be viable here.

I was at Osborne Park Hospital for many years. That hospital tried sessional appointees in the 1980s. It reverted to the VMP system about five years later. The work ethic is not there; they do not do the work. Specialists here might do five or six cases in a list, whereas under sessional arrangements they might do two or three. The anaesthetist will not do the work. That is what I found in the metropolitan area, and I think the same would be found here. They will receive the same dollars whether they do one case or ten. We must be careful in determining that the work they are doing is legitimate, and that they are not over-servicing to increase their income. We must be very mindful of that.

The CHAIRMAN: He is getting $329 000 a year. How many hours does he put in?

Mr Canning: I think that the committee is meeting with the obstetrician this afternoon. He has withdrawn his obstetrics services from us, because he is in dispute with us over medical indemnity payments. We have not come to an agreement with him on that. It has been going on for two months now. He spends an exceptional amount of time in this hospital. He is the only specialist obstetrician here. He is on call 24 hours a day, seven days a week. He does a heck of a lot of work for the North Goldfields Health Service. Surgeons are available. At least there are two of them to share the on-call service. We have a surgeon available 24 hours a day, seven days a week, which is a pretty good service.

The CHAIRMAN: How many hours would they work? I know that they are on call, but how many hours would they work for this $329 000 a year, or how many procedures would they perform?

Mr Canning: I could not answer that without doing some figures. For instance, I know that Ian Skinner is here most weekends because of his orthopaedic work. He puts in exceptional hours. I think that they all put in exceptional hours here. Sure, it is a high income, but there is the throughput as well.

The CHAIRMAN: How much of their practice is conducted here? Is it 70 per cent here and 30 per cent elsewhere, or is it 50-50?

Mr Canning: They do all their procedures here, because there is nowhere else they can do it.

The CHAIRMAN: They do it here. I am asking whether the $329 000 represents 40 per cent, 60 per cent of how much of their income?

Mr Canning: I am not sure what they would make in their private rooms. I really would not know. Only seven per cent of patients in this hospital are private patients.

The CHAIRMAN: Is there a private hospital here?

Mr Canning: No, there is nothing else here. GMF Health had a day surgery unit here up until three years ago. That was closed, and that created a fair number of problems for us, because everybody had to come here. This is the argument I have always put: they cannot utilise any other facility to take private patients.

Mr HOUSE: Did you say that seven per cent of admissions were private patients?

Mr Canning: Yes.

Mr HOUSE: Would a higher percentage of the population have private health insurance?

Mr Canning: Sure. When people come in here as public patients they have choice of doctor and they cannot get any better facility. We do not have a range of facilities here for which they can nominate; we do not have enough single rooms. A lot of them are allocated for medical referrals. Why would they come in as a private patient when they would have to pay the gap? Depending on what the doctor charges them, there would be a gap to pay. As you know specialists get more on the WA schedule than they do on the commonwealth schedule, which I have always had a problem with.

The CHAIRMAN: What is the schedule for a public patient of a visiting medical practitioner?

Mr Canning: A VMP gets the WA schedule, which is a combination of our own schedule and the commonwealth medical benefits schedule.

The CHAIRMAN: Plus the premium?

Mr Canning: I am not sure what you mean.

The CHAIRMAN: How does that compare with the maximum schedule fee that HBF Health Insurance approves for specialists? When they go above that fee they are wiped off HBF's

approved list and their patients cannot claim any gap? What is the schedule fee compared with the VMP fee, because that would be critical in the number of private patients attending the hospital?

Mr Canning: In a comparison between the two schedules, the WA rates have always been higher in the range of seven per cent to eight per cent. The new schedule comes out on 1 December. We are trying to move the WA rate closer to the CMBS. We would all like to see it the same as the CMBS. I do not think we should have a separate state schedule. Unfortunately, that has been the case for many years now.

The CHAIRMAN: There is no incentive for the doctors to treat private patients, because they will get more for public patients using the VMP system.

Mr Canning: I have had a number of discussions within the Medical Advisory Committee - I had one this morning - trying to raise the profile of our private patients. The argument I get is that they will not come as private patients unless they can get a single room. However, most of our single rooms are taken up by medical referrals. We have single rooms available in obstetrics to some extent, and we get more private patients in obstetrics. Most of our private patients are compensable. Not many private patients come through here. Monty is right; I am sure the number of people in this city with private health insurance would be high. We have one of the most affluent health funds in Australia, but people do not use it. People use the public facility.

The CHAIRMAN: That is one of the pressures on the health system.

Mr Canning: We are forever pushing to try to get doctors, but they want to know what is in it for them and for the patients. We have jazzed up a few things in the wards, but we need the doctors' support to do it. The only way patients can do it is if the gap is kept down. When the Australian Medical Association raises its fees, that increases the gap, and people do not want to come in and pay that.

Mr BRADSHAW: It is a disincentive to come in as a private patient.

Mr Canning: Yes, at the moment, because of the schedule. The sooner we can get the schedule down to the same figure as the commonwealth schedule the better. I know that it is getting closer, but it is not close enough.

