PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON MONDAY, 10 JUNE 2002

SESSION 1

Members

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

The committee met at 9.45 am

BENNETT, MR CRAIG ANTHONY
Chief Executive, Sir Charles Gairdner Hospital,
examined:

PLATELL, DR MARK
Acting Executive Director Medical Services,
Sir Charles Gairdner Hospital,
examined:

The CHAIRMAN: I welcome Mr Bennett and Dr Platell. The committee hearing is a proceeding of the Parliament and warrants the same respect as proceedings in the House itself. Even though witnesses are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you completed details of witness forms?

Dr Platell: Yes.

Mr Bennett: Yes.

The CHAIRMAN: Do you understand the notes attached to that form?

Dr Platell: Yes.

Mr Bennett: Yes.

The CHAIRMAN: Did you receive and read an information for witnesses briefing sheet?

Dr Platell: Yes.

Mr Bennett: Yes.

The CHAIRMAN: Have you made a written submission to the committee?

Mr Bennett: No.

The CHAIRMAN: Is there anything you would like to tell us by way of an opening statement?

Mr Bennett: No.

The CHAIRMAN: What are the employment arrangements for visiting medical practitioners or visiting medical officers at Sir Charles Gairdner Hospital?

Dr Platell: Visiting medical practitioners is a term used for fee-for-service doctors employed in the peripheral hospitals. As such, Sir Charles Gairdner Hospital does not have visiting medical practitioners working at its site. The doctors working at our site are a combination of specialists, junior medical officers and university appointments. VMPs per se do not come to our hospital.

The CHAIRMAN: We understand that. How are VMOs employed?

Dr Platell: They are employed at the peripheral hospitals; they are subcontracted to those hospitals.

The CHAIRMAN: What about the sessional doctors who are employed on a specialist basis and/or who provide specialist services?

Dr Platell: The sessional doctors are employees of the hospital. They are employed for periods of up to five years in numbers of sessions, from one through to eight. We have full-time doctors who are employed somewhere between eight-tenths and full-time. We have university employees who are generally full-time.

The CHAIRMAN: For how many sessions would a private specialist be employed?

Dr Platell: The usual number is three to five; the surgical people are generally employed for three sessions and the medical people are often employed for five sessions - a session notionally being half a day a week.

The CHAIRMAN: Are they paid on an hourly or a sessional rate?

Dr Platell: They are paid on a sessional rate of about $300 a session.

Mr DEAN: Is that true for both categories, the surgical and the medical?

Dr Platell: Yes. All doctors get paid the same amount when they are employees, based on years of experience as a specialist.

The CHAIRMAN: Is that a standard rate or is it specific to Sir Charles Gairdner Hospital?

Dr Platell: It is a standard rate across the metropolitan system in keeping with the AMA enterprise bargaining agreement.

The CHAIRMAN: An amount of $300 seems very low in comparison with what is being paid elsewhere and in the other States. Is there any explanation for that differential? That means $600 a day if they are working eight hours. Not too many people will work for $600 a day.

Dr Platell: That is true. Most sessional people are not working at the teaching hospitals for the dollars; they are working there for other reasons. The rate is determined basically as being one-tenth of what a full-timer would earn in the system. The new arrangement for a full-timer comes in at about $190 000 a year. So for each session they are getting approximately one-tenth of that amount. A lot of specialists, especially the surgical ones, lose money when they take up teaching hospital appointments. The money they forgo is not compensated for by the amount we pay them. They are putting something back into the public system, they are there because they like teaching, they like the milieu of the teaching hospital or the research opportunities offered by the hospital.

The CHAIRMAN: It has been suggested that the process of employing the VMOs is one of the problems in the training of specialists in Western Australia. The teaching hospitals have these VMO arrangements whereby specialists come in for only very short sessions, which has a negative impact in that they are not available to train new specialists. Have you found that to be the case?

Dr Platell: Generally not. The coverage of the specialty, the number of doctors covering it and the number of trainees is usually fairly well balanced and has a history, and there is a bit of give and take to make sure the balance is right. There are a number of specialties where that is still the case, but for the general medical or surgical things, the amount of training supervision versus the amount of work and the number of beds and the number of trainees is in good equilibrium.

The CHAIRMAN: Evidence presented to this committee has shown that there is a shortage of general surgeons. The AMWAC study indicated that the number of training places was supposed to be 21 - we currently have only 18 - but more importantly there seems to be only one graduate coming out of general surgery in the next five years. If you are telling me that is well balanced, someone has a problem.

Dr Platell: When I said well balanced, I meant anyone who is a trainee has adequate supervision within the system. It is not well balanced if you look at the total number of doctors being produced in this State and, therefore, the total number of specialists that are coming out of those trainees. We are training about 120 graduates a year at the moment; about half of those will go into specialist practice and about half into general practice. We are not training enough doctors to sustain the needs of the teaching hospitals for coming years. Yes, there are shortages in attracting people to general surgery, general medicine, orthopaedic surgery, vascular surgery, as instanced within the teaching hospitals.

Mr BRADSHAW: Are positions available for training those people?

Dr Platell: We have vacancies for junior medical staff across Perth. We bring in a lot of overseas-trained doctors to fill the positions within our hospitals. At last count something in excess of 200 junior doctors working in Perth had come from overseas. Yes, we do have difficulty filling spots for junior staff and for trainees.

The CHAIRMAN: You have trouble filling the spots, but is that because there are not enough students?

Dr Platell: Yes, not enough doctors to go around.

The CHAIRMAN: The evidence we have been given is that there are not enough training positions available in the hospitals; there are not enough specialists available to train. It is a catch-22 situation. Somebody is obviously telling a story. You are saying you cannot get enough students and the evidence we have received indicates that there are not enough training positions for specialists.

Dr Platell: There is a range of training positions and some are more desirable than others. General medicine as a training specialty is not as desirable as doing a sub-specialty area of medicine, like neurology, oncology or rheumatology. We do have some vacancies in those general areas but we do not have a high demand. We have over-subscription for the more desired training posts, and that is most of the specialist surgical training posts and most of the specialist medical training posts. We are short of staff in the general medical training and general surgical training area. People are not as interested in pursuing a career in those areas as other options.

The CHAIRMAN: What about the principle that there are not enough training positions available? Could you put on extra trainees tomorrow if they were available?

Dr Platell: Physically, I could put in some extra trainees, but there would be a limit because I do not have enough specialists to supervise those trainees. I do not have the beds or the budget to increase the workload to make sure that their training is meaningful. I could physically put them on, but unless I have some work for them to do it is not a very good training experience.

