PUBLIC ACCOUNTS COMMITTEE

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

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

FOURTH SESSION

Members

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

WILSON, MR IAN WESLEY,
Councillor, City of Albany,
examined:

HAMMOND, MR ANDREW,
Chief Executive Officer, City of Albany,
Albany, examined:

MALONEY, PROFESSOR JOHN,
Executive Chairman, Consulting International Partnerships,
examined:

WELLINGTON, MR DENNIS WILLIAM,
Business Proprietor, Albany Health Action Group,
examined:

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

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the "Information for Witnesses" briefing sheet about giving evidence before a parliamentary committee?

The Witnesses: Yes.

Mr Hammond: I have been invited to address this committee and I thank the committee for that opportunity. I have with me two councillors and a member of our economic development unit, which is a subcommittee of the council, to provide their views on this issue. The views expressed by these people are their opinions and not council policy. The council does not have a stated policy on this matter.

Professor Maloney is not representing the views of the Albany economic development unit, although he is a member of the committee.

The CHAIRMAN: Have you made a formal submission?

The Witnesses: No.

Mr Wilson: I have been 14 years as a registered nurse. I have experience in Albany, Perth and Kalgoorlie hospitals. My concern is the inequity between the regional hospitals in Western Australia of the number of resident medical officers. It is a rhetorical question, but I am asking the inquiry why the residents of Albany are disadvantaged by not having medical officers located in the Albany Regional Hospital or, conversely, why the other regional hospitals have them.

The CHAIRMAN: That is a good question. We have had evidence presented to us all day saying that the Albany model is the best model.

Mr DEAN: They do not want residents.

The CHAIRMAN: That is the view of the community. Are you saying the opposite?

Mr Wilson: A factual example is when a patient is admitted to the accident and emergency department on an evening shift. Nurses telephone a doctor, who instruct that a patient should be admitted to a ward and will be visited by the doctor in the morning. The patient dies. When the observations are shown to the doctor, they show a heart attack and that there could have been a different outcome.

The CHAIRMAN: Is that evidence factual?

Mr Wilson: That happened to me personally in this hospital.

Mr WHITELY: How long ago?

Mr Wilson: In about 1980 or 1982. The principle applies to other hospitals.

The CHAIRMAN: It must be factual evidence. We do not want hearsay. Did that actually happen in this location?

Mr Wilson: That is correct.

The CHAIRMAN: We have asked doctors here about having an emergency operation. The suggestion was that the nurses cover it. I made the same point that you have just made; that is, what happens when someone is in an acute situation and there is no doctor. The comment made was that the nurses are very well trained and probably are better than some of the doctors working in salaried positions.

Mr Wilson: The question is not the level of skills of the nurses or doctors; it is their availability and ability to implement and demonstrate those skills.

Mr BRADSHAW: We just had a doctor say that the experience and expertise of the visiting medical practitioners is higher than the expertise of salaried doctors. What you are saying is contrary to the experience I have had with a constituent of mine who went to one of the hospitals you are talking about. He was told to go home and lie down. He found out later from a doctor in Fremantle Hospital that he was having a heart attack. It can therefore work both ways.

Mr Wilson: It certainly can. As I said, it is not a question of skills; it is a matter of being able to demonstrate them and they cannot do that if they are not here.

Mr WHITELY: Do you have any more recent examples of bad practice - 1980 or 1982 is a long time ago? The level of skill of the resident nurses might be higher and current VMPs might respond more quickly? Are there current examples of concerns? You have said what can go wrong with a system that is not operating properly. However, that is an ancient example.

Mr Wilson: I agree

Mr DEAN: The evidence given this morning was that there were four general practitioners 20 years ago. The increase in numbers has occurred only in the past 10 years. We can discount that example.

Mr Wilson: Alternatively, I would like some skill assessment of every general practitioner in Albany who attends the hospital. There are some experienced and aged practitioners. I would like to ask whether they are all competent in electrocardiography.

The CHAIRMAN: We are not in the business of checking that. You also made the comment that you worked at Kalgoorlie.

Mr Wilson: Yes.

The CHAIRMAN: Kalgoorlie is the exact opposite; it has salaried emergency registrars from Royal Perth Hospital working six months on and six months off.

Mr Wilson: That is correct.