Mr HOUSE: That is the WA schedule compared with the commonwealth medical benefits schedule?

Mr Canning: Yes.

Mr HOUSE: Is that achievable?

Mr Canning: I think that the decision should be made, but it is a question of timing. It will have an influence, particularly on general practitioners. That is because the visiting fee to see a patient in hospital is very small, and they are better off sitting in their rooms seeing patients rather than coming to the hospital. That means they will not refer patients to the hospital; they all end up coming through the emergency department.

The CHAIRMAN: Are there any doctors who bulk-bill in Kalgoorlie?

Mr Canning: I am not aware of any.

The CHAIRMAN: That is another problem.

Mr Canning: Some of them bulk-bill pensioners, but generally it is not a bulk billing town.

The CHAIRMAN: Do you have an idea of the average fee charged by the GPs?

Mr Canning: No, I do not go to a GP, so I am not sure.

Mr BRADSHAW: What is the waiting time like for outpatients when people rock up with a cold, a sore thumb and that sort of stuff as against accident victims?

Mr Canning: They go through triage to see what category we will put them in. It can vary. Going on our last data, we were well within the timeframes set down by key performance indicators. Yes, we have the aberration when a trauma situation occurs - as we did last week with the plane crash here. Generally, the KPIs are within the guidelines. People can wait two to three hours for a sniffle - a cold - and we suggest that they go and see a practitioner. However, a lot of the GPs do not open after hours. Only one practice in town opens until eight o'clock at night. Other than that the hospital is the only place open.

The CHAIRMAN: We are using the Skinner example because we stumbled across it this morning. What sort of mechanism do you have in place to check that the doctors do not send people here as public patients? Do you have checks and balances that show what is going on is nonsense and you need to pull it back into line?

Mr Canning: The big issue is inpatients and the contractual arrangement between the doctor and the patient. Normally they come in here with their consent form signed, whether they are public or private patients. That is arranged, and we do not get involved in that. That is the relationship between the doctor and the patient. Even though they can come in here as public patients, that is something they have to sort out with their doctor. Mostly they get a choice here between coming in as a public or a private patient. When the doctors bill us we check our records. We check the database to confirm that the patient was in hospital at that point in time - the dates the doctor says the patient was in. We check the operation and whether the procedure was performed. Those checks are made regularly on those cases.

The CHAIRMAN: What about a further check on whether patients have been billed separately? You do not have any idea do you?

Mr Canning: No.

The CHAIRMAN: You have no way of checking whether the doctor has billed the hospital and also billed the patient.

Mr Canning: We do not know that. We are on the Health Insurance Commission payment system. I am not sure whether that is compared with our data, or whether that is interlinked with commonwealth payments to private patients. We are two separate databases and I do not know whether there is any interlinking. One of the reasons we went over to the HIC system was that the overservicing issues would be picked up. I do not believe that has happened to its full extent at this point. It is operating only as a payment system. However, I see no reason that the database cannot be linked to whatever is being paid through Medicare. I do not think that happens.

Mr DEAN: How many beds and nurses do you have here?

Mr Canning: We have wards closed at the moment. We are running on 111 beds at the moment.

Mr DEAN: What is the breakdown?

Mr Canning: Unfortunately at the moment medical and surgical wards are joined; we have 34 beds there. We have 20 beds in maternity, 12 beds in the children's ward, 18 beds in the restorative unit, five beds in dialysis and five special care beds.

Mr HOUSE: How many beds are closed?

Mr Canning: We have a whole ward closed, which is 32 beds. That is through staffing issues.

Mr DEAN: How many nurses do you employ?

Mr Canning: Our staff is about 180.

Mr DEAN: How many beds do you have all up?

Mr Canning: That is based on 111 beds. That includes our special care units and other core units.

Mr HOUSE: What is the waiting time for elective surgery?

Mr Canning: Basically, nil. We have a short waiting list on eyes, because that is a visiting service. Ian Skinner may have a short list, but we do not have any waiting lists in this city.

Mr HOUSE: That is fascinating, yet you have 32 closed beds. Is that because of different medical practices in surgeries these days so that people are not staying in hospital?

Mr Canning: We had to close beds because we were not able to get staff. One way we could continue with the service level that we were providing was to join the medical and surgical beds. I was at a Medical Advisory Committee meeting this morning. We are coping quite well with that. It is not the ideal situation, but we have not deferred any surgery or admissions. We are still coping with the volume that we would have had when we had both wards open. Economically, you might ask why we are doing it. It is because it gives us a bit more flexibility. We do not have the staff to operate the two wards. We are drawing heavily on agency nurses. We have had as many as 40 agency nurses. We are not funded for it. It blew out our budget last year. We had to do other things to try to cope with the shortage.

Mr DEAN: So 40 out of 180 are agency nurses?

Mr Canning: Today we have 19 agency nurses. I am trying to pull that back. We cannot sustain those levels. The maximum I would like to see is 15. I would like to see them go altogether, because it is an impost on the health services. It is one of those things that should never happen.