Mr DEAN: In the past couple of months we have learnt that an extra 40 places will be provided next year; it is still being debated whether that will be at Notre Dame University or the University of Western Australia. Are you saying that after those students have finished their six years, you may not be able to place them in a specialist category?

Dr Platell: We have untapped capacity for training people in the peripheral hospitals. I was talking about teaching hospitals. Peripheral hospitals represent the next step in training positions.

Mr DEAN: Have you looked at that issue? Peripheral hospitals are also of interest to this committee. We have seen that area as an untapped resource. Have you explored that area or is it just your gut feeling?

Dr Platell: No. I guess it is gradually creeping into the system and the training being offered in the peripheral hospitals is slowly increasing.

Mr WHITELY: A lot of those hospitals employ VMPs, and one of the arguments is that they are interested in throughput, and training is a barrier to throughput.

Dr Platell: It is.

Mr WHITELY: How would you see that problem being overcome? Unless you take them on as full-time employees, they may be reluctant to put the time in to train junior staff.

Dr Platell: You are quite right there. The benefit for them is that they have a pair of hands to help them with the work, so that they do not necessarily have to come back into the hospital to see the patients themselves. If someone needs an IV inserted or a medication chart written up, a junior doctor can do that for the specialist. The downside is that when they are in theatre or doing a procedure, they are probably slowed down by about 50 per cent while they are training.

Mr WHITELY: One of the arguments for VMPs is that they work faster on piece rates and give higher output. Given that there is a shortage of surgeons, we need high output but of course if the time is not put in for the training of staff in the future, you will have that problem. What possible solution is there?

Dr Platell: From a personal point of view, I would see a time probably not too far into the future when all doctors working within the metropolitan area are basically working on a salary or a sessional rate. The fee-for-service system has a place in the metropolitan area, but it is more to do with emergency call-backs out of hours as a way of keeping the staff in the system.

Mr WHITELY: How do you achieve the output? We have heard arguments that doctors have come in and said they have worked very hard, very fast and efficiently, and that is what keeps the health system going. How do you overcome that problem? Are they overstating the case?

[10.00 am]

Mr Bennett: I will give a practical example. I am the Chief Executive of Sir Charles Gairdner Hospital and I am also the acting chief executive of what will be the north metropolitan health service, which will include responsibility for the Osborne Park Hospital, Graylands Hospital and a range of community health services. Most of the surgical services at Osborne Park Hospital are provided on a modified fee-for-service basis. It is difficult getting a lot of multiday category 3 surgery done at Sir Charles Gairdner Hospital. Osborne Park Hospital has the capacity through free theatres.

The CHAIRMAN: We have had evidence of that.

Mr Bennett: We have negotiated the lists at Osborne Park Hospital whereby our salaried and sessional surgeons have started all-day lists. We will see the hybrid system that the committee has been talking about. Sessional doctors will work side-by-side with visiting medical practitioners. We believe that is sensible; it will enable work that is currently not done at Sir Charles Gairdner Hospital because of priorities to be done in an environment that does not have emergency department pressures, such as at Osborne Park Hospital. We think it is a win-win; we will see more of that. If we can demonstrate that it works, it will shore up the training opportunities. At the moment, trainees are not getting exposure to a range of cases at Sir Charles Gairdner Hospital and we need to demonstrate that they can get exposure to such cases at Osborne Park Hospital.

Mr DEAN: The people going from Sir Charles Gairdner Hospital to Osborne Park Hospital are not teaching at the moment?

Mr Bennett: Yes, they are.

Mr DEAN: At Osborne Park?

Mr Bennett: They are doing lists such as all-day lists, and including short-stay surgery. Osborne Park Hospital does not have an emergency department or a high dependency unit. The cases seen there have to be of a relatively short stay without any complications. After-hours care is provided by junior doctors rotated from Sir Charles Gairdner Hospital. That is a form of teaching and training. We work closely with the surgeons from Sir Charles Gairdner Hospital. We do not want to spread their work across too many sites. We would like them to work more geographically full-time; that is, we would like to create positions to have people working full-time in the public system because that helps with continuity of care. Because of the pressures on the emergency department at Sir Charles Gairdner Hospital, we think a sensible alternative is to use the capacity at Osborne Park Hospital. We have that up and running. If we can demonstrate that it works, it will develop into more of the teaching hospital environment.

The CHAIRMAN: What will happen to the visiting medical practitioners who are already working at Osborne Park Hospital? There is a conflict between sessional salaried doctors and the visiting medical practitioners because the VMPs are only interested in throughput and getting the job done.

The sessional doctors have responsibility for total care. How is it working there between the two types of practitioners? Is a problem being created in that some VMPs are being squeezed out of Osborne Park Hospital?

Mr Bennett: No. In doing this we negotiated carefully with the VMPs at Osborne Park Hospital. It was on the basis that the system would not substitute for VMP sessions. We are using sessions not used by the VMPs at Osborne Park Hospital. We wanted to use the theatre capacity at that hospital. We negotiated on the basis that it was a sensible thing to do for the benefit of our region. Ultimately, we will obtain a mix there that, from our point of view, on the surgical side, will not be a problem. It has not been a problem on the anaesthetics side either. All parts of the system know there are pressures and stresses and that they are mainly played out in the teaching hospitals. Hospitals such as Osborne Park Hospital can fulfil a role. The VMPs at that hospital are very supportive of what we are trying to do.

The CHAIRMAN: Teaching hospitals are developing allegiances to secondary hospitals not before time. It is something that has been very obvious to the committee from day one: that the major hospitals are individuals competing with one another rather than being part of the one system. Will it be extended to registrars? Swan District Hospital was not able to obtain a registrar because Sir Charles Gairdner Hospital and Royal Perth Hospital had huge numbers of them and no-one wanted to work there. In having a north metropolitan health service will it be possible to direct registrars to secondary hospitals to provide extra care?

Mr Bennett: It will happen in a sensible and agreed way. We have surgical lists up and running. For some time, we have had a general medical unit at Osborne Park Hospital. We have the only emergency department in our region apart from the Joondalup Health Campus, which is managed separately. We get a lot of people from the Osborne Park catchment area who, for example, fall over at home and attend the emergency department. Once patients have passed their assessment phase at Sir Charles Gairdner Hospital it is sensible to transfer them to Osborne Park Hospital because it is closer to where patients live. The general medical unit now has a capacity of 20 beds. In getting it up and running we have had to provide after-hours medical cover, which is not a feature of non-teaching hospitals. The quid pro quo is that Osborne Park Hospital has put in allied health staff and nursing staff. For us, that is a sensible way to go. We have a demonstrated record that we can make it work in the general medical area. The surgical area is far more sensitive because of the VMP issue. Ultimately, we are trying to manage the resources of our region in a sensible and integrated way in which Sir Charles Gairdner Hospital has a key role. We are convincing our doctors, both senior and junior staff, that the future in providing options for care and training is through working closely with places such as Osborne Park Hospital.

