PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT ST JOHN OF GOD HOSPITAL, BUNBURY
FRIDAY, 23 NOVEMBER 2001

FIRST SESSION

Members

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

DONALDSON, MS LINLEY ANNE,
General Manager, Bunbury Health Service,
PO Box 5301,
Bunbury, examined:

MULLIGAN, DR JONATHON BRUCE,
Director, Medical Services, South West Health Services,
PO Box 5301,
Bunbury, examined:

Mr HOUSE: I apologise on behalf of the chairman, John D'Orazio, who unfortunately had to go back to Perth late last night due to a family commitment. Hopefully the rest of the committee will be able to manage the issues.

This committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the Details of Witness form?

The Witnesses: Yes.

Mr HOUSE: Do you understand the notes attached to it?

The Witnesses: Yes.

Mr HOUSE: Did you receive and read the Information for Witness briefing sheets regarding giving evidence before the parliamentary committee?

The Witnesses: Yes.

Ms Donaldson: I am also known as Anne.

Mr HOUSE: Did you make a formal submission to this inquiry?

The Witnesses: No.

Mr HOUSE: You are aware that the proceedings are recorded by Hansard and you will receive proof of those proceedings at a later date. As soon as they are transcribed, they will be sent to you. Do you want to make a preliminary submission before we begin?

Ms Donaldson: No.

Mr HOUSE: Do you have anything you want to say at this stage?

Ms Donaldson: No.

Mr HOUSE: This week the committee has taken evidence from around country Western Australia. We would like to hear how the visiting medical practitioners system works at Bunbury Regional Hospital. That is the committee's brief and it aims to make recommendations that will improve the system. In order to do that we need to know the issues and problems that hospitals face. How does that system work in this hospital, which is unique because it is a dual hospital system?

Ms Donaldson: Three groups of doctors work at the hospital. The groups are predominantly made up of VMPs who fall into two categories: general practitioners and specialist groups. In addition, we have emergency department full-time and sessional salaried doctors who work at the emergency department. About 10 years ago, the emergency department moved to a system of salaried doctors. I was not here at that time but I have inquired into the history of that change. At that time, the demand to meet emergencies as well as to provide the VMP's own practice services became too stressful for the general practitioners, so negotiations were conducted to set up a salaried medical

emergency department. A specialist emergency department doctor and resident training doctors came from Perth to staff the emergency department. At that time they had a lot of backup from the VMPs.

About four years ago it became apparent that the young doctors lacked supervision and that we needed to consider appointing senior medical officers to the emergency department. It was not possible to have one specialist supervise those doctors 24 hours a day, seven days a week. That matter was put to the board and we negotiated with the Health Department about how to change the structure of the emergency department. Some negotiations occurred about what it would cost to move to a senior medical officer salaried staffing structure within the emergency department. About two or three years ago, we moved to that structure, which has worked reasonably well. We brought in a new director for the emergency department and a group of senior salaried doctors. This year we have been accredited through the Australasian College for Emergency Medicine to take a registrar through that unit.

Within the hospital structure we have credentialled VMPs. The Bunbury Health Service has 107 doctors. A core group of about 70 doctors work with us and the others visit from Perth from time to time. Of those core doctors, a group of general practitioners admits patients to the hospital. We have other groups of specialist doctors, of which the main groups include obstetricians, gynaecologists, medical physicians, trauma proceduralists, general surgeons, orthopaedic surgeons, anaesthetists, ophthalmologists, a urologist, ear nose and throat specialists and paediatric specialists. In addition, we have cardiology and dermatology specialists and a group of psychiatrists. They are the main groups of doctors who work with us.

The VMPs are paid on a fee-for-service basis and predominantly receive their work through referrals from general practitioners or from the emergency department; they do not determine their own workload. Each year, we negotiate with the Department of Health for the range of work that the Bunbury Health Service will provide. That is discussed with the specialist groups as well as the general practitioners, who are aware of the work the Bunbury Health Service provides. Over the past couple of years we have noticed that about a third of the work of the core proceduralists is emergency work, which is on the increase. That is creating some dilemmas because of the number of hours of work that has been requested of that group. We have no on-call payment arrangements for those doctors. They are requested to be on call on a roster, for which they will be paid a fee for service, but there is no on-call payment to them as such.

Mr HOUSE: Would it be useful for doctors to work at both hospitals?

Ms Donaldson: They do work at both hospitals.

Mr HOUSE: Do any doctors work at only one or the other of the hospitals?

Ms Donaldson: Some of the general practitioners and some of the salaried doctors do. However, we have an arrangement with the private hospital - St John of God Health Care - and the salaried doctors. Our emergency department doctors are permitted to provide services at the private hospital in dire emergencies.