The CHAIRMAN: You obviously worked in that system.

Mr Wilson: Yes.

The CHAIRMAN: Did you find that system works well?

Mr Wilson: Yes, it does. If you are in the back of an ambulance and the doors open, who do you want to greet you, a doctor or a nurse?

The CHAIRMAN: The comment made by some of the specialists at Kalgoorlie was that it was the best of both worlds, having on-call doctors and specialists in town. They have highly qualified specialist and general practitioners who can provide a back-up service, but with that first line of salaried officers working in the hospital. It is more expensive because obviously there is an added cost. However, working on the evidence presented yesterday and today, it appears that the cost of treating those patients here is more expensive than it is at Kalgoorlie. That is a contrary view. Is this your view or a community view? We cannot seem to get the community's view.

Mr Wilson: It is a personal view. I obviously left nursing for these reasons.

Mr WHITELY: How long ago was that?

Mr Wilson: That was 1988.

Mr WHITELY: Do you have any more recent examples?

Mr Wilson: I have been out of nursing since then.

Mr WHITELY: Do you have any more recent examples as a community member?

Mr Wilson: I have heard similar examples, but I cannot quote them because I do not have the details.

The CHAIRMAN: Do you have much to do with the nursing staff at the hospital?

Mr Wilson: Yes I do. My wife is still a registered nurse.

The CHAIRMAN: Do they feel the pressure? The indication from the Geraldton nursing staff, who have the same arrangement, is that they are under pressure. We did not get specific examples, but the union representative said that they were worried about the pressure they were being put under to make decisions.

Mr Wilson: Mark Olsen would be the best person to comment on that.

The CHAIRMAN: It was not Mark who made the comment. We do not have that physical evidence but we have asked for some examples. I am trying to get a feel for this. All day here we have had people saying that this is the best system and it does not need any changes.

Mr Wilson: I did a telephone poll yesterday - I do not have the figures confirmed in writing - but Bunbury Regional Hospital has 115 beds for a population of 30 800. It has six registrars, five interns and two medical officers, 24 hours a day, seven days a week.

Mr DEAN: I am the member for Bunbury. I would like to correct you. Bunbury has 115 beds, but not for 30 800 people.

Mr Wilson: The city's population is -

Mr DEAN: You forgot about the other 30 000 people in Australind, Eaton, Clifton Park, Dardanup, Boyanup and so on; it is their hospital too.

The CHAIRMAN: It has registrars and interns.

Mr DEAN: Do you agree that the population is much closer to 67 000?

Mr Wilson: For the region? I said the City of Bunbury.

Mr BRADSHAW: They draw on Capel and Australind; that is not Bunbury.

Mr Wilson: The City of Bunbury's population is 30 800, Albany's is 30 000. It is equal.

The CHAIRMAN: What about the catchment area around Albany?

Mr Wilson: There is the Jerramungup Nursing Post, Lake Grace District Hospital and other district hospitals. However, it is a regional hospital and serves the city. I was right. That is the point I am trying to make. The point is that they have two medical officers 24 hours a day, seven days a week for the region.

The CHAIRMAN: Are they salaried?

Mr Wilson: Yes. Kalgoorlie has one medical officer, 24 hours a day, seven days a week in the accident and emergency department. Port Hedland has 62 beds for 16 000 people. Karratha hospital, which is just down the road, has two medical officers, 18 hours a day, seven days a week. It closes between 2.00 am and 6.00 am, but the officers are on call. Albany has none. That is the point I am trying to make.

The CHAIRMAN: That point is very well made.

Professor Maloney: I hold a different view from the one expressed. Interaction with my friends in Albany and those I speak to about this matter suggests that they like the concept of a fee-for-service arrangement. Apparently this view has been expressed earlier today. It effectively gives a choice of doctor in an area like this in which the individual's own GP can follow them through. Fortunately, I have not been sick here, so I have not been able to test that view.

The CHAIRMAN: Let us talk about from start to finish.

Professor Maloney: There is a continuity of health care delivery.

The CHAIRMAN: On that point, some of the specialists we met yesterday said that that is rubbish because it is all broken down anyway.

Mr WHITELY: In fairness, it depends on the type of treatment. To be fair we should not overstate that.