Mr BRADSHAW: Is this being done at Sir Charles Gairdner Hospital, because theatres are used full-time and there is no space available for the operations? Is that why they are being done at Osborne Park Hospital or is it because of spare beds?

Mr Bennett: We are doing it because of the pressures on Sir Charles Gairdner Hospital. We have commitments to a range of wait list surgery. If we are under pressure through our emergency department, we have a natural tendency to give priority to that area because it is immediate and needs to be dealt with. Therefore, elective surgery, by its very nature, can be deferred. Sometimes that is a painful decision, particularly if the surgery is category 1 or category 2. We have had situations in which some of the more routine surgery on our lists could not be done or given priority because of those pressures. We have made the decision that we can get such work done by doing it at Osborne Park Hospital. It is a sensible use of resources. The Royal Australasian College of Surgeons survey team visited us in February and looked at the accreditation of our advanced training positions. We explained what we were doing and they were very supportive of that move. It is reflective of what many major public hospitals in Australia are doing to try to counter the pressures that the major teaching hospitals are under. Our future is making integration between Sir

Charles Gairdner Hospital and Osborne Park Hospital work in a win-win way so it is not seen as a takeover by a teaching hospital, but something that will be of benefit to patients. We hope that it will get all doctors working cooperatively, although they may be remunerated in different ways.

The CHAIRMAN: Would it not be better if the whole system were integrated? The witness is talking just about Sir Charles Gairdner Hospital and Osborne Park Hospital but we have to consider Swan District Hospital, Kalamunda District Community Hospital and Armadale-Kelmscott Memorial Hospital. They should all be brought into the system. The witness is commenting specifically on Sir Charles Gairdner Hospital and Osborne Park Hospital. We need integration across the board; not just for those two hospitals, but all secondary hospitals. Those other hospitals have a shortage. There is spare capacity and we need to use resources in the best way possible. Extra training positions will be created by using secondary hospitals. That will enable more specialists to be trained. Why are we sticking just to Sir Charles Gairdner Hospital and Osborne Park Hospital rather than including the other hospitals?

Mr Bennett: I am responsible for Sir Charles Gairdner Hospital and the north metropolitan region. The points made are issues for the system, but I accept that they are reasonable issues to be progressed. The history, personalities and issues are very different across the metropolitan area.

The CHAIRMAN: I understand that but it appears that each hospital operates as an individual unit. It may be a hangover from the previous Government whereby it wanted competition between hospitals to create better productivity. It appears to be a fallacy in health to have individual hospitals competing with each other. It only pushes up the rates for the VMPs and creates artificial shortages of doctors. If we had an integrated system in the metropolitan area - which most other jurisdictions have - we would have a better use of resources whereby we can use the spare capacity at Osborne Park Hospital. The committee was shocked to hear that Osborne Park Hospital had spare capacity yet we read in the newspapers that Sir Charles Gairdner Hospital and Royal Perth Hospital have problems dealing with what they have. We now hear about spare capacity that is not being used because one area was not talking to another.

Mr Bennett: I have great sympathy for what you say. I am doing my bit.

Mr DEAN: How long has this been done? Is it early enough to show any tangible outcomes from the point of view of Sir Charles Gairdner Hospital?

Mr Bennett: The general surgical lists started a few weeks ago. The general medical unit at Osborne Park Hospital has been up and running for more than one year. We have had other initiatives that reflected different funding sources that also worked; for example, an orthopaedic step-down unit whereby multiday category 3 elective orthopaedic surgery was done at Sir Charles Gairdner Hospital. Typically, two or three days after surgery, patients were transferred to Osborne Park Hospital for the completion of their rehabilitation prior to discharge. We are looking at a range of initiatives to bring back that sort of thing. They were funded under initiatives of the Central Wait List Bureau. We have to find the money to do that in our allocation. We have a fair degree of goodwill with Osborne Park Hospital. We have worked closely with it and we will see more of those sorts of initiatives. In the relationship between teaching and secondary hospitals I believe we have demonstrated what can be done.

The CHAIRMAN: Are the specialists working at Osborne Park Hospital taking their trainees with them? Are specialist training positions going to Osborne Park Hospital?

Mr Bennett: Not at the moment.

The CHAIRMAN: Will it happen?

Dr Platell: It will be a natural evolution of the process.

The CHAIRMAN: Will there be more training places available? Will more specialists be trained at Osborne Park Hospital if more work is done there?

Dr Platell: If more cases are being looked after it provides the capacity to provide more training positions. If funding is provided we can train more people.

Mr DEAN: How long will it be before the surgical lists at Osborne Park Hospital will have an impact on Sir Charles Gairdner Hospital? Will it be one month or six months? How long will it be before it can be said that the pressure has been reduced because of outsourcing surgical lists to Osborne Park Hospital?

Mr Bennett: I cannot give a definitive time frame. We will look at it very closely, evaluate the outcomes and make sure that cases are not going back to Sir Charles Gairdner Hospital with complications. All our initiatives at Osborne Park Hospital have been subject to careful evaluation to ensure that it is good for both hospitals. It is a sensible thing to do and we want to see more of it.

Mr BRADSHAW: Funding is a very important point. With more throughput, costs will rise. Are the budgets being managed so that this can occur? Obviously, the hospital is not getting a large increase in its budget. I suspect that will be the telling point. I believe that Osborne Park Hospital has closed 110 beds because of a lack of funding. How will that difficulty be overcome?

Mr Bennett: As we move from individual management arrangements for all hospitals to that of a regional structure, we will deal with that. I am the acting chief executive for the north region and I have been given an indicative allocation for the region for 2002-03. It gives me greater ability to look at issues like that. I have lots of performance targets with financial outcomes and waiting lists. I have to ensure that resources are used as sensibly as possible. I have greater scope to do that. There is a great degree of goodwill in working through the issues with Osborne Park Hospital.

The CHAIRMAN: Does it mean that there will be specific cost savings through the new structure? Will they come from looking after half the metropolitan area?

Mr Bennett: No, it is a larger budget but it provides more flexibility using resources in an integrated and sensible way. If that means looking at the pressures that Sir Charles Gairdner Hospital is under because it is the only hospital in my region with an emergency department and balancing that with a reasonable amount of elective surgery, then, yes, I will look at where the work can be done in the region.