Mr BRADSHAW: Does providing on-call payments to VMPs not hold back some of the doctors who would otherwise wish to work after hours at the Bunbury Health Service?

Ms Donaldson: Do you mean in terms of new proceduralists coming into the Bunbury Health Service?

Mr BRADSHAW: I am talking generally. Does that situation create a problem? Is there demand from some of the doctors for on-call payments, whether they are specialists or general practitioners?

Ms Donaldson: Yes, there is. Some tension has been caused because we do not have on-call arrangements, but as part of their work agreement with us, doctors are expected to be on call. It has been a contentious issue for some time. The doctors want to know whether an on-call allowance

will be provided under the new agreement. The tension will continue to build as the amount of emergency work increases, because some of that emergency work is very demanding to the point that all our theatres have been sometimes occupied at night because of a major road trauma. We may also be faced with a major medical or obstetric emergency. We have had to have down time in our theatres on the mornings following such emergencies because all our staff have worked through the night. That puts pressure on the specialists.

Mr BRADSHAW: An on-call payment will not fix that problem. More doctors are needed in the area.

Ms Donaldson: It might fix it. We have been negotiating with the doctors and the specialists about the minimum core group of doctors that is required to provide an on-call service. Dr Mulligan has had a considerable amount of discussion with the surgeons on that issue.

Mr HOUSE: Are all the doctors on call or do some refuse to be on call?

Ms Donaldson: Again, that is a contentious issue. Some doctors are prone to be on call more than others. The anaesthetists, general surgeons, orthopaedic surgeons, obstetricians, gynaecologists, psychiatrists and paediatricians are on call. Those who are not required to be on call as much are the ophthalmologists, because emergencies do not often occur in that area, the ear nose and throat specialists and the urologist. Those sub-specialties do not have as many demands placed on them.

Mr HOUSE: The committee has heard evidence from some doctors who have refused to be on call because the contractual arrangements do not suit them. Is that a problem faced by this hospital? For example, has any surgeon refused to be on call?

Dr Mulligan: One recently announced that they would not be available for emergency services and our response was that they would not work in this hospital. We will not accept that doctors are unavailable for emergency cover if they want to provide routine services.

Mr HOUSE: What was the result of that?

Dr Mulligan: The service reverted to the status quo.

Mr HOUSE: Is the supply of doctors in this region sufficient to take what I would consider to be a risk in making that type of demand?

Dr Mulligan: The regional role of the Bunbury hospital is such that it must be able to ensure the availability of key specialists if it is to cope with the emergency demand. An essential part of the contract must be the availability of the doctors for emergencies. The current contract does not allow us to demand that that cover is complete, but we expect that the new contracts will have such a provision.

Mr WHITELY: A VMP, who was a general surgeon at a previous hospital, was on call but he often did not receive a call; consequently, he did not earn any income for the on-call period. Other doctors in the region supported him and said that it was not such an issue for them because they were professional practitioners and were earning an income when they were on call because they were frequently called in. Is it the same situation here? Is there a general surgeon who is often not called in but must sit at home and wait for a phone call?

Dr Mulligan: No, as Anne has explained, the after-hours work here is onerous. The difficulties faced the next day by practitioners who have heavy after-hours workloads are fatigue and overwork during their normal activity. They face a potential impact on the quality of their work and exposure to potential risks.

Mr WHITELY: What were the circumstances of the person who threatened to refuse to be on call. Was it a general surgeon or did that person earn a decent income when he was on call? Did the person say he wanted to have payment for being on call as a matter of principle?

Dr Mulligan: The individual expressed a view that he did not wish to participate in the emergency cover arrangements for a range of reasons. We have now resolved those issues.

Mr WHITELY: What were the reasons?

Dr Mulligan: They included actions to withdraw payment of superannuation to visiting medical practitioners, questions of an increase in exposure to high risk patients and the increase in medical indemnity insurance costs not being reflected in the range of fees, and the onerous nature of after-hours responsibilities.

Mr WHITELY: Was it a general surgeon?

Dr Mulligan: Yes.

Ms Donaldson: The other issue was that we had not been able to negotiate the new medical service agreement. The doctors are not aware of what is in that package. They think that we are reneging on our agreement to negotiate a new MSA this year.

Mr BRADSHAW: I thought the agreement was given to the doctors last year. Why have they not seen the agreement?

Ms Donaldson: The agreement was put out for discussion with the specialists and all the VMPs at about this time last year. At that time, there was a lot of dissatisfaction with the content of the document and it was taken back for revision. The revised contract has not yet been put into the public arena. However, it is close to being completed and the specialists want to see the content of the document.