The CHAIRMAN: I am not overstating it, I am just putting a contrary view to that position.

Professor Maloney: Obviously, I am not talking about a visiting specialist. Continuity of care may or may not lead to a better quality of care, but it is an important aspect. For one thing, it avoids duplication of interviewing about symptoms, possible drug referrals and so on. A choice of doctor and the ability of the doctor to follow through a case for an extended period are very important. Although you may have contrary evidence, a view has been expressed to me that the appropriate costing would prove the service to be cheaper, largely because the doctors provide a lot of their own infrastructure and are able to follow up patients in their own surgeries.

The CHAIRMAN: We do not have contrary evidence; that is the evidence presented by numerous parties.

Professor Maloney: It appears to me that continuity of care is very important. It is more efficient and effective because the medical practitioner has his own infrastructure. There is a notion of the repetition of questioning, experience and drug therapy. There appears to me to be less opportunity for confusion as one doctor hands over from another if there is continuity of care. The health system is complicated. I have run a university in the past and I know what it is like when one has a complicated system. One tends to try to squeeze the one template throughout the system. It does not work. Therefore, although there may be elements of rural health in general that are similar to metropolitan health, it should be regarded as different from metropolitan health.

I do not know whether the committee is looking at a model under which there are various forms of health care delivery throughout the State and whether there will be a significant difference between visiting medical practitioners in metropolitan areas and VMPs in rural areas. However, I urge the committee to consider that it may be worthwhile thinking about different models in different places. Certainly, one cut would be the difference between metropolitan and rural health.

The CHAIRMAN: That is obvious, and all the examples we have seen show it. There are numerous models, and the players in those models think there are good and bad elements in all the systems. I am not sure at this point what our position will be; we are just taking evidence.

Professor Maloney: I think there would be an argument. Based on the demography of this area, as I understand it - this may have been mentioned to the committee before - with 30 per cent of our population over 65 years of age, there will obviously be different health delivery requirements than in some of the areas in the north where the demography and the split between indigenous and non-indigenous populations is different.

Mr HOUSE: I do not think we need any convincing of that. We are quite aware of that. I am saying that to put your mind at rest. It would be very different if a large indigenous population was being serviced or if someone happened to live 2 000 kilometres from the centre of the decision making, because a whole a range of things would change. The committee is aware of that. To put your mind at rest, the other thing is that the committee, informally, is very strongly of the view that country doctors, nurses and other health care people do a fantastic job. The evidence presented to us indicates that they are hardworking, dedicated people. They need from government a bit of support in some areas. Part of what we are trying to do is to find out where that support is needed. That will be different in different places. Broadly, we accept what you are saying.

Professor Maloney: Thank you very much for that.

Mr WHITELY: It is unlikely that we would come up with one model for all areas.

The CHAIRMAN: The specialist services are not available to provide one model. It cannot happen.

Professor Maloney: That is reassuring.

The CHAIRMAN: However, there are one or two fundamental issues, such as access to emergency departments and the fact that there are no medical officers there. A cost benefit must be weighed up. That will not be our decision.

Professor Maloney: Yes. There are anecdotes about people going to their cardiologist and getting a big tick, then walking out the door and dropping dead from a heart attack. That happens.

The CHAIRMAN: Absolutely. We will not make value judgments like that. In the end, a number of models will be acceptable.

Professor Maloney: Thanks, Mr Chairman.

Mr Wellington: I am a counsellor, as I mentioned before. However, I am also a member of the Albany Health Action Group. That was formed primarily when we saw the results of the budget for this hospital, which has a deficit of about $1.5 million.

Mr DEAN: That is not true.

The CHAIRMAN: That is not true.

Mr Wellington: It depends how it is put.

The CHAIRMAN: You should explain what you mean.

Mr Wellington: We have been advised by the people involved that we will be short by the end of this year to the tune of $1.5 million, with this community receiving the same level of services that it received last year. You can tell me that we have received an increase in the budget of 9 per cent, which is correct. We have also had an increase in the costs, which are far more than that and which have resulted in the deficit in delivering services of $1.5 million. Whichever way one wants to look at it, as far as the community and I are concerned, we are short to that point in receiving services that we received last year.

The CHAIRMAN: That is not true. The hospital administrator was asked that question this morning, and he said that he can live within his budget, albeit tightly.