The CHAIRMAN: Are visiting medical practitioners a hindrance to the process? Is there a role for VMPs in the metropolitan area?

Mr Bennett: I understand the history and why they were introduced in the metropolitan area some time ago. It is fair to say that metropolitan Perth is probably the only metropolitan area in Australia in which these arrangements exist. It is a different argument in country areas. Over time, the proportion of salaried sessional work in non-teaching hospitals will increase. Whether that comes from a policy decision by the Government or by evolution, I do not know.

Mr DEAN: Dr Platell said that he sees an end for the VMPs in metropolitan areas. What leads to that conclusion? Is it possible to put a time on that?

[10.15 am]

Dr Platell: I am a bit like my colleague here. There are a lot of small 'p' politics involved with changing the system and it has happened in every other capital city in Australia. It is inevitable that it will happen here, it is just a matter of when and not if. When junior medical staff are placed in these hospitals there is a compelling argument that the nature of the work is changing from a production line, which is pushing patients through, to a training and research environment. It becomes more like a teaching hospital with a learning and research orientated environment and at that stage, the role of the visiting medical practitioner is not warranted.

Mr DEAN: The problem with that is that with the private system working side by side with the public system, the best and brightest doctors may go to that area. Those receiving commonwealth medical benefit scheme payments and so forth would probably stay. Is there a danger that the

public system may become second-rate because good visiting medical officers are working privately?

Dr Platell: We have the best and the brightest medical officers already working in the teaching hospitals. It is a competitive employment environment and we get the cream of the crop applying for teaching hospital positions.

The CHAIRMAN: Is that because of status?

Dr Platell: It is hard to quantify the reasons but that is one of them.

The CHAIRMAN: It seems strange that someone could earn a $2.5 million salary or work for a teaching hospital for $190 000.

Dr Platell: Many doctors cannot explain it and keep saying that their wives tell them that they are mad. They do not know why they keep working in a teaching hospital. It is hard to explain but it is not just about dollars. There are many other drivers that bring people into teaching hospitals.

Mr DEAN: Some doctors might be going to work at Sir Charles Gairdner Hospital only one day a week, and still do a lot of work at the Armadale-Kelmscott Memorial Hospital, Swan District Hospital and so forth and still be in the public system. However, if they are not going to be paid the current VMO rate, they will withdraw their labour and work at the private hospitals. Doctor who are then in the position of working one day a week at Sir Charles Gairdner Hospital and four days in the other secondary hospitals in the public system will not continue to do so.

Dr Platell: I hear that argument. However, if they need to work and there is not enough work in the private area, then they must work somewhere.

Mr BRADSHAW: You foresee that there will be more salaried doctors teaching at secondary hospitals. However, the throughput will not be there and the waiting lists could get larger. How is that problem overcome?

Dr Platell: The teaching hospitals tend to be innovative with new technologies, techniques and ways of looking after patients. They are already dealing with things like day care, day surgery sites, day surgery admissions and a range of new technologies. It is not a matter of just continuing to do what you do to get the best value out of the system in terms of patient throughputs or value for dollars. If there are salaried people who have the time to sit down and to think, plan and participate in the ongoing management of the hospital, it makes the hospital more efficient. However, if people are paid for each procedure they perform, there is no incentive for them to be involved in the running of the hospital to help it evolve. There are the paybacks in the teaching hospitals from having doctors involved in the management of the hospital, which is not as apparent in the peripheral hospitals.

Mr WHITELY: It is interesting that you should make that point. When we visited Sydney and Melbourne, a common comment was that by giving doctors a sense of ownership in the running of the hospital, they were far less worried about the dollars they earned and the argument of disappearing for higher dollars elsewhere. What practical things are you doing to give doctors that sense of ownership and to let them have a greater say in running the hospital?

Dr Platell: In Sir Charles Gairdner Hospital the management has devolved down to a clinical level so that the hospital has an executive that comprises 17 people, 12 of whom are practising clinicians - six doctors and six nurses. They are very much empowered in the running of the hospital. This is a comparatively new management exercise of empowering clinicians with -

Mr WHITELY: Do they make budgeting decisions?

Dr Platell: Yes.

The CHAIRMAN: How long has this been in place?

Mr Bennett: Since 1996 following the revolution in the national health service to establish clinical directorates and to have practising clinicians lead a directorate system. As Mark said, we have a devolved management structure with six clinical service units in Sir Charles Gairdner Hospital. They are led by a medical and a nurse co-director who sit around the executive table. The clinicians around the table participate fully, and often robustly, in discussions about priority setting for the various initiatives that we would like to bring on stream and where the savings will be found to live within the allocation that is given.

The CHAIRMAN: I will now go off on a different tangent. In the eastern States there is a registrar rotation system in place within the teaching hospitals. Have consideration been given to doing that in WA whereby, as part of the registrars' training they are compelled to spend at least 12 months at one of regional hospitals, whether it be in Kalgoorlie, Geraldton, Albany, Bunbury or wherever, on a rotational basis? This guarantees then that the trainees are exposed to that sort of medicine but, more importantly, the hospital is exposed to the possibility of someone staying and working in that regional centre.

Dr Platell: It has been considered and has been in place for a number of years at various levels. At any one time in Sir Charles Gairdner Hospital there are 39 registrars who work outside the main hospital. They are working at Osborne Park Hospital, Joondalup Health Campus, Hollywood Private Hospital, Port Hedland Regional Hospital and one hospital in the community -

The CHAIRMAN: Is that a compulsory part of the process? In Sydney the registrars had to do 12 months in a regional centre.

Dr Platell: It is not compulsory but in the advertisements for the positions it is stated that a certain number of positions are rotational through country or peripheral hospital posts. When people apply for these positions it is understood that they will not be spending all their time at Sir Charles Gairdner Hospital.

Mr WHITELY: What proportion of them go to the country?

Dr Platell: There is only one position at Port Hedland from Sir Charles Gairdner Hospital.

The CHAIRMAN: Is there a possibility of getting more of those placements in the regional centres? Hollywood Private Hospital, Osborne Park Hospital and those places may be rotational but only within the metropolitan area, which is of no help to the system. The system has a shortage in regional centres. The eastern States, especially Sydney, are forcing the registrars to do at least 12 months in a regional centre.

Dr Platell: They can be forced, as a condition of employment, to take those rotations. Some rotations are more attractive than others. As long as there is teaching and meaningful clinical work at the rotations, then they are popular and valued and people will compete for them. When registrars get transferred to a peripheral hospital and there is not the level of supervision that they feel they need or the training, those positions become unpopular and people do not want to go there. If the training system is good at these rotations, the trainees will go there.