Mr HOUSE: Does the Bunbury Health Service have enough VMPs in all the areas of need or are there any gaps in the system?

Ms Donaldson: We have discussed with the surgeons the minimum number of surgeons that would be required to create a core group for on-call work. They say that they may need another one, which would make a group of six surgeons. We currently have four orthopaedic surgeons, but one is on maternity leave. They deal with a lot of trauma work and are keen to attract another specialist. The viability of that depends on the amount of work coming through here. A third of our work comes from outside the greater Bunbury area and two thirds comes from within the greater Bunbury area.

Mr HOUSE: Can you give me an example of an area outside what you call the greater Bunbury area?

Ms Donaldson: We attract work here from the whole of the south west - from the Wellington, Warren-Blackwood, Vasse-Leeuwin area through to Bunbury.

Mr HOUSE: Does it include Manjimup, for example?

Dr Mulligan: Yes.

Mr HOUSE: Do people use this hospital who bypass the Manjimup hospital?

Ms Donaldson: No. A case that comes to mind is when someone was involved in a major accident in Manjimup who was driven by ambulance through to Bunbury for checking. A clinical decision was then made on how the person would be managed.

Mr WHITELY: How many accident emergency patients did you see last year?

Dr Mulligan: Just under 20 000.

Mr DEAN: Can you give us a breakdown of the cost of the accident and emergency department?

Dr Mulligan: From memory it was about $1.2 million in medical costs. I do not know what it was the year before.

Mr DEAN: We encountered in Albany for the first time yesterday 16 000 accident and emergency patients. It was indicated that of that 16 000, only 8 000 ever saw a doctor. They managed to deflect the other 8 000 with the use of a highly trained triage nurse or group of nurses within the accident and emergency department. Do all your 20 000 accident and emergency patients see a doctor? What proportion are deflected by triage nurses?

Dr Mulligan: Every one of them is seen by a triage nurse. They end up in the emergency department after being triaged by a nurse.

Mr HOUSE: What percentage follow through to a doctor?

Dr Mulligan: They are all seen by a doctor.

Mr BRADSHAW: How many might see the triage nurse?

Dr Mulligan: I do not know. I do not have that information. It would be a small number because the role of the triage nurse is to identify the level of need so that those at the lowest level of need may well decide to see their own practitioner or they may wait. I do not know how many make that choice. We could probably obtain that information, but I do not have access to it here and now.

Mr WHITELY: Are there any other factors that would account for the fact that 16 000 people in Albany are seen at a cost of $450 000, and 20 000 people at Bunbury are seen at a cost of $1.2 million in terms of doctor care. Are they all in-house?

Dr Mulligan: We have an emergency department fully staffed by salaried doctors 24 hours a day, and about 70 per cent of the work that goes through the emergency department is out of hours. I cannot speak about Albany. I am a relatively recent arrival in the south west.

Mr WHITELY: Are there any particular types of accident and emergency cases here that could differ from those elsewhere, which would account for that cost difference or do you simply put it down to visiting medical officers versus salaried staff?

Dr Mulligan: I do not think I can comment on that. I can simply say that the spectrum of activity in our emergency department is about what can be expected in a regional hospital of this sort. The spectrum from the very seriously injured to the very minor medical complaint is about the same here as elsewhere.

Mr BRADSHAW: What is the waiting time in the accident and emergency department? I know you have a system of one to five or whatever.

Dr Mulligan: I do not have the figures here but our response times are better than the national average.

Mr HOUSE: What about your waiting time for elective surgery?

Dr Mulligan: I think it is pretty good. It is important to make the point that the efficient operation of hospitals and theatre facilities requires that there be some sort of pool from which to book patients.

Mr HOUSE: I accept that, but what would it be?

Dr Mulligan: I do not have the numbers. It is not great compared to other places.

Mr BRADSHAW: Do you keep waiting lists? Years ago when I asked a question about waiting lists, I was told there were no waiting lists.

Dr Mulligan: Perhaps the best answer I can give is that the Central Wait List Bureau, which I presume is known to the committee, maintains figures on people who have excessive waits. We can access patients from that list. Very few of them live in the Bunbury area.

Ms Donaldson: The biggest wait list is for orthopaedics because most of the specialist work fits into the trauma category, so their elective work; that is, work being referred by GPs, is increasing.

The Central Wait List Bureau has said that if we can get some extra lists in, we can clear some of the elective work.

Mr HOUSE: What is the time delay for the orthopaedic list?

Ms Donaldson: I cannot give you a time but I can give you a figure. I think it is more than 100 at present.

Mr HOUSE: How many operations a week are done here in orthopaedics?

Dr Mulligan: At a guess, 20.