Mr BRADSHAW: I am not sure that he said that.

Mr HOUSE: No, he did not say that. He said he has been asked to deliver, and he will attempt to do that. The record will show quite clearly that that is what he said. However, let us not get into a demarcation dispute about that.

Mr WHITELY: We need to also recognise that last year the hospital ran over budget. Whether that was because the budget was inadequate or managed inadequately, we do not know.

Mr Wellington: No, we believe we -

The CHAIRMAN: We do know that the State is carrying 16 aged care patients here that it should not be carrying. They should be paid for by the federal system.

Mr Wellington: We are aware of that. We do not have those facilities available at the moment. In terms of administration, we firmly believe that we have the best administrator in the State, so we have no argument on that.

Mr WHITELY: I did not make a point. I simply said that this committee does not know the answer. It is not our brief; it is not what we are looking at. The administrator acknowledged that the budget had received a 9 per cent increase. He also acknowledged that last year the budget was overspent by $600 000. That may have been because the budget or the management was inadequate. I do not know. I am not offering an opinion. I do not know how productive it is for us to debate something of which we do not have knowledge.

The CHAIRMAN: I know, but, for the record, the figures given to us were $22.3 million for last year's budget, and this year it is $29 million, although some allocations in that need to be deducted.

Mr BRADSHAW: Also, $600 000 came out of it from the deficit from last year.

The CHAIRMAN: Yes, so that must be carried over.

Mr BRADSHAW: It is not as good as it sounds.

Mr Wellington: I am giving you the community perspective.

The CHAIRMAN: We want a community perspective on VMPs, not on the justification or otherwise of the budget.

Mr Wellington: My explanation was of the reason that the Albany Health Action Group exists. My committee believes that the VMP system is the best system available to us for delivery of services to our community.

The CHAIRMAN: On what basis?

Mr Wellington: It is a cradle-to-the-grave-type service. It gives people the opportunity to have the same doctor from start to finish, providing a continuity of service prior to hospital, in hospital and outside hospital. We do not believe that changing from one doctor to another and having after-hospital care back at the hospital is the best possible service. We believe that the system that we currently enjoy is the best system available to us. We would also accept that when we go well past the level that we are at now, and we have a population base of around 50 000, that demography will change in terms of the best system. Currently, for a population of around 30 000 people, we believe that the VMP system is the best to deliver the services.

The CHAIRMAN: What about the argument that people cannot get to see their local doctors when they want to, that bulk billing is minimal and that puts more pressure on the outpatient system because people have to come here to be treated, and that the fee for service, on that basis, is far higher than it would be under a different system?

Mr Wellington: That is probably correct. However, there are holes in any system. In providing the best service for the community, we still feel that this is the best overall system. The services provided within the hospital will not be of the same quality or experience that our community service provides now by nature of the junior doctors, who will primarily be employed to staff the hospital. It will be nowhere near the same level of service. If the committee wants a current history of problems with hospitals, I can say that my mother was in the hospital here during June and July on four separate occasions. The doctors could not find the problem. She was taken to the Mount Hospital in Perth for one night and to Sir Charles Gairdner Hospital for every test possible under the sun by the resident medical staff there. She was discharged on Monday afternoon and flew home on Monday night. She was dead by Wednesday morning. The in-house staff system that was mentioned before is not necessarily a great improvement on what we have.

The CHAIRMAN: Obviously, that is an opinion of half a dozen people. What is the basis of your complaint?

Mr Wellington: We had a meeting recently attended by 150 people to support the actions of the Albany Health Action Group. A deputation of Professor Maloney and I saw Bob Kucera. We have had immense support from the community. Peter Watson could tell us how many letters or postcards he has received as a result of that meeting.

The CHAIRMAN: You are giving evidence to us.

Mr Wellington: He could confirm the number of responses -

The CHAIRMAN: That is not the question I asked. Are you saying that your organisation has resolved that it would like the current status of the operation at Albany to remain, including the VMP operation?

Mr Wellington: Yes.

Mr DEAN: Was there any indication, written or otherwise, from any person or minister that it would not stay the same?

Mr Wellington: No.

Mr DEAN: Why was there a resolution?

Mr Wellington: Because it is the system that we have.