Mr DEAN: From scuttlebutt, you have a high turnover of nurses in the outer areas such as Laverton and Leonora. Is that continuing?

Mr Canning: Overall the turnover in the Northern Goldfields Health Service is about 55 per cent.

Mr DEAN: Is that annually?

Mr Canning: Yes. It is ongoing. It has never been any different. That has been the case in the five years I have been here. Before that it was the same; it has never changed. It is a phenomenon in Kalgoorlie and this area.

Mr DEAN: It is extraordinarily high.

Mr Canning: It creates a lot of problems with staff orientation and staff development. We face those issues all the time because we always have new staff. We also have a lot of junior staff, and that adds problems as well.

The CHAIRMAN: Let us get back to the specialists whom you provide with rooms etc. What benefit is that to the hospital system, and do you charge them? Do you get a percentage of their fees?

Mr Canning: We provide it as a service to this community. Basically, we have 22 visiting services coming into this city from dermatology to ear, nose and throat specialists. We provide the rooms and they pay $20 for a clinic; that is it. We provide them with a room, and that is a service to the city. That has always been the case. It has not been different while I have been here.

Mr HOUSE: I am a bit confused about what would happen. Even if those 32 beds could be open, there would be no point in having them open. Are you saying that there is no waiting list for elective surgery; there is no problem in delivering services from that point of view, so there is no point having them open?

Mr Canning: You could put that logic to it. As I was saying, I was told this morning by medicos that that is an accountant's view of the world.

Mr HOUSE: In other words people are bypassing the system here and perhaps going to Perth?

Mr Canning: I do not think so. It is a result of better management of the beds. They are managing well. As I said this morning, I appreciate what they are doing. We are not keeping people in; their length of stay is reduced, although we are not sending people home unnecessarily. We keep them

here if need be. However, we are able to manage the community's hospital care with the beds we have at this moment.

Mr HOUSE: All I am concerned about is that we are not forcing country people into the city system and creating a problem there rather than using country facilities.

Mr Canning: We push hard to keep everything in this city.

The CHAIRMAN: Because you are so efficient we are considering sending some of the waiting lists from Perth to Kalgoorlie.

Mr Canning: If we had some of the specialist procedures here we would do them.

The CHAIRMAN: It would save us money. Have you done an analysis of the net cost per patient per visit. We are investigating the situation with visiting medical practitioners and some emergency departments are not operating with salaried staff, but with VMPs. You obviously have a pretty busy operation and staff. Have you broken down the net cost per service of the outpatient's operation?

Mr Canning: We have it available. There is a cost centre for the emergency department.

The CHAIRMAN: What are the figures? People are quoting us all sorts of figures, yet a VMP fee-for-service is $72 to visit an outpatient emergency centre. I would like the numbers officially. Do you have any indication of the cost?

Mr Canning: The medical side costs us about $600 000 a year just to have the residents there.

The CHAIRMAN: How many patients does that entail?

Mr Canning: We are talking 19 000, but there is the nursing staff on top of that.

The CHAIRMAN: Nursing staff would be there anyway. The other emergency departments also have nursing staff. We want to compare doctors with doctors.

Mr Canning: Residents cost us about $600 000 and the other cost is for general practitioners and specialists. Last week a heap of doctors were here when those cases came in. They were here for most of the night. That was an extraordinary event. However, generally the cost is around $700 000. There is pressure for us to put a physician in charge of the residents, which, once again, would cost us another $300 000 and more.

Mr DEAN: Would that be a director of emergency medicine?

Mr Canning: That is one thing we do not have here. We cover it through a combination of the specialists, and the GPs cover us for that as does the medical director.

Mr DEAN: Are you saying that your total is about $1.3 million for accident and emergency?

Mr Canning: I think I said the residents cost us about $600 000 a year and add perhaps another $100 000 for GPs and specialists when they are called in. Occasionally we use interns when they get busy. The figure is around $750 000 for that group of doctors.

Mr DEAN: Do you do 19 000 "look ats" for $750 000?

Mr Canning: From the doctors' side, yes. I would be cautious with that figure. I can get the figures formally, but I am just looking at the staffing numbers.

Mr DEAN: They seem low, that is all.

Mr Canning: There are residents and availability of GPs and specialists.

Mr WHITELY: Is the figure only an extra $150 000?

Mr Canning: I am guessing what that figure is. I work on an average of $150 000 for the residents.

The CHAIRMAN: Can you service outpatients for somewhere between $30 and $40 each using salaried staff doing 19 000 visits a year?

Mr Canning: Based on those figures, yes. The system works quite well here for the residents.

The CHAIRMAN: I am not questioning that. You have clearly demonstrated that.

Mr Canning: That is one area that works extremely well and I would not like to see it working any other way here. I know others do it and Geraldton and places like that have GPs running the system. We have the consistency. Sure, we have problems with Royal Perth Hospital when it does not send us residents and we battle because we must call the GPs in to help us out. However, generally we are pretty well serviced by those residents; it provides a very good service.

The CHAIRMAN: For how long do residents come in when they are seconded?

Mr Canning: Three months at a time.