Mr HOUSE: Can we presume the waiting list is five weeks long?

Dr Mulligan: This may not be the place to have a discussion about the statistics relating to waiting lists, but a range of issues are involved. It is important to understand that with waiting lists it is not just a number, the more important thing is how long people wait, which is why I put the emphasis on people who have been waiting excessive times. It is not simply a case of saying we do 20 a week. It is also a matter of how many are being referred as well as how many are being cleared.

Ms Donaldson: The other component with a waiting list is that they are categorised according to the degree of emergency. Some people are delayed for extensive periods compared with people in other categories, who are categorised as a level 1 or level 2 emergency. They are more likely to be cleared.

Mr HOUSE: What is the average occupancy at the hospital?

Dr Mulligan: It is about 85 per cent.

Ms Donaldson: That is averaged down because of the day stay and the way that the census is done. More than 60 per cent of our work in the surgical area is day stay.

Mr HOUSE: Do you do a midnight count?

Ms Donaldson: That is universal across the State.

Mr HOUSE: Have many of what I call "potential" clients, defected to the private hospital?

Ms Donaldson: None.

Dr Mulligan: In the sense that every person has a right to access the public hospital, I suppose you could say that every person who goes to the private hospital could seek to access the regional hospital. However, the arrangement here is that privately insured patients can go to the private hospital without having to make any additional payments because of the contractual arrangements between St John of God Health Care and the private health insurers. Most people who are insured choose to go there.

Mr HOUSE: What percentage of patients in the public hospital have private insurance?

Dr Mulligan: It is minimal. I do not know what the figure is.

Mr HOUSE: Would it be 10 per cent?

Dr Mulligan: I do not know what the figure is. I do not think it would be near that.

Mr HOUSE: They tend to come to St John of God hospital.

Dr Mulligan: The uninsured generally are in the public hospital. The privately insured generally are in the private hospital. It is a little different in that regard from some other places because it is a convenient choice and there is a single triage point. An emergency case goes to the emergency department and the choice is exercised there.

Mr HOUSE: Is there any evidence that patients would be bypassing this regional hospital and going into the metropolitan system because, for example, the waiting list may be too long for their surgery or specialists tend to take them that way?

Dr Mulligan: We know a substantial proportion of local residents' major hospital service is provided elsewhere. Statistics are available on what is called regional self-sufficiency. The aim of the Department of Health and the planning associated with this campus has been to try to retain locally more and more of those patients. To some extent, part of the service planning here must be not only about the growth in population in the south west but also about bringing back people who are being serviced in Perth.

Mr HOUSE: In your judgment what is causing that bypass at the moment?

Dr Mulligan: There is always a bit of a lag in referral patterns. The expansion in specialty services here has been relatively rapid. It takes a while for that to catch up. My guess is that it has been a convenient alternative when any delay has occurred in accessing speciality services locally. I do not think we have any information that suggests that people are choosing services elsewhere that are readily available here.

Ms Donaldson: There is also another issue. If one of our core specialties is not on call, we have a gap in our roster. If it is deemed necessary, that person will be ambulanced either by road or air to Perth. There are occasions when we do not have a core specialist available for whatever reason. If that occurs that person will be moved to Perth.

Mr HOUSE: The reason for the question is that we are keen to see as much of the service delivered locally as possible in whatever area it may be. Equally, if they bypass local services, they compound the problem that is evident in Perth with over-extended waiting lists. Are a number of your visiting medical specialists visitors in the true sense that they come from outside the region? In other words do they come from Perth, or are most of your specialists resident here?

Ms Donaldson: Most of them are resident here.

Mr BRADSHAW: You said that the bed average is about 85 per cent, and 15 per cent of cases are done by day surgery - I assume that is above the 85 per cent. Does the Bunbury Regional Hospital have the capacity to accommodate the people who are bypassing local services?

Ms Donaldson: We are in the process of negotiating. We have 10 rehabilitation beds that still need to be commissioned. We have a business case ready to present to the Department of Health about the development of that rehabilitation unit. That would redisperse some of the load. We are doing minimal rehabilitation in some of our surgical/medical areas now. That would change that. The other component we have been considering is the work we do in Bunbury and the work that might be done in other parts of the south west. In considering viability, we must look not only at the Bunbury beds but also the conglomeration of beds throughout the south west.

With regard to the point about St John of God as a private hospital, we had the reverse situation occur not so long ago when St John of God hospital was full and private patients who wanted to opt for their right to have private cover complained that they had to come across to the public hospital. We have had a situation in which, because of the change in the need for private health cover, people opted for that right. Sometimes a juggling act occurs depending on the surgical work being done at any one time.