Mr DEAN: No, why was there a public resolution?

Mr Wellington: Because we looked at all the possibilities to save money. One of the things that came up was to have in-house staff.

Mr DEAN: That does not save money.

The CHAIRMAN: It costs more.

Mr Wellington: That is exactly right.

The CHAIRMAN: Why was there the resolution when the facts are that it will cost more.

Mr HOUSE: I think it is fair to say that, as a consequence of this committee, there was doubt in the community, and people were trying to get a clear position to put to this group of people, which I think is a very reasonable thing to do.

Mr Wellington: We are covering all angles. We have absolutely no idea where the committee is coming from.

Mr HOUSE: That is fair enough. To put your mind at rest, from the evidence we have taken in country areas in the past week, we concur broadly with your view. As **The CHAIRMAN** indicated earlier, there is some tweaking and refining to be done, and some additions are needed. However, broadly, we do not disagree with that point.

Mr Wellington: We did that to cover all issues. We had no idea what the committee's brief was, where it was coming from and what its intentions were. We covered every issue to try to find out what would be the best system, or, if you like, the best value for our buck.

The CHAIRMAN: Would your group support a private clinic on the hospital land, which would provide a bulk billing-type service and would also be able to cover categories 3, 4 and 5 on a private basis? In other words, they could then be bulk billed.

Mr Wellington: Sure. We would also agree if we could get a ward of the hospital subleased to an aged care group to take those 16 patients for whom the Government is paying.

The CHAIRMAN: That is one issue. Another issue is that many people who come to the hospital and are treated as outpatients should be treated under the Medicare system, to take the pressure off the state system. A way of doing that could be - there are lots of hassles with it - to have some sort of clinic on deck that is operated by GPs, which would either bulk bill or have some other arrangement. Even if the hospital met the gap between Medicare and the fee for service, it would take pressure off the state system.

Mr Wellington: I understood that meeting the gap was not legal in Western Australia.

The CHAIRMAN: No, I mean the gap between the Medicare payment and the VMP fee-for-service payment.

Mr Wellington: That is what I am talking about. I understood that that was not legal.

The CHAIRMAN: Between Medicare bulk billing and a salaried officer it may be okay. These are the things you need to look at.

Mr Wellington: We have not exactly looked at the salaried people.

The CHAIRMAN: Someone must man the clinic, so there must be a way to do it. That is just another idea. These are the issues being thrown into the melting pot. It has been considered by others to see whether it is feasible to do it.

Professor Maloney: I think in New South Wales there is a -

The CHAIRMAN: I think it is in Goulburn.

Professor Maloney: I am not certain. On this concept of someone else covering the gap, the dissuading feature about health insurance for many people is still the gap, so they present as public patients when they could present as private patients, but they do not do so because of the gap. We have tossed that concept around. We are not certain of its legality. However, those members of the community who have private health coverage would be comfortable if that solved some of that problem.

Mr Wellington: As I understand it, about 55 per cent of our population is covered by private health insurance, and only 24.5 per cent use it when they come to hospital.

The CHAIRMAN: It is less than that; it is 10 per cent.

Mr Wellington: If we undertake an education program in the community -

The CHAIRMAN: The disincentive is that if people come as private patients they have to pay $300 or $400 because of the gap, whereas if they come as public patients, and there is no waiting list, they pay nothing, so why would they come as private patients?

Mr Wellington: I understood that the local doctors have reached an agreement whereby they do not charge more than the prescribed amount, so there is no gap.

The CHAIRMAN: We asked that of the surgeon who was here earlier, and he said that there is no such agreement.

Mr Wellington: Was that surgeon a visiting specialist?

The CHAIRMAN: A specialist. The evidence was that there is no agreement, so I asked that specific question.

Mr Wellington: That is different from what we have been told.

The CHAIRMAN: The administrator told us this morning that there had been an agreement, but obviously -

Mr HOUSE: Joe Lubich gave evidence that there was -

Mr Wellington: That is a specialist, not a general practitioner. I am talking about a general practitioner. I think the agreement is there. I cannot comment on the specialists because we have not spoken to them in any way, shape or form. We have spoken only to the general practitioners in our community. I believe that is the situation in their case, but it would not cover visiting specialists.

The CHAIRMAN: Not visiting specialists, but your specialists here.