The CHAIRMAN: Is their secondment to give them some country practice, which becomes part of their training?

Mr Canning: They get plenty of exposure and they really enjoy it here once they get here. It is a matter of trying to get them here. We have difficulty with most rosters in trying to get residents to come to Kalgoorlie.

The CHAIRMAN: Forget the hospital; how many doctors are in the town?

Mr Canning: There are normally about 21 or 22 GPs in town. There are five or six, depending on the day, in the Aboriginal Medical Services. There are four Royal Flying Doctor Service doctors.

The CHAIRMAN: The RFDS is separate.

Mr Canning: We have one at Kambalda, Leonora and Laverton. In all, there are about 30 to 35 doctors in total. Some work part-time and some work full-time. About 20 visiting specialist services come into town regularly.

Mr HOUSE: If you could improve the system in any way by waving a magic wand, what would you do?

Mr Canning: I think the VMP system works extremely well in the rural sector for the general run of the mill stuff and for normal medical admissions. It is the only way to keep doctors in the rural sector. We have had difficulty in the past. It took us nine months to get an orthopaedic surgeon. The general surgeon moved out of town a few weeks ago to go to the city. However, he felt it was not too good after all so he came back. He decided we did not treat him too badly at Kalgoorlie after all. It is always difficult filling those positions with physicians. We have been trying to fill them for three years. We still have only one staff and one living in town. We would like another physician. We have one paediatrician in town and we need two plus to work in the city and to cover the whole region because we outreach to the central desert.

Mr HOUSE: We will be talking to her later in the day. She made a written submission to the committee, which I thought was interesting.

Mr Canning: She may have a different view from us.

Mr HOUSE: I accept, as the chairman indicated, that you are doing a pretty good job. Are there any areas in which you feel a difference could be made? Does anything rankle that you would like to change?

Mr Canning: The thing that rankles with us all is the problem of agency nurses. We are all trying to drive change in that area. However, we cannot do without them at the moment. I would not have Laverton-Leonora operating if it were not for agency nurses. The cost impost of that is out of kilter.

Mr HOUSE: Can you walk us through the pay scale difference for an agency nurse?

Mr Canning: I do not think they earn all that much more money. The cost is driven up by what the company earns.

Mr HOUSE: Can you give me the cost to you of accessing a service?

Mr Canning: It is 30 per cent above the cost of employing our own staff.

The CHAIRMAN: Twenty per cent goes to the company. In Broome we were talking about tendering out specialist services. Do you see some merit in that? In other words rather than having a fee-for-service criteria as agreed by the Australian Medical Association in 1996, which is very high, they would tender out each of their services. Is that feasible here?

Mr Canning: To try to get the obstetrician back to work I broached that as a contracted service. It would be possible. It would depend how tightly the guidelines and specifications were drawn to ensure we received the service we wanted. Whether anyone would be interested in doing it is another matter. It is done elsewhere. I know obstetric services in the eastern States do it; and that is why I approached the obstetrician to do that here. We would desperately like to see our specialist obstetrician back here delivering babies because a number of women have to travel to Perth unnecessarily to have their babies. He is still holding out because there is an issue with medical indemnity. We are considering how we can accommodate that in other ways. It is a Pandora's box. Where do we stop?

The CHAIRMAN: If you do that for the obstetrician, you must do it for all the rest of the doctors.

Mr Canning: The income is reasonable. Compared to the premium paid by surgeons, obstetricians pay a high premium for the number of deliveries they do so they do not get a fair share.

Mr HOUSE: Do doctors not have their own insurance system?

Mr Canning: They are all medically indemnified.

The CHAIRMAN: They do but they have a different scale of fees.

Mr HOUSE: Do they not "out insure" with an insurance company?

Mr Canning: Medical Defence negotiates for them.

Mr HOUSE: For example, in Canada they have their own system.

The CHAIRMAN: We pay in but they go to "out insurance" because they do not take the risks. They "on-insure" with a company. There is no way even Medical Defence can take the risks. If they have 20 payments of $10 million each they would go broke.

Mr Canning: That is the issue now. Three significant cases have occurred in the past three weeks of claims against obstetricians and it has cost in excess of $20 million. We can see what will happen to the premiums next year. He will argue again and again. I think he has some valid comments. I think we need him in this city. He carries out an exceptional workload. We had the work he did reviewed about 18 months ago. The review found that the level of work he is doing would not be expected in the rural sector.

The CHAIRMAN: Other than those who are here, because they have their own arrangements, would it not be more feasible to arrange the services of some of the other VMP specialists who come in from Perth on a sessional basis rather than a VMP-type basis?

Mr Canning: We do not pay them. All we do under the visiting practitioner scheme is pay their air fares and accommodation if they stay over night. They bill their patients.

The CHAIRMAN: Are they not proper VMPs? You are not paying them out of your budget. They are therefore not VMPs at all.

Mr Canning: They are not paid out of our budget except for their airfares. The only difference is that two come from Royal Perth Hospital and we pay Royal Perth Hospital for their services.