Mr WHITELY: Some of the regional centres in New South Wales are much larger than those in Western Australia. Do you see that as being a barrier? For instance, a place like Port Hedland has a population of only about 5 000.

Dr Platell: It is a barrier but it depends on the standing of specialists at the place. If they love teaching and have a lot of input into the training of these people, then word will filter around the system and it will become a popular term. There are other practical considerations like, for example, accommodation, which does not exist for families up in Port Hedland. If a trainee is married with children there is not the lifestyle to accommodate a family, which is a problem at some sites. The single doctors tend to provide the recruitment pool for regional placements. As part of the training program for registrars, weekly educational sessions are run from one of the teaching hospitals, and they are highly valued as part of their ongoing training. The trainees feel that if they

go away for three months on a regional placement they miss out on those things. We need to be smarter in terms of giving them telelink access to ongoing educational services, which are sporadic at the moment and not formally linked to the training program. However, with better linkages and well-known educators at the peripheral sites we can get people out there.

The CHAIRMAN: We have seen examples in the eastern States of outpatient clinics that have operated in a way that is more financially viable for the States - to put it in a nice way - than cost-shifting back to the Commonwealth. Have consideration been given to the possibility of outpatients being attended to by outside teams and pushing the costs back to Medicare? More importantly, have we any system for dealing with privately referred non-inpatients, which means that the Commonwealth pays for those patients? In Sydney a system has been in operation for a while in which the hospital does not admit the patients but rather, they are called a day surgery case and the hospital can therefore charge the Commonwealth. Indications are that this provides a huge saving to the system in the vicinity of $500 million or $600 million a year. It is not a small amount money. Have we such a system in place, what are we doing about it and how difficult is it to implement?

Dr Platell: We have certainly considered this and we have been looking with jealous eyes at the dollars that the eastern States hospitals have been able to raise through these initiatives. We have been considering it in this town on and off for the past 10 years. Princess Margaret Hospital for Children first put its toe into the water with these initiatives about 10 years ago. There have been a number of initiatives system-wide to coordinate it but they have been blocked for a variety of reasons at a state health department level or a political level above that. As we speak now there is certainly another group -

The CHAIRMAN: Why would anybody at a state or a political level stop an initiative that will save, in our case, $60 million to $100 million?

Mr Bennett: There is the fear that the Commonwealth will claw moneys back under the Medicare agreement if it sees discernible cost shifting.

The CHAIRMAN: That is okay but it has just cost shifted to us by not increasing the Medicare rebate and forcing those costs back onto our emergency departments. Should we ask the Commonwealth to give us back the money that it has just cost shifted to us?

Mr Bennett: You must appreciate that we are not policy makers.

The CHAIRMAN: I understand that, I am just worried that our bureaucrats and our politicians in the past have not made those decisions which are costing us, in comparison to the eastern States, in the vicinity of $600 million. That is a lot of money for a health system.

Mr Bennett: Absolutely. The other States have been doing it for some time. I have been in Perth for only three and a half years, and Western Australia was always conservative about these matters. The Commonwealth is clearly aware of what is going on and probably has a more robust attitude about cost shifting. It has indicated that if it were done, then it would look at the Medicare payments. We are just about to head into the process for renegotiating the next five-year Medicare agreement. However, we are interested in that system, and system-wide work is going on at the moment, led by Dr Amanda Frazer, to look at these options. We are considering what is being done interstate and we are particularly interested in what is called the Westmead model, which you may have heard of -

The CHAIRMAN: We went to Westmead Hospital and were well briefed on that.

Mr Bennett: We have taken legal opinion and also had discussions with the Health Insurance Commission about its view on these matters. At Sir Charles Gairdner Hospital we only have a few of those types of private non-inpatient referred clinics, and they have generally been set up separately from the hospital. Entities have been established on the Queen Elizabeth II Medical Centre site providing services in areas such as sleep disorders, bone density and pain management.

By and large, we have not gone down that path to any great extent at all. We need a system-wide decision to be made on what will be done and how the political ramifications will be managed.

The CHAIRMAN: What about the system whereby emergency departments are broken up and doctors provide Medicare-type arrangements? Level one, two and three patients are looked after through the hospital system but level four and five patients - those who should go to their general practitioners for treatment - are put back into that system by an arrangement of the hospital. Is that being considered by Sir Charles Gairdner Hospital?

Mr Bennett: Not that I am aware.

Dr Platell: I will challenge the assumption that level four and five patients should be seeing their GPs and are not serious patients.

[10.30 am]

I would like to make two comments. Firstly, even with the fours and fives, one in five will require admission to the hospital. Many of the fours and fives are referred from general practitioners who are unsure about what is going on with the patient, and they want a specialist opinion or an urgent appointment to get them into the outpatient clinic system. Although they may not require acute attention, many of the fours and fives still require a significant amount of attention or investigation to quickly establish what is going on. A general practitioner has between five and 10 minutes to work up a patient, but even at level four and five such patients may take more time to work up, so they are not necessarily just GP cases.

The CHAIRMAN: The clinics are already on hospital property. Therefore, in such circumstances they are referred into the system. It is a matter of looking at who is paying and of getting more dollars into the state health system. That is the basic idea. There are no ifs or buts about it. The Victorians are absolutely professional when it comes to getting the federal Government to pay for things that the State is doing. This is just another way of trying to increase the share or the burden of the federal Government, rather than letting it fall on the State Government.

Dr Platell: There is the capacity to run GP clinics in association with or nearby to emergency departments, but a lot of the work that we are seeing in our emergency departments is not suitable for GP practices. That is a general statement. There are exceptions when we consider after-hour and weekend attendances when general practitioners are not open. Such patients are coming through to the emergency department.

The CHAIRMAN: I am talking about the after-hour operations and not the normal day-time operations.

Mr WHITELY: Over the past nine months there has been a decline in the number of Medicare payments -

The CHAIRMAN: It has been 0.6 per cent in a quarter.

Mr WHITELY: The previous two quarters were 0.9 per cent. That is 2.4 per cent in the past nine months. Dr Kerryn Phelps stated that this was because the payment was too low. This translates into emergency departments seeing different types of patients, and more of the patients that should be seen by the general practitioner. Have you noticed a trend along these lines?