Mr Wellington: I believe you will find that an agreement is in place for general practitioners.

Mr HOUSE: I think that was the evidence that Joe Lubich gave this morning.

The CHAIRMAN: Joe would do it, but I am not sure about the others.

Professor Maloney: There are others who will do it.

Mr DEAN: Are there any other suggestions from your health action group regarding VMPs about which we should know? You appear to be jumping at shadows. Are there any other concrete recommendations of which you would like us to take note?

Mr Wellington: Not specifically. We probably are jumping at shadows. However, because we had limited contact with the people who were making some of the decisions, we were never too sure how many of the shadows were real. We are beginning to learn a lot more as we go along. We are still of the opinion, as far as the community is concerned, that we are short served this year. However, in terms of visiting MPs, no, there are no recommendations.

Mr BRADSHAW: For how long has your health action group been going?

Mr Wellington: About three months now.

Mr BRADSHAW: Has it had contact with the hospital board, or does it work independently?

Mr Wellington: A member from the hospital board is on our board. Evan Argyle came to the third meeting. He came to the public meeting, and I invited him to the next meeting. At that meeting I invited him to become part of the system. We have invited the chairman of the board on two occasions, but he has not turned up. We have also invited Keith Symes on two occasions, but he has not been able to make it. However, Keith was present and spoke at the public meeting.

The CHAIRMAN: I do not see it as a conflict of interest to be on the board and to be part of an action group.

Mr Wellington: Neither do we. Evan Argyle is a great member of the board. He is the Anglican priest from Mt Barker. He is on the Mt Barker hospital board and on the regional board and he is on our committee.

Mr DEAN: Surely that could be a conflict of interest?

Mr Wellington: In what way?

Mr DEAN: If he is on the boards of the action group and the hospital, he is obviously in a situation in which he potentially will make contradictory recommendations.

Mr Wellington: No, I would not think so. He is trying to do the best thing for the community on both occasions.

Mr Wilson: What is the mission statement of the committee?

The CHAIRMAN: I do not want you to argue among yourselves.

Mr Wellington: I do not think that is relevant -

Mr Wilson: Presumably he would have the best interests of both groups at heart.

Professor Maloney: I was following up on a question that Mr Dean posed about other concepts or ideas that one might explore. If the Public Accounts Committee recommends a model or models, it may be in the committee's interest to use an area such as this area as a pilot study and put in place that model for a period. Like all models, they look good on paper and occasionally certain variables that should have been added to the trial of a model for, say, rural health care delivery do not appear.

The CHAIRMAN: That sounds good. However, in some areas the services that are needed to do that are not available. It is not about plucking a specialist from there and putting him here to provide a service. There are no orthopaedics, paediatrics or general surgeons. It is very difficult.

Mr WHITELY: Without pre-empting what we will determine, there are different specialists for different operations. In many cases those solutions already would have been developed by the existing structure. There are some problems with the visiting medical practitioner system. We are doing an overview of the whole system. There are some differences between the structure in the metropolitan area and that in the rural area which one can generalise about. I can understand where some of the angst is coming from because the system might change. We are looking at the total system. We are not going to Albany, Geraldton or Kalgoorlie to do a job on them, and I reassure you that that is not the case.

The CHAIRMAN: If we did not do it, people would ask why we did not look at their VMP system. The greatest amount of VMP money is spent in the secondary category metropolitan hospitals.

Professor Maloney: There may be enough general features. In a rural area there is a central hospital and then there are other smaller hospitals in the area, but some distance separates them. There may be a way of looking at some new models. I do not know the answers to this; that is why we need time to think about it to develop it. If there is excess capacity in some areas at some time, that may be used to the benefit of the whole system. That is what I am thinking about. This may not be the correct area in which to do it, but it is a good area in the sense that we have a very good group of practitioners who are willing to try some different approaches. I am not a medical practitioner, but they impress me. As Dennis said, we have a great general manager at the hospital, who is also able to think off the wall. These problems are so important to the community that it may be appropriate for the committee to reflect on some other matters.

Mr HOUSE: Can you tell us what you think they are?

Professor Maloney: What do you mean?

Mr HOUSE: You said that these problems are of concern to the community. Can you outline those problems?