Mr HOUSE: That is really interesting because it affects our figures. If Royal Perth Hospital is paying for a service that is being provided in the country, the figures we have are not a true indication of the expense in the country.

Mr Canning: Mark Thomas comes here to administer renal dialysis. I think we pay $800 for a day to Royal Perth Hospital. I trust that is offset against his salary, rather than put into some other bucket. You should not double count that dollar.

The CHAIRMAN: The amount of $800 is very low for a sessional doctor for a day.

Mr Canning: He is not sessional; he is salaried. Two salaried doctors come here from Royal Perth Hospital.

Mr HOUSE: You pay Royal Perth. That does not show up in your figures anywhere here.

Mr Canning: No it does not. They are not VMPs and that is what you asked for. The only other figure you asked for related to when we bring in the doctors who relieve our physician. We pay them $1 000 a day. They are listed and the other one is a psychiatrist. We do not have a resident psychiatrist. We have all visiting psychiatric services into town. We must pay them a daily rate, which is $1 300 a day. Those figures are in the figures I provided you with.

Mr HOUSE: Unless I can be corrected, the point I am making is valid. The figures we think are being paid for provision of a health service in a certain area are not inclusive of the figures that have been indicated to us. We should get those figures because they give us another dimension.

The CHAIRMAN: They would not be large but some extra money is involved.

Mr HOUSE: It may be different in other hospitals. I did not ask that question in Broome so I am not sure about those figures.

Mr DEAN: That double-dipping of salaries is worth following up because that was happening in Bunbury.

Mr Canning: The residents in Royal Perth were charging Bunbury and recouping it from Bunbury when they already had the money from the department.

Mr Canning: We have checked that out. They are not doing that here. However, I am not sure about the small ones. They are only small amounts.

The CHAIRMAN: It will not be big money. It will be only a few thousand dollars.

Mr Canning: It was thousands of dollars in Bunbury because they were charging them for the resident doctors, yet Royal Perth Hospital's budget had been loaded with that money and they were recharging Bunbury so they were trying to get it twice. It was worth a try!

The CHAIRMAN: If it is feasible to get these specialists you need here on a sessional basis and it is costing $1 000 a day is it not possible to get others up here on a sessional basis to take some of the pressure off? We do not want to destroy your service because you are doing a good job.

Mr Canning: That is the issue. It would drive the resident specialists out of town. If they end up not getting the income they are used to they will leave town.

The CHAIRMAN: They are substantial incomes.

Mr Canning: They work for it. I know it is an issue, but they put in the hours and the workloads and their availability is extremely good. We would not see that in the city.

Mr HOUSE: How do their salaries compare with, say, Ballarat, Goulburn or somewhere in the eastern States?

Mr Canning: The only time I hear about it is when the obstetrician tells me how much they earn over there.

The CHAIRMAN: They do not have visiting medical practitioner services over there. How does it follow?

Mr Canning: The only one I am aware of is the obstetrician who indicated they earn a heck of a lot more than he does.

The CHAIRMAN: Is that because he does more private work? If he does more private work, he could say that.

Mr Canning: He was talking about public work only.

The CHAIRMAN: How do they pay VMPs in places such as Northam?

Mr Canning: As I have said, some of doctors are on contract. They work out an agreement. The obstetrics service in places like Mildura is run on a contract basis from a group of obstetricians who have contracted with the health service to provide the service. The obstetrician would say, "Give me $600 000 a year and I will run the obstetrics service for you."

The CHAIRMAN: Do you think that "whatever you need we will provide" would be a better way of providing the service, because then there would not be the problem of over servicing?

Mr Canning: That is what I offered him. He said no.

Mr BRADSHAW: Does he do private work?

Mr Canning: He does not do much. His gynaecological work is about 20 per cent private and his obstetrics work is 10 per cent private.

Mr BRADSHAW: He stopped working here because of the indemnity in the public system.

Mr Canning: He cannot work anywhere else.

Mr BRADSHAW: Is he doing any private work?

Mr Canning: Not in obstetrics, because he cannot.

Mr BRADSHAW: That is what I am trying to find out.

The CHAIRMAN: He is basically taking two months holiday.

Mr Canning: He is doing gynaecological work only.

Mr BRADSHAW: Where do people have their babies delivered?

Mr Canning: We have six very competent general practitioner obstetricians in town. Although he is not doing deliveries, he is standing by and is helping them out. When there is an identified difficult birth ahead or twins, the woman will go to Perth in advance for delivery, which is, I agree, unacceptable.

Mr BRADSHAW: He might be running a risk if he does not have indemnity.

Mr Canning: He does not actually deliver babies; he gives advice to the general practitioners.

Mr WHITELY: You said previously that you did a cost-benefit analysis of the obstetrician. Was that with a view to having a look at the role of the visiting medical practitioner? What was the focus of that cost-benefit analysis?

Mr Canning: The only one we did was on the physician. We had experience of this when we had only VMPs in this town. We said that we would take on a physician if it meant providing a service to the community. In the 12 months, it is costing in excess of $350 000 a year for him; whereas the physician's costs were running out at about $200 000. We believe that we may be $100 000 to $150 000 out of pocket by having a specialist in town.