Mr HOUSE: Where does the gap insurance come into that issue? Do they become your patients when they come over the corridor? How does the charging apply?

Dr Mulligan: If a person chooses to be admitted to the regional hospital as a private patient, the hospital is entitled to charge a bed-day fee. The responsibility for the medical fees becomes the patient's responsibility rather than a VMP payment.

Mr HOUSE: Does St John of God hospital have a contractual arrangement with the Department of Health whereby there is no gap?

Dr Mulligan: No. It is not a St John of God issue. If St John of God hospital does not have a bed, the patient does not have a choice of going to St John of God hospital. His choice is to come to the

regional hospital as either a public or private patient. However, that person would be a patient of the regional hospital.

Mr BRADSHAW: You said that the question of all the beds in this area must be looked at. Has that been done in the past, or will you be saying that some operations or services can be provided at other hospitals?

Ms Donaldson: It has been done in the past. We are currently looking at the role delineation that has been discussed previously. One of the issues that must be looked at with that is to make sure that the procedural work is carried out in a safe environment. You are probably well aware that standards there are changing, almost on an annual basis. One of the questions that needs to be asked when looking at role delineation is, whether the facilities and staffing arrangements are correct and what changes might need to take place if we wanted to do a range of work across the south west? That is being looked at. The other dilemma is that we now have a lot more births here. A lot of practitioners are saying that they do not want to be involved in that area because of the cost of their insurance premiums each year. It is one of the issues that the doctors have been talking to us about. Each year those premiums are increasing, which is creating more and more pressure on them.

Mr BRADSHAW: If doctors deliver babies, they pay high insurance; they cannot meet it half way.

Ms Donaldson: They cannot, and that is why they are pulling out. Proceduralists are moving about the region and doing different procedures across the south west.

Mr BRADSHAW: Do you have a policy of when people have had their procedures undertaken in Bunbury, they are taken back to their home-town hospitals for after care?

Ms Donaldson: Yes, that does occur. We do it as frequently as we can because it is often better for their recovery. However, there is another issue with that. When a surgical procedure is done, the surgeon is paid the fee for providing that service, so the doctors need to agree on a fee-splitting process.

Mr HOUSE: You were asked by our researchers to provide a list of the doctors. Have you got that list for us?

Ms Donaldson: Did you want them for two years?

Mr HOUSE: Yes, please. Is the fact that the hospital has salaried doctors the reason the number of people has increased who are presenting at accident and emergency departments and "using the system" rather than going to their doctor's surgery?

Ms Donaldson: Possibly. I have only anecdotal information from talking to different people. There are two issues for them. One is that it is very hard to get into a general practitioner's surgery. Sometimes people must wait in excess of a week to do that. The second issue is that people must pay the gap when they go to their general practitioner, and they get a free service when they come into the emergency department. There are issues that centre around people using the emergency department.

Mr HOUSE: Does it take a week to see a general practitioner in Bunbury?

Ms Donaldson: Sometimes, yes.

Mr HOUSE: Are there any bulk billing clinics in Bunbury?

Ms Donaldson: Not that I am aware of.

Mr HOUSE: Do you know what percentage of people presenting at the accident and emergency department would be in categories 4 and 5?

Ms Donaldson: I would be guessing.

Mr DEAN: Is it 54 per cent?

Dr Mulligan: About that. Categories 4 and 5 do not necessarily equate with general practice. It is a common misunderstanding that people who present to an emergency department in those categories could be dealt with in a general practitioner's surgery. That is not necessarily the case, because the categorisation is based on the time that the triage nurse thinks is reasonable before the patient sees a doctor. Somebody could be seriously ill but not necessarily need attention within 60 minutes.

Mr WHITELY: I did not realise that. I thought people in categories 4 and 5 had the sniffles or a cut finger.

Dr Mulligan: They could do. If they are in category 4 it does not necessarily mean that is all that is wrong with them. A proportion of those patients is quite appropriately being treated in emergency departments rather than in general practitioner surgeries. The extent to which that is true varies a bit from place to place. It depends on the accessibility of general practitioner services.

Ms Donaldson: The other component is that once people come to an emergency department, we are legally obliged to follow through with their care. They can chose to go somewhere else, but we cannot tell them to go somewhere else. Once they have connected with us, we are obliged to follow through with treatment.

Mr HOUSE: Do you have 24-hour cover with the salaried doctors?

Ms Donaldson: Yes.

Mr DEAN: Can you go through the staffing component of that 24 hours, seven days a week service in the accident and emergency department?