Mr Bennett: I have some material that I am happy to provide to the committee. If we look at what has happened in our emergency department over the past five years, a couple of things stand out. There is no doubt that the numbers have increased. Five years ago there were 34 000 attendances in our emergency department. This year the figure is 37 500. Members of the committee are probably aware that we are in the process of planning and designing a new emergency department, which is our one chance to get it right for the next couple of generations. We are planning an emergency department that will have the capacity to handle 45 000 attendances. That will give members some idea of the growth that we envisage. One of the remarkable things that has happened is that when I

first arrived in WA, Sir Charles Gairdner Hospital was admitting just over 40 per cent of people who were attending at the emergency department. This is shown on the graphs that I have just handed out. Over the past couple of years, that admittance rate has headed towards 50 per cent. That indicates that people who present to the emergency department are, by and large, in need of care at the emergency department, and they are being admitted in greater numbers and in a greater proportion. That tells us that we do not necessarily have such a great problem with fours and fives. We do not have a nearby general practitioner clinic, but the Hollywood Specialist Centre has an after-hours GP service to which people can go. That does not take a great load off our emergency department. Typically, we are seeing many older and sicker people at the emergency department who are, by and large, being admitted closer to 50 per cent than before. They require the services that we can provide. If members have a look at some of the graphs, they will see that that has had a great impact on a major teaching hospital like Sir Charles Gairdner Hospital, because more of our work is driven by what comes through the door in our emergency department, and this has put pressure on elective work.

The CHAIRMAN: Between 1999 and 2002 there has been an eight per cent increase. That is a huge increase in numbers when we consider that Medicare has dropped by 0.6 per cent, which is two and a half million claims in a quarter.

Mr WHITELY: It is in a year.

The CHAIRMAN: Even if we take 10 per cent, it makes a helluva difference in the pressure that is applied to your system, because treatment is free at the State's public hospitals but we have to pay when we go to our own doctors. People will go to outpatient services or emergency departments for treatment. We must acknowledge that and get the funds from the federal Government, because it is putting extra pressure on the State system.

Mr BRADSHAW: The material just handed out refers to DIR and WL. Will you explain their meanings?

Dr Platell: DIR refers to direct admissions that come straight from the outpatient clinic or from a doctor's room. WL refers to off the wait lists, and that would be categories one, two and three from the waitlists.

Mr Bennett: Category ones are those that clinically should be done within 30 days. Category twos are those that clinically that should be done within 90 days, and category threes are those that clinically should be done after 90 days.

Mr WHITELY: I am trying to reconcile what seems to be conflicting trends. There are fewer Medicare payments and you have stated that the people who are coming to you are sicker because they are being admitted in high numbers. Could it be that people are choosing not to go to their local GP for financial reasons, their conditions become worse, and they then present themselves to the emergency department?

Mr DEAN: Is it more of a reflection of the demographics and that more older patients are showing up in the system?

Mr Bennett: It is a mixture of both. The reality is that we have noticed the considerable increase in the numbers of people who present to our emergency departments. Overwhelmingly, they are older, sicker and, I understand, disproportionately female. We do not know a lot about the sequence of events in terms of the alternative forms of care that such people have sought. A major five-year study was recently launched that will look into emergency presentations across the system in the metropolitan area of Perth. It will look at the outcomes in terms of what happens to people when they present at emergency departments, how long they stay in hospital and what happens to them after they are discharged from hospital. We have noticed the effect. We have anecdotal views about the pressures. Like members of the committee, we see bits and pieces of evidence, and we are also trying to work it out. It is probably a combination of people who are not going as often to

the general practitioner because there are fewer general practitioners who bulk-bill, and when they present at our door they are sicker and therefore require more resources, stay longer and the like.

The CHAIRMAN: There are more people and they are sicker - it is a double whammy.

Mr WHITELY: It is the cost shifting from the federal Government to the State Government that is resulting in people getting sicker, and that results in a greater burden on the health system. They might be admitted when it was not necessary.

Mr Bennett: If we look at the interactions between the Medicare-funded general practitioner system and the public hospital system, which is 50-50 Commonwealth and State, the cost shifting argument is a very sophisticated one, and it does not necessarily go one way all the time.

The CHAIRMAN: Exactly. However, there seems to always be only one argument: that the States are doing untoward things to the Commonwealth and not the other way around.

Mr Bennett: The member is correct. If there are pressures in general practice, or if people require drugs that they cannot afford in the private system, they turn to the public system. That is an example of how the State is picking up a disproportionate burden.

The CHAIRMAN: I turn now to the pharmaceutical benefits scheme. Victoria has a formal agreement with the federal Government to use the PBS system for the supply of drugs at its teaching hospitals. The Victorian health department indicated that this saved it about $40 million a year. Is such an arrangement in place in Western Australia? The Victorians were surprised that other States were not active in taking up the program, given that it is a formal agreement for which the federal Government has agreed to pay.

Dr Platell: It will happen. The committee that is charged with implementing the system is conducting its first meeting at 3.30 pm this afternoon. We have been doing our homework about the implications that such a program will have, and we will start running pilot sites before moving it across the system.

The CHAIRMAN: Is it an across-the-board system or is it just at your hospital?

Dr Platell: It is for all public hospitals. Basically, the agreement states that we can issue PBS scripts for which the Commonwealth will provide the money. I assume the Commonwealth will take back the money by altering the subsidy in subsequent years. There is a cost to the system in implementing the guidelines. We must have a computerised billing system and a computerised communications system with the Commonwealth. We must also agree to implement pharmacy guidelines. These are good practice guidelines that should be happening anyway. There are small costs associated.

The CHAIRMAN: Being a pharmacist, I know that the compliance costs are pretty minimal. It is about $30 000 for a normal operation. It is not a huge cost, and it is of great benefit. The implementation of that system will be a saving. Will any hospitals look at their own prescribing lists, because the PBS is a narrow schedule? As indicated by Mr Bennett, when people cannot afford $1 000 for a drug that is not on the PBS list, they will go to the public hospital system and get it for nothing.

Dr Platell: We have an agreed drug formulary at Sir Charles Gairdner Hospital. There is a drugs and therapeutic committee that evaluates whether a new drug should be added. Any time a specialist at the hospital wants a new and expensive drug added, he must prove that a certain drug is useful for a certain condition or for a particular patient. If such evidence is forthcoming, the committee will agree to issue the drug as a general formulary drug or for a certain patient or class of patients. A new committee is being formed to coordinate the thoughts of all the drug committees around Perth, so that each teaching hospital is consistent in the way it develops its formulary and in the way the drugs are supplied on the formulary.

The CHAIRMAN: I turn now to hospital trust accounts. Will you brief the committee about the way in which trust accounts operate at Sir Charles Gairdner Hospital? Do you have trust accounts at Sir Charles Gairdner Hospital? What is their scope? What is the nature of such funds? How do they arise, and how are they administered?