Mr WHITELY: You said you did a review of the obstetrician's work a year or so ago. What was that review?

Mr Canning: That was only a clinical review of the work he is doing here, because there were some concerns at the number of difficult deliveries being claimed. Harry Cohen came up here and reviewed all the obstetrician's difficult deliveries over a 12-month period to ensure that the difficult deliveries claimed were appropriate, and they were. He checked all of them and indicated that the

level or work the obstetrician was doing was far in excess of what should be done. He said that he was quite happy about it because otherwise they would end up in King Edward Memorial Hospital.

Mr HOUSE: In a general sense, how do you compare the average delivery of service here? If I were Joe Blow on the street with the average problems would the service I received be as good as I would get if I were a city patient in Osborne Park?

Mr Canning: If we are comparing the service at Kalgoorlie with the service at Osborne Park, yes. The only thing we have a problem with is staffing. The problem of keeping the continuity of services going is not so much on the medical side, even though we have had some gaps; it is allied health. We have not had speech therapists here for six months; we have had a visiting service from Perth. Someone will be arriving at the beginning of next month. Our waiting list for speech therapists is about eight weeks compared with nine months in the metropolitan area, so it is still not too bad. It is not good enough, because we have been used to a better level of service. No audiologists have been in this region for nearly 15 months, and we are buying a little bit of time from the Commonwealth on that. Those are the things we are missing out on that may be available in the city. I believe the service levels are extremely good here.

Mr HOUSE: What about the level of nursing skills and after care?

Mr Canning: It is quite good. As I said earlier, we have a lot of junior nurses here. We support the graduate program, which is one way of getting nurses here. We always retain about 50 per cent of them after their year here, which is good. We would like to see more clinical nurses here. We just cannot get them at the level we would like. That puts a lot of pressure on the junior nurses.

The CHAIRMAN: Were you at Osborne Park Hospital when it ran the obstetrics sessional program?

Mr Canning: Yes.

The CHAIRMAN: Did it work well? The fee for service cost for obstetrics seems very high. It means that the budget gets blown out. We have been told by the people running it now that it works really well.

Mr Canning: Obstetrics works well there because the clinics and so on provide antenatal treatment. There are resident doctors and the sessional specialists to oversee them. I do not think the system would work in any other way at Osborne Park Hospital, because it is still delivering something like 1 000 babies.

The CHAIRMAN: Why then are we talking about closing it?

Mr Canning: I think it is ridiculous. I spent half my life in Osborne Park Hospital, so I think it is a great place.

The CHAIRMAN: Exactly. Rockingham-Kwinana District Hospital cannot get any obstetric services, yet Osborne Park Hospital is working really well, and we are talking about closing it.

Mr Canning: It is one of the most efficient obstetric services in the metropolitan area.

The CHAIRMAN: How many services does it provide compared with a VMP-type service? We are trying to compare a sessional operation with a VMP service for which a doctor is paid a fee. Osborne Park Hospital was working on a sessional basis.

Mr Canning: The number of deliveries, the resident backup and the number of specialists at Osborne Park Hospital ensure that it works quite well. I cannot see it working any other way, because it is also running the clinics, instead of running those services out of its rooms. The doctors and the specialists there still think it is the way to go. They were given the opportunity to go back to VMPs, but they said no, that they wanted to stay working on a sessional basis.

The CHAIRMAN: Their salaries are about a third of what they could earn as VMPs.

Mr Canning: They still have their private practices, of course. As you know, a number of obstetricians went north and are working out of Port Hedland and Derby. With the volume of deliveries and the antenatal care given, the service works well.

The CHAIRMAN: Are you saying that you could not set up such a model here?

Mr Canning: We would not get the obstetrician to work with us on it, because it would reduce his income by two-thirds.

The CHAIRMAN: That is the problem. The system works.

Mr Canning: We would also have to employ residents and have them on stream. We could not get away with employing only the obstetrician. We would have to have two residents because of the availability factor. Osborne Park Hospital was a VMP-delivery hospital for many years until about 1984. It then converted to recruiting on a sessional basis.

The CHAIRMAN: Was that done on the basis of cost benefit?

Mr Canning: No, I think it was a government initiative. We were told we had to do it. The surgeons pulled out of the sessional arrangements and the anaesthetists maintained the sessional system for a number of years. However, I think has converted back. It still provides an obstetrics service. In Wanneroo at that time the general practitioners were involved, but that was a chaotic point-scoring system. We never had that at Osborne Park Hospital.

The CHAIRMAN: How long have you been here?

Mr Canning: Five years.

The CHAIRMAN: You obviously like it in Kalgoorlie. You are not looking for a career change in Perth, are you?

Mr Canning: No. I have had 35 years in this business. It may be that my time is coming to and end, but I hope not.

The CHAIRMAN: It appears that you have problems getting physicians to come here. Is that because there are not enough physicians or is there a more fundamental problem?