Dr Mulligan: We have a mixture. The staffing consists of one director, who is a specialist in emergency medicine; a number of senior medical practitioners, who are very experienced but not specialists; and some junior staff. As Anne has explained, the department has recently been accredited for specialist training. In the next year we will have two registrars. We will have an intern. The staffing is rostered on the basis of two doctors on duty during the normal part of the day, and one overnight. At weekends and other predictably busy times, such as public holidays, a third doctor will be there.

Mr BRADSHAW: Do you have much trouble attracting doctors to work under this arrangement?

Dr Mulligan: It has been pretty good. In my experience, it is very difficult to get emergency department doctors, and I think it has been in the past, but this year we seem to have been able to attract sufficient people. It has been necessary because we have taken on the responsibility of staffing the Busselton emergency department, as I imagine you are aware.

Mr DEAN: What is your turnover of emergency department doctors?

Dr Mulligan: The junior staff change regularly. The interns change every three months and the registrars change every six months. The senior doctors have been pretty stable. There is a pool of sessional doctors. They too have been pretty stable.

Mr WHITELY: Earlier you said that the VMOs do not determine their workload. Are there many cases of VMOs referring patients from their private to the public hospital and then doing the operation themselves? Do they refer at an individual level rather than a global level?

Dr Mulligan: A surgeon has his rooms and will have a referral from a general practitioner to his rooms, and then determine whether that person needs surgery. He will book him or her into the hospital for surgery, or through the emergency department. The surgeon will be contacted to pick up an emergency and deal with the person. They determine what procedure needs to occur or what care is required, but they do not make the initial contact with the patient. The initial contact with the patient is made either through the general practice surgery or through an emergency department. A referral is then made to the specialist.

Mr WHITELY: I imagine this is a difficulty in all health systems, but how is accountability achieved to ensure that a surgeon is not over-servicing? Are there any clinical controls?

Dr Mulligan: I am sure that the committee members are aware of the extensive efforts being made by the Health Insurance Commission to apply various criteria to the practice of private practitioners billing Medicare for health services, and the arrangement that the State has with the Health Insurance Commission to have VMPs paid through the Health Insurance Commission. It will enable us to benchmark against the Health Insurance Commission's standards, but that capacity is not available at the moment. We are dependent on being able to internally benchmark one practitioner against another, and explore issues that are brought to our attention through patient complaints, staff comments and those sorts of things.

Mr WHITELY: The highest payment for a VMP is just under $500 000. That VMP also earns income from elsewhere to a total of $575 000. Is that VMP a general surgeon?

Dr Mulligan: Yes.

Mr WHITELY: The fees for that surgeon increased from $319 000 last year to $499 000 this year. Are you aware of any reason for that jump?

Dr Mulligan: I cannot really speak about last year, but I can say that the per-case costs of that individual are in the mid range of the per-case costs of the five general surgeons who are operating here. The income reflects the number of services provided by that person.

Mr WHITELY: It is 1 700.

Mr HOUSE: He obviously works damned hard and a great many hours.

Dr Mulligan: Indeed. If one were trying to find a model workaholic, he would be the model. That is one surgeon who will always be on call for us. He fills many of the gaps that are left when other surgeons are not available. It causes a degree of tension with his practice because he is generally available.

Mr HOUSE: At least you know he is there if you really need him.

Dr Mulligan: He endeavours to make himself available. In fact, we had a previous surgeon, who is now retired, who was very similar in that respect. He felt he had a duty to be available. However, in cases like that the question of burnout arises. The surgeon is generally available.

Mr WHITELY: How many hours does the surgeon typically put in at the public hospital?

Dr Mulligan: For that surgeon it is difficult to say. He is here for long hours every day.

Mr WHITELY: Does he also operate out of the private hospital?

Dr Mulligan: Yes.

Mr WHITELY: Is the time split 50-50?

Ms Donaldson: I cannot comment on that. He is a very efficient surgeon, as you would be told if you spoke to the theatre staff. He always starts on and finishes on time. He is very efficient with his throughput. The staff does not have any difficulty working with that surgeon. He is very focused on what he must do, and he does it.

Mr HOUSE: We have taken evidence of both extremes on this issue; from surgeons who do not have enough work to others who are obviously very stressed by their workload, because they are operating individually and finding that other aspects of their lives, such as their family life, are being left out. One model does not fit all. It will not be possible for the committee to make a recommendation on how to do it.

Ms Donaldson: There is an individual component in it. Recently we gave evidence to the task force. It was quite clear from one of the task force members, who is a general practitioner, that that

particular surgeon is always available to the general practitioners. They can depend upon him. A relationship then starts to evolve in the whole process.

Mr HOUSE: How many general practitioner-surgeons do you have?

Dr Mulligan: Essentially, none. A couple has very minor procedural privileges here.