Mr Bennett: I will set the scene by saying that the hospital operates three bank accounts. Not surprisingly, they are called account No 1, account No 2 and account No 3. Account No 1 is the hospital's normal operating account. Account Nos 2 and 3 were set up in 1989 with Treasury approval. They are the two accounts in which special purpose funds are accounted. Account No 2 essentially deals with research moneys that come into the hospital and with donations that are made to the hospital. Account No 3 deals with the clinical staff education fund. Under private practice arrangements, our doctors direct some of their private practice earnings in favour of study leave, conferences, seminars and so forth. Under certain conditions that are overseen by a committee, doctors can draw down on their accounts to attend overseas conferences and seminars. All funds at Sir Charles Gairdner Hospital - irrespective of whether they are in accounts one, two or three - are deemed to be under the control of the hospital. Special purpose funds are managed by the hospital in accordance with the Financial Administration and Audit Act, and with hospital policies.

The CHAIRMAN: Therefore, are there no true trust account funds?

Mr Bennett: We have to make a distinction. The two trust accounts that I would regard as trusts are separately identified. They are the Queen Elizabeth II Medical Centre Trust, which has its own accounts and provides its own report to Parliament; the other trust fund is the Foundation For Advanced Medical Research. If we put them to one side, we have 383 special purpose accounts that are accounted for in account Nos 2 and 3.

The CHAIRMAN: We are interested in the 383 accounts. They are special purpose accounts that are not with a trustee and/or supervisory body. However, they consist of funds from doctors who have private practice rights at the hospital. Such doctors can put money into these funds on the understanding that they can draw down on them for related purposes. Is that correct?

[10.45 am]

Mr Bennett: Correct. However, the hospital has the clear view that all those moneys come under the control of the hospital and that the use of those funds must comply with the Financial Administration and Audit Act and hospital policies. I can table for the committee hospital policy Nos 107 and 153, which deal with the oversight and the financial delegations in the hospital and, in particular, the financial administration and governance of hospital special purpose trust and blend accounts.

The CHAIRMAN: When did they come into vogue?

Mr Bennett: Hospital policy No 107, which is the financial delegations document, was originally issued in July 1996 and was last reviewed in April this year. Hospital policy No 153, which is the financial administration and governance of hospital special purpose trust and blend accounts, was originally issued in June 2001. I also have a statement of account No 2 and account No 3. Just to give the committee a little background, account No 2 contains all the National Health and Medical Research Council research grants that our doctors win competitively. That money comes into the hospital. Once it comes into the hospital, it is governed by those policies and procedures and must comply with how we deal with all moneys. It also covers other things. For example, when Charlies had its own board, Fred Johnson was a former chairman of the board, and he donated money to the hospital. Every two years a scholarship of up to $10 000 is provided to a full-time hospital employee to go overseas and pursue studies in hospital administration. We have just awarded that scholarship for 2002. That account is a special purpose account, which comes under account No 2. Account No 3 is essentially for the doctors who, under their private practice arrangements, contribute some of their private practice earnings in accordance with their industrial agreement.

Their money is held in account and when they put forward proposals to go overseas for study leave or conferences they can draw down from their individual accounts.

The CHAIRMAN: That is what I understood. You are talking about people drawing down from their accounts. I know that new guidelines came into operation in June after we started our inquiries and that they seem to be across the whole of the Department of Health. Does the new set up include a committee that covers these doctors who are going overseas? In other words, do they have to justify to anyone - other than themselves - that they will be involved with legitimate conferences or studies?

Mr Bennett: Yes, there is. A clinical staff fund committee is chaired by a senior doctor and meets regularly. As chief executive I am given a copy of the minutes. I read them, and if there was anything I regarded as untoward I would take that up with the chairman of the committee. The guidelines are updated and reviewed on a regular basis.

The CHAIRMAN: This all started in June?

Mr Bennett: No, that has been in place for a long time.

The CHAIRMAN: So, in your operations, none of your trust accounts can be subject to abuse through the unscrupulous use of these SP accounts?

Mr Bennett: I cannot give you that guarantee. However, I can say that the hospital has a clear view that all moneys are under the control of the hospital and therefore must be treated in accordance with FAAA and hospital policies. I have tabled the two relevant hospital policies for your information.

The CHAIRMAN: In evidence presented to this committee previously we were told that moneys that were paid to Sir Charles Gairdner Hospital that were meant to be part of the normal operating budget went to a trust fund, and when you needed money for a capital project, suddenly up popped three and a half million dollars which was supposedly for operating the hospital but which was sitting in a trust account? Can you explain that?

Mr Bennett: Yes, I can. When that matter was raised at your hearing in late November, I provided a briefing note to the minister and spoke to the minister personally to outline what had happened, and he was entirely satisfied with that. That was not a trust account matter in my view. In other words, it was money associated with account No 1, which is the hospital's operating account, rather than account Nos 2 or 3, which hold the trust and special purpose accounts.

The CHAIRMAN: If that is true, why was that not reflected in your budget? If you are saying that it did not go to a trust account, why did it not show up in the hospital's budget?

Mr Bennett: It always was accounted for in our operating account. It was actually a capital carry forward account and had nothing to do with the doctors at the hospital. It reflected a time, some time ago -

The CHAIRMAN: I understand that. However, our concern is that you could transfer operating moneys -

Mr Bennett: That is not true.

The CHAIRMAN: We were told it was - into a capital fund and not tell anybody; more importantly, not tell the minister.

Mr Bennett: If I can explain? The moneys existed because there was a regime previously where hospitals that wanted to do major capital works projects would be given the entire budget up-front. Therefore, there was an incentive: if the hospital was able to complete the project within that up-front money, there would be moneys left in the capital account. That happened at Charlies and at other hospitals. In addition, that money accrued interest, and at Charlies it grew over time. There was no way in which that money was able to be transferred or used for recurrent expenditure. It

stayed in that capital account and grew. When I came to the hospital in late 1998, the policy for funding capital works had changed from getting the money up-front to having our costs reimbursed. In early 2000, the Office of Auditor General asked why all this money was in the account. That was also an issue raised at the other hospitals. When I was aware of it, I went to the Commissioner of Health and said that we had all this money in this capital account. I said that the department could have it back because it was technically Department of Health money or capital money. I said that I had a range of capital works projects that I would like to do at the hospital and I asked whether I would be able to put up a proposal for the money to be spent on capital works and equipment purchases. The commissioner said that if I could put a proposal to the Metropolitan Health Service Board, he would be interested in their response. I then went away and put a proposal to use all the money that had been accumulated in this capital fund, and the Metropolitan Health Service Board allowed me to spend the money on capital works. The account has now been closed. There was no way in which the money was able to be transferred from capital to recurrent accounts. There were no doctors involved. It was not a trust account matter; it was an account within the hospital operating budget. Money had accumulated over time. It happened before I was there and in a time when the department funded capital works in advance. That no longer happens. The matter was dealt with transparently and openly and it could not occur again.