Professor Maloney: In a tight budgeting situation, and with demography like we have here, we must find solutions to acute beds being held by elderly patients who have nowhere to go. We have outlying hospitals that deliver various services, which from time to time may not be being used to full capacity. Could that excess capacity or those dollars somehow be used in another place at another time? I do not know; I am just speculating. I am trying to think outside the box.

Mr HOUSE: One of the problems we have identified is that there is no balance in the system. For example, the surgeon in this town works three and a half days a week. However, there is no gynaecologist resident; there are only two visiting gynaecologists. There is also a gap in other areas. Some of the evidence indicates that if only one doctor is attracted, the overload on an individual because of the call-outs, weekend work and evening call-outs is huge. The pressure on

an individual in some of those practices is huge. This town in nowhere near big enough to have two, so we cannot recommend that one model fits all even within a region, because it will be different for different disciplines. That is one thing that this committee will have to tangle with.

The CHAIRMAN: How do we take spare capacity from, say, Albany and use it in Kalgoorlie?

Professor Maloney: I do not know. However, we must be able to think about that. There might be a way to do that which we have not come up with before.

Mr HOUSE: There might be a way to use hospital beds in Kojonup, Gnowangerup and other places by doing after care in those areas, or by taking care for some operations out there. That is being done in some respects by the work that Tony House was doing out of the University of Western Australia. That needs to be looked at. We are also concerned that Albany people might be bypassing this service, accessing a service in Perth and filling up a waiting list and a doctor's time when we would all rather that process be done here, because it uses a facility and the local doctors to the best advantage.

The CHAIRMAN: It also gives people the opportunity to have access to a service that they would not normally have.

Mr Wilson: That is the case.

Mr Wellington: It is an ongoing problem. The problem is trying to treat people equally.

The CHAIRMAN: It is different in each major regional centre. Two places that are the same size have totally different structures. It is very difficult to recommend something that will work everywhere.

Mr HOUSE: Albany has more elderly people. Kalgoorlie has more trauma patients because of accidents. Broome, which has a large indigenous population, has more people presenting as outpatients. Martin was clearly making the point that there will be complex answers. We must try to fit them into particular areas rather than provide a sweeping answer, because that will not do it.

We were also very impressed with the hospital management in Albany. One can have only praise for the way the hospital manager goes about his work and has organised things to make his budget operate. He does not stand alone. All the managers to whom we have spoken have been pretty good. In fact, we all made the comment that they survived despite the bureaucracy in Perth, which seems hell-bent on buggering them up.

The CHAIRMAN: That was the universal comment; that is, there seems to be a lot of bureaucracy in Perth, which makes the process even more difficult.

Mr HOUSE: We are not helping them.

Mr Wellington: The suggestion has never been made that the management has been the cause of any of our problems or that it has been a problem to us. It should be praised for what it does.

The CHAIRMAN: Relatively speaking, the VMP service in Albany is substantially inexpensive compared with other examples we have seen over the past few days. That is surprising. I even made the comment to the surgeon that what he is getting is ludicrous, because it costs him more to operate his practice than he is making.

Mr Wellington: That is why the community has come out so strongly about the budget. The VMP cost to the hospital is not large at all.

Mr DEAN: It is 16 per cent.

Mr Wellington: Three parts of seven-eighths is nothing in terms of budget.

The CHAIRMAN: It is not exactly nothing. It is nearly $4 million out of a $29 million budget.

Mr Wellington: In terms of what would be provided alternatively, it is a cheap exercise, is it not?

The CHAIRMAN: It is service delivery as well. One might say that it is the cheapest option, but is it the best service? That is the question that must be answered.

Mr DEAN: We have contradictory views, as does, I presume, the community.

Mr Wilson: Not entirely. Visiting medical practitioners do an excellent job. The model that they continue to see outpatients in the surgery is not a poser. Emergency care and having someone from the public patients unit in the hospital have still not been addressed.

The CHAIRMAN: That seems to be the chink in the armour. A community group in Geraldton was set up to lobby about the emergency care in Geraldton. However, it is not an issue in Kalgoorlie. The specialists in Kalgoorlie said that it is a fantastic service having the registrars work with them and then getting them in for whatever extra help they need. In Broome it is all funded salary. There are different models, and I am not sure which is the best model. I am not sure whether any of us will be able to answer that question.