Mr HOUSE: It seems to me - correct me if I have this wrong - that the critical mass of availability here is large enough to allow some balance in your system, and it is up to the individual doctors how they fit into it in the sense of how much work they want to achieve. Would that be a fair comment? It is different from other places that have overloads and underloads.

Dr Mulligan: It would be fair to say that because a degree of work is being done outside Bunbury. If there were greater capacity, either because of the availability or willingness of the local specialists, there would be an infinitely expanding pool of work for them to do, if they chose to do it. The arrangements with the VMPs means that the referral of patients is the same for private patients as it is for public patients; in other words, it is at arm's length from the hospital. General practitioners and other specialists refer patients to the specialist they think is most appropriate for that person. It is at that point that the question arises, if patients need admission to hospital, whether they are public or private, because they are essentially private referrals up to that point.

Mr BRADSHAW: You said that the surgeons make themselves more available. It there a roster system so that if you ring up someone and they say they are not available, you eventually get to one who is available?

Dr Mulligan: That is the default position. We run a roster system with named individuals on the roster. As I said earlier, the current contracts with visiting medical practitioners do not oblige them to fill every gap in that roster. We intend to move to a situation wherein we will have the capacity to require people to fill every gap in that roster. In circumstances where there is no name of the person who is available on that day, the default position is that the emergency department must ring around and try to find someone.

Mr BRADSHAW: With this type of work it would be hard to have a diagnostic related group or costings. If it is a motor vehicle trauma, a range of things must be done. You said this doctor works in the mid range of costings. How does the fee-for-service work?

Dr Mulligan: The fees are specified. There is a Western Australian Government fee schedule, which is applicable across the State. The services are billed according to the services provided. When the bill is presented, it is checked to see that the service billed for was provided.

Mr BRADSHAW: It is not done on an hourly basis. If a patient has a broken arm -

Dr Mulligan: It is a fee-for-service. There is a fee for mending a broken arm. It is the same fee whichever doctor does it.

Ms Donaldson: It is a total cost. We do a 100 per cent audit of the medical records. Our finance people go through them.

Mr HOUSE: Is that 100 per cent?

Ms Donaldson: We check against them. The Health Insurance Commission has not found any anomalies with the work we have done or the work the proceduralists are doing because we do a 100 per cent audit of all the medical records before payment is put forward.

Mr HOUSE: Who does that?

Ms Donaldson: We have dedicated trained staff in the finance area who understand the components they must look for and who check the information.

Mr HOUSE: Would it be better to outsource that work?

Ms Donaldson: It is outsourced too, because we pay HIC to deliver the cheques. Two audits take place because HIC is checking it too.

Mr HOUSE: If you had a totally free hand to make some changes to the system of visiting medical practitioners - which none of us has - what would you do to improve it?

Dr Mulligan: I have some sympathy with the position of VMPs on call. There are designated specialities that we need to be able to access on a reliable basis. I am unable to analyse the arguments for and against the position of the department but there is a component built into the fee to cover on-call availability. Of course, that is the same for everyone, whether they have onerous on-call responsibilities or not.

Mr HOUSE: Would you pick out certain specialities and provide on call for those only, or would you do it across the board?

Dr Mulligan: If we require someone to be on call, they need to be paid for it.

Mr HOUSE: Regardless of the speciality?

Dr Mulligan: Yes.

Mr HOUSE: What about telephone calls?

Dr Mulligan: I want to make the point that there is a view that that is the position because it is reflected in the fees currently.

Mr HOUSE: Should you pay for on-call telephone calls?

Dr Mulligan: Having someone available is disruptive of their social and professional lives. It is not straightforward, because these people are also in private practice. They have to make themselves available to private patients. There is an argument that if they want to be in private practice, they must be available to their private patients, so they should be to public patients.

Mr HOUSE: What about general practitioners - should they get an on-call fee also?

Dr Mulligan: We do not call on GPs; or hardly ever.

Mr HOUSE: Some public hospitals do.

Dr Mulligan: I would not distinguish between them. If we require someone, to be assured of our capacity to provide a service to the community -

Mr HOUSE: Have you done an exercise to see what that would cost in this hospital?

Dr Mulligan: We know that if we were paying on call at the rate paid to salaried doctors - which is currently $8.37 an hour - that would cost about $50 000 per service per annum. We have six core specialities here.

Mr HOUSE: You are saying that it would be $50 000 per speciality, not per specialist?

Dr Mulligan: I am talking about the speciality; it is divided among however many there are.

Mr HOUSE: You are talking about adding $300 000 per year to the budget for that on-call service.

Dr Mulligan: If it were regarded as an added cost. There is an argument that one would partition the fees.