The CHAIRMAN: Getting back to the trust accounts, you said that you have 300-odd accounts as a result of doctors giving you some of their salary. In that case, would it not seem that these are true trust accounts? It is not the hospital's money. The money is under the hospital's control, but they are true trust accounts, so why are they not operating under a proper trust account arrangement whereby there are proper trustees? Under the current arrangement, it could be claimed that they are payments to the hospital, and that would have tax implications for a lot of people.

Mr Bennett: I am happy to table the documentation signed off by Treasury in 1989 which established account No 2 and account No 3, under which the special purpose accounts are held. That will give the committee some idea of the rationale that was used to establish them.

The CHAIRMAN: I understand the rationale; we are now looking at the issue of trust accounts. The dilemma we have is that some hospitals treat them as trust accounts when they are special purpose accounts, and where they are trust accounts there is no formal structure in place to control them. If they are trusts, and they are legitimate, let us make them legitimate and put in place a proper structure. You have said the doctors have to apply to a committee, which is great as that provides accountability. However, legally it is either a trust or it is not. We need to clearly identify that. The accounts that are trusts need to be operated properly. Somewhere down the track, someone will claim there is a problem with trust accounts. We are now looking at this issue, and you are saying that these are funds generated by the doctors for their so-called benefit and that of their associates. Why not therefore set up a proper trust document so that the hospital and the doctor are protected and everybody understands the process?

Mr Bennett: I have great sympathy with your points, and the work that the Auditor General is doing at the moment is looking at that governance - the set of arrangements across the system. We have now seen the draft recommendations that have come out of that part of the Auditor General's work, and we do not have a problem with them. I was referring to what has been set up for particular reasons at Charlies; it is convoluted and it has 383 trust accounts. I can assure the committee that we have been rationalising and reducing the number over time. However, it is a cumbersome system. There is not the same oversight of the research moneys as there is of the travel and education money. I accept there is an argument that all public hospitals should submit to system-wide policy and procedures. However, I make the point that Charlies has had a strong view for a long time that all of the moneys in account Nos 1, 2 and 3 are under the control of the hospital and must therefore comply with FAAA and hospital policy; and we have tightened up the hospital policies. There has always been an oversight of the travel education moneys, and under industrial agreements the doctors can draw down the moneys they contribute. I receive a copy of the minutes

of that committee and am involved in the oversight of that. I make the point that this can be done better on behalf of the system to ensure that the governance arrangements are appropriate for 2002.

Mr WHITELY: You talked about the integration of Osborne Park and Sir Charles Gairdner Hospitals and the better use of Osborne Park Hospital as a teaching hospital. Is there any cooperation across the regions - north, east and south - and are there any benefits from that or any barriers to that cooperation?

Dr Platell: Yes, there is cooperation across the whole system. We were talking earlier about arrangements between Sir Charles Gairdner and Osborne Park Hospitals. Generally, if doctors had their druthers they would work at one site only, although they are happy to work at two sites. However, they do not want to work at more than two sites. There is a reasonably convincing argument that when doctors work at a limited number of sites they have a chance to develop a team around them and they have confidence in the abilities and the skills that this team has, so doctors are happy for them to look after their patients. When we talked about cooperation within Charlies and Osborne Park, it reflected that two sites is the right number. If we try to get them to go to more sites it is problematical.

Mr WHITELY: Is that because they lose their sense of ownership?

Dr Platell: Yes. If the two sites are geographically close that tends to be a good reason to link those two sites. We could link sites that are further apart, but people tend not to like the travel and distances involved.

Mr WHITELY: So there is a certain logic in the placement of regions?

Dr Platell: There is some logic in having a regional approach to how we run the system. Certainly, cooperation across the system does exist at a higher level, and in terms of training positions and opportunities and registrar rotations, so that those people can progress around the system. Each of the medical colleges has its own subcommittees which look critically at the work being done and the opportunities for development in a cooperative way across the system. There are things running at the hospital level and outside the hospital system.

The CHAIRMAN: What is the total dollar amount involved in the 383 accounts?

Mr Bennett: As at 30 April this year the combined total of all special purpose funds across cost centres was $19.057 million. Just to give the committee a breakdown, of that $19 million approximately $7 million related to research grants; $8.5 million related to training, education, development and welfare; and $3.6 million related to equipment replacement. It is our view that there are no state government funds in any of those special purpose accounts; no state government moneys are involved.

The CHAIRMAN: So doctors have contributed $8.5 million to their own fund?

Mr Bennett: Essentially, yes; that is the figure.

The CHAIRMAN: Do you have any other comments you would like to make to the committee?

Mr Bennett: The point that you made about regional integration is the way forward. We are working in our patch and we have a responsibility to ensure that we share ideas and work with the other regions. That is the idea of coming together under a state management team. There is a degree of difference though in the north. We have a significant issue with mental health services, which is a major focus because we have Graylands Hospital, which is a psychiatric teaching hospital. We have only one emergency department, which is at Charlies, and we have Joondalup Health Campus, where we have an emerging operational involvement but not a contract management role. In the other regions, the south has three EDs at Fremantle, Armadale Health Service and Rockingham-Kwinana District Hospital; the east has two at Swan District Hospital and Royal Perth Hospital. The opportunities vary; I still think they are there. As a state health

management team, we bring together the various initiatives to plan, organise and manage services on a regional basis, so it makes sense for the system as a whole.

[11.00 am]

The CHAIRMAN: As long as you do not create an air of this being your little patch and that being their patch, because that seems to be the whole problem with the health system. Everybody protects their own patch, but people do not talk to each other. The centre does not know what each arm is doing, and that is the problem.

Mr Bennett: We are all now on the state health management team, and we all have a responsibility to manage not only our areas but also the system as a whole. It will be a test of the state health management team to make sure that we do not focus exclusively on our regions.

The CHAIRMAN: That is a great start, but we would like to see more interaction between the regions, and even in the metropolitan area, because that will still be a problem.

Mr Bennett: Do not forget that the permanent appointments to the area chief executive positions have not yet been made. When that is done, I am sure that a lot of these things will progress over time.

Dr Platell: I would have thought that the emergency department cooperation is a good model to be built into future networking and coordination of the system.

The CHAIRMAN: Thank you very much for your evidence and for being so frank with us.