Mr BRADSHAW: A situation could arise in which a salaried doctor is working here, whereas some nights there will be three VMPs. If there is just one doctor working, people will wait for hours to be treated under those circumstances. It is a bit of a worry having salaried doctors as opposed to visiting medical practitioners, which is what occurs here currently.

Mr Wilson: Why would they not be invited to call on their own patients as well?

Mr BRADSHAW: They might say that if the service is going to be provided, they will not do it anymore.

Mr Wilson: However, their patients are asking them to come in.

The CHAIRMAN: There are different models. The comment in Kalgoorlie was that the doctor is so busy that the people were happy to have extra doctors. That may not be the case elsewhere.

Mr Wilson: So people would not take out private health care, because they do not know that their doctor will come.

Mr Wellington: Private health coverage in Albany is the highest in the State.

Mr Wilson: That is so people get transferred to Perth to see a specialist who is not in Albany.

The CHAIRMAN: They are the dilemmas you must face. That is the problems that are created. Albany has probably the highest private patient ratio.

Mr HOUSE: I do not think there is an easy answer to that. Some people will not like a doctor for a reason and they will want to bypass that doctor and go somewhere else. That happens and we all know it happens. That is life. People must be allowed the opportunity to do that. Our job is to make this the very best possible service so it attracts the greatest majority of people. That is what we are trying to do. However, it will not be perfect.

The CHAIRMAN: We are trying to provide the best service for the best outcomes in dollar terms.

Mr Wellington: That is also what we are trying do. You should give us all the money you have!

Mr HOUSE: Money is not always the answer.

The CHAIRMAN: Exactly.

Mr Wellington: No, money is not always the answer.

Mr HOUSE: Other issues are involved. We have seen some clear examples of problems that money will not fix. A doctor who works seven days a week, is hugely stressed and never has a day to spare gave evidence that he cannot afford to have more than one beer at night and has not had an uninterrupted night's sleep for years. Money will not fix everything. He is a different deal. He is doing his very best, but he needs help.

The CHAIRMAN: He needs another specialist to help him, but there are not the bodies to provide that help.

Mr DEAN: We also learnt this afternoon that extra money would probably not be of any use here, because the local doctor does surgery for three and a half days a week, and then has no list for the next week, simply because the work is not here. Nothing will be solved by chucking an extra $100 000 or $200 000 at surgery, because there is no work.

The CHAIRMAN: He does surgery on only three and a half days a week, and then has a spare one and a half days. How do we use those days?

Mr HOUSE: Getting back to your point, the other issue is to make sure that people accessing specialist services from what I call the hinterland are coming this way and not going to Perth. We must encourage as many of the people from places like Gnowangerup, Ongerup and Jerramungup who need specialist treatment to access that treatment in Albany rather than Perth. That would help solve the problems. There is work to be done in that areas by groups such as yours. It is also our and the council's responsibility to encourage that. Every person who comes this way for treatment adds value to the area's ability to attract and retain services.

The CHAIRMAN: Is there anything else you would like to add?

Mr Wilson: Did the hospital administration make any comment regarding the number of aged care and mental health patients who have nowhere else to go or are waiting for placement?

Mr DEAN: Yes.

The CHAIRMAN: I do not know about mental health, but aged care was definitely mentioned.

Mr DEAN: Sixteen to 20 hospital beds are being used by those people.

Mr BRADSHAW: A new private aged care facility is being built.

The CHAIRMAN: Yes; that will open in February.

Mr Wilson: That issue relates to supply and demand.

The CHAIRMAN: The witnesses commented that it is putting pressure on the hospital's operations.

Mr Wilson: Mental health is another issue.

The CHAIRMAN: That was not raised.

Mr HOUSE: Tell us about mental health.

Mr Wilson: I do not have the details. I suggest somebody should do that work.

Mr HOUSE: Perhaps somebody could supply it to the committee as supplementary information.

The CHAIRMAN: Are beds taken up by mental health patients?

Mr Wilson: Yes, because G ward (special psychiatric unit) is usually always full.

The CHAIRMAN: We will make some inquiries. Thank you for your time. If you want to make any further submissions, feel free to send them to Stephanie, and we will take them on board.