Mr Canning: I think it is a combination of things. There is a shortage of physicians. It is difficult to attract them to this city. We are working with the City of Kalgoorlie-Boulder, the chambers of commerce, the goldfields medical fund, the Chamber of Minerals and Energy, and the Shire of Coolgardie. We regularly meet a group called the Doctor Shortage Group into which a number of companies have put money in. We are advertising for physicians to come here with their wives and families to have a look around to see whether it is what they want. It is still not working. The Goldfields-Esperance Development Corporation will run an event in Perth tomorrow. We will follow that up with an Australia-wide advertisement in *The Australian*, which will be funded by the companies in Kalgoorlie, to try to attract people. It is not only about doctors; it is about allied health staff and nurses. We are plugging it pretty hard and working on it as a community issue. It was seen as our issue. I said that it was not only our issue; it was the city's issue. The community has got together now, which is great, to see what can be done. We are all working together for the one cause of trying to provide a service in the city and to retain staff.

Mr BRADSHAW: If you do not have some of those services -

Mr Canning: We have got them.

Mr BRADSHAW: How will you pay for them?

Mr Canning: It is a question of trying to make them better. For example, we have one paediatrician and we need two for the required coverage. Dr Christine Stokes cannot provide all the services that are required. She cannot be on call 24 hours a day, seven days a week. She has young children and a life outside. We must give them support. Currently we bring physicians here, which

is costing us in excess of $100 000, so it would be preferable to have our own person here, if we achieve that.

The CHAIRMAN: Do you have complaints from the general practitioners in the town about how busy your emergency department is? Yesterday it was indicated to us that there was some resistance from general practitioners towards people constantly going to emergency departments. Does that resistance exist in Kalgoorlie? You seem to be fairly well organised here. Do the doctors complain that they are not getting enough patients?

Mr Canning: No, we work extremely well with the medical practitioners in town. We have good liaison and work closely together. I bounce a lot of ideas off them. They are busy. We have had ups and downs with the number of general practitioners. The general feeling is that they do not need any more GPs. Once again, people must look after their income base. However, the time will come when two or three will go. We lost three or four earlier this year. It took a little while to get them replaced. Their loss creates a waiting time for the general public to see them. If people want to see a particular doctor they might sometimes have to wait a week, whereas if they shop around they can see a doctor sooner. I think that generally in this city there is a waiting time to get in to see general practitioners.

The CHAIRMAN: They can come here, can they not?

Mr Canning: They can walk in that door. If they have only a sniffle they may have to sit around for a while, but if they are suffering true trauma, they will be looked after.

Mr HOUSE: Can you give us a bit of an idea about indemnity insurance premium figures?

Mr Canning: The only case I am aware of is that of the obstetrician, because he is the one I am negotiating with at the moment. His premium this year is $55 000, which increased from $18 000 in 1996.

Mr HOUSE: Is that figure included in what you pay him?

Mr Canning: No, he pays that independently. That is his argument; he feels that he needs some support because 90 per cent of his patients are public, and we are not paying anything for his indemnity.

Mr WHITELY: Are those figures volume dependent?

Mr Canning: They apply whether they see one or 100 patients. There is talk that the premium will go to $100 000 next year.

Mr HOUSE: Are obstetricians at the high end of people paying insurance premiums?

Mr Canning: They are the highest.

Mr HOUSE: So that I am clear, that figure does not appear in your payment, but it is his payment directly.

Mr Canning: We do not make an ancillary payment to the doctors. They get a VMP payment and nothing more.

The CHAIRMAN: The VMP payments are very high, so it allows many things to be included in the payment.

Mr Canning: The new contracts have a rural attraction allowance, but no-one has negotiated a contract here, except a doctor at Leonora.

Mr BRADSHAW: How would an obstetrician be paid for a confinement?

Mr Canning: For a normal delivery he receives about $750 and for a difficult delivery about $960 to $1 080 from 1 December 2001.

Mr BRADSHAW: To earn $55 000, he would need to do a lot of deliveries.

Mr Canning: Yes. Last year I think the records show that he delivered about 90 difficult births and about 50 normal births.

The CHAIRMAN: That is $140 000, which is a heap of expensive operations.

Mr BRADSHAW: Half his pay is gone in premiums.

Mr Canning: That is right. I think he has a bit of a case compared with everyone else. We will not get another one. That is the point. There are no obstetricians out there. If we lose him, we have lost our obstetrician. We are trying to work out with him how we can keep him in the city.

Mr HOUSE: Do you go any deeper into the system? You said, for example, that you are involved in a graduate program for nurses, and visiting doctors come here as part of their training. Do you visit at university level to try to convince young people that it is a good thing to come here?

Mr Canning: We are always there. The students also come through here for allied health and nursing. We attend any graduations and student days. The GEDC is putting on an event in another forum tomorrow. We are part of that. We also have a project officer in Perth. The rural general manager has appointed her for 12 months to see what can be done with allied health. We are funding a project officer for nursing for 12 months to see how we can lighten the burden on the number of nurses we have.

Mr HOUSE: You made an interesting point earlier when you said words to the effect that once people get here they find it is quite a nice place. Most of us who live in the bush find the same applies to school teachers, policemen and whoever. Once they get there, they find that the little communities that we live in have a lot going for them. The problem is getting them over the hurdle of deciding to live there.

The CHAIRMAN: Do you have a process in place to ensure that the services have been provided for which VMPs are claiming payments?

Mr Canning: At Laverton and Leonora we check every record.

The CHAIRMAN: How?

Mr Canning: The health service manager goes through the dates and documentation in the records to check that the service has been done. In Kalgoorlie, because of the volume, we check everything against the health care system. We check the registers for the date, the procedure that has been done, and what is claimed. If we see an anomaly, we call for the records. We do only about a 10 per cent check on the records in Kalgoorlie.

The CHAIRMAN: Is it like an auditing process?

Mr Canning: Yes. We would need another couple of people to do a full audit.

The CHAIRMAN: In what percentage of the audits has there been a problem?

Mr Canning: It is mainly documentation. If there is no documentation, we will not pay.

Mr DEAN: We learnt yesterday in Geraldton that a very low amount of discharge documentation was completed. The hospital had to use a carrot and stick approach to get that documentation in place. What is the rate of compliance with discharge documents?

Mr Canning: It rises and falls. There are 400 discharge summaries outstanding as at last night. Some 170 are attributable to the obstetrician who unfortunately will not do them on principle at the moment. We are negotiating that issue. The resident doctors have not done the others. We had a discussion with them this morning so that they can get their act together. We have problems with about four doctors. We are always riding them. It is important to us under the current payment system that we get these records in, but there is an aberration because of the obstetrician.

Mr DEAN: Will you withhold payment until that is done?

Mr Canning: We have not. I did not want to get into a complete debacle with our obstetrician and precipitate his walking out of town, which I think he would do. There is still a bit of room for negotiation.

Mr DEAN: How many vouchers per year do you refuse?

Mr Canning: We have not refused any.

The CHAIRMAN: What about the other 230 doctors?

Mr Canning: You are meeting with Mr McGushin, the general surgeon. It is within his area of responsibility that the interns have not been completing the documentation. He was following that up this morning to make sure that it was done. The paediatrician is a little bit behind and so are two of the general practitioners. If we can get rid of the big backlogs of the paediatrician and the surgeon we will be better placed. We normally expect to have about 100 outstanding at any point in time.

The CHAIRMAN: Do you know who is responsible for some of the higher figures?

Mr Canning: They are for procedures only. There are two general surgeons, the orthopaedic surgeon and the obstetrician.

The CHAIRMAN: They must be the top four income earners.

Mr Canning: The other one must be the specialist anaesthetist.

The CHAIRMAN: There are a couple of others: one who earns $176 000 and one who earns $200 000 plus.

Mr Canning: Your figures are slightly different from mine, because they are off the Health Insurance Commission system. Ours are off our own system. Therefore, they are slightly variable.

The CHAIRMAN: We just want to get a handle on it and do not have the exact figures.

Mr Canning: The general practitioner anaesthetist is one of them.

Mr DEAN: To go back to what you were saying about insurance, do you have any evidence, beside anecdotal evidence, that premiums will skyrocket next year?

Mr Canning: I have only anecdotal evidence. In the eastern States premiums are much higher than in Western Australia. Their premiums have gone up significantly this year. As I said, they have gone up from $18 000 in 1996 to $54 000 this year. The goods and services tax component might be $5 000, but the increase is still fairly significant.

Mr DEAN: At what time of the year will the premiums be set - 1 January or 1 July?

Mr Canning: I think it is July.

Mr WHITELY: If you had an in-house obstetrician, what would be the cost of the insurance premiums, which would presumably be borne by the hospital?

Mr Canning: Our risk cover insurance this year is $800 000, but that includes all our workers compensation as well as our medical indemnity.

Mr WHITELY: Suppose that your hospital had a full-time obstetrician working through the same volume of patients as the current obstetrician from outside, what would it add to your insurance premiums? Would there be a difference or would you simply end up paying $55 000 on his behalf?

Mr Canning: He would be covered by risk cover, which would be the same situation that occurs in Port Hedland and Derby where so many people are covered by risk cover. There is a bit of risk involved, which is the trouble we have with our current risk cover. We must refund a pool every three years. We are paying in excess of $500 000 this year, which is throwing our budget out a little bit. If a claim were made, they would get us at some future time. The cost is not in the premium, even though they may push that up.

Mr WHITELY: The premium may initially be lower, but if claims skyrocket, three or four years from now you will get hit.

The CHAIRMAN: If there are no claims, it will go down.

Mr WHITELY: Is it a hospital-specific pool or is it a general pool?

Mr Canning: We have our own specific pool, so does Geraldton and everyone else. It depends on the claims experience.

Mr WHITELY: If a hospital had very few incidents, it would presumably have a very low premium.

The CHAIRMAN: It may go down.

Mr Canning: It should go down.

The CHAIRMAN: It should go down, but it does not necessarily go down.

Thank you very much for your presentation. Stefanie will be in touch with you for the information you said you would provide.