Mr HOUSE: Would you reduce the fee and pay an on-call fee?

Dr Mulligan: That is one argument.

Mr HOUSE: You would need the wisdom of Solomon to negotiate that little deal. If you think you have troubles now, you would have troubles negotiating that.

Mr DEAN: Would that be cost neutral?

Dr Mulligan: It would certainly be cost neutral if you took it out of the existing fees and applied it to the on-call arrangement.

Mr WHITELY: There has been an argument about a hybrid system, whereby you have an on-call allowance paid when you do not earn below a certain figure.

Dr Mulligan: That is not an unusual arrangement in salaried service.

Mr WHITELY: I think the total operating costs of payments to VMPs and salaried staff is about $7.2 million for 9 855 public patient admissions and 20 000 accident and emergency incidents. A hospital like Kalgoorlie Regional Hospital with 19 000 accident and emergency cases - 1 000 fewer - but about 700 more admissions has a total payment to VMPs and salaried staff of $4.5 million. There is a difference of about $2.7 million on roughly the same operating figures. Do you have any insight about the difference? I could do a similar analysis in Albany. Its costs are $3.3 million - that is all VMPs - with 8 500 public admissions, which is 1 000 fewer than yours, and about 4 000 fewer accident and emergency incidents.

Dr Mulligan: I cannot comment on the other hospitals; I do not know them.

Ms Donaldson: I suggest that the emergency departments have an impact. We have fully salaried emergency departments. Kalgoorlie still depends on registrars going through. The use of senior medical staff in an emergency department changes the cost structure immediately.

Mr WHITELY: That is still only $1.2 million. If that were free, it would still be $6 million as opposed to $4.5 million and $3.5 million. It is still more than twice as much as Albany and about 70 per cent more than Kalgoorlie.

Dr Mulligan: I do not think you can do an analysis like that without having a picture of the complexity of the work. That is not reflected in admission numbers. Therefore, 9 000 admissions does not sound enough to me. It is more than 11 000 admissions and about 10 000 scaled central episodes for Bunbury health service. I am not sure which year you are referring to.

Mr WHITELY: It is 2000-01.

Dr Mulligan: The comparison would need to take into account the spectrum of work and the extent to which it deals with the problem locally as opposed to assessing it and shipping it out. I do not know anything about how various hospitals compare on that basis. I cannot help with a comparison.

Mr WHITELY: Is there nothing that comes to mind about population or demographics, closeness to Perth or anything else that could be a factor?

Dr Mulligan: If it were a question of proximity to Perth, the ease of access could reduce our costs. However, I suspect that we keep more of the complex work here.

Mr HOUSE: How many beds do you have in the public hospital?

Ms Donaldson: We have 130, but 10 are still to be commissioned. That includes the psychiatric beds.

Dr Mulligan: There are 120 at the moment.

Mr HOUSE: So that 10 are closed.

Ms Donaldson: They are still to be commissioned.

Mr HOUSE: How many are there in St John of God Health Care?

Ms Donaldson: It has 80 beds.

Mr DEAN: Can you give an idea of the full component compared with that in other hospitals. How many nursing staff do you have? Can you give a breakdown of the type of beds you have, for example, medical, surgical and so on.

Ms Donaldson: We have 30 surgical beds, 30 medical beds, 10 obstetric beds, 15 psychiatric beds, 10 rehabilitation beds, seven neonatal cots and 12 paediatric beds.

Mr HOUSE: What percentage of those beds are day beds?

Ms Donaldson: We have an additional eight ICU and eight day stay beds.

Mr HOUSE: Is that in addition to the others?

Ms Donaldson: That is part of the 130.

Mr HOUSE: How many nurses do you have?

Ms Donaldson: I would have to get those figures.

Mr HOUSE: I would like those figures supplied. How many of those nurses are agency nurses?

Ms Donaldson: We have a very small percentage of agency nurses. We are very fortunate that way.

Mr HOUSE: That is good. You provided one example of how you could improve the system. Are there other examples of things you would do to the visiting medical practitioner system to improve it?

Dr Mulligan: We are in some difficulty as a result of the impact of the Trade Practices Act on practitioners. I am sure members would appreciate that it is a contentious issue. The practitioners have a view that the Trade Practices Act prevents them from collaborating in organising the coverage of services in a hospital like this. We have advice that it should not. Arrangements that somehow made it possible for us to deal, for example, with all the general surgeons together and try to organise the provision of general surgical services would be very helpful to planning and service development activities, certainly with the after-hours roster.

Mr HOUSE: That is federal legislation.

Dr Mulligan: Yes. That would be one thing. Strengthening the contractual arrangements so that we can require people to provide us with after-hours cover will be forthcoming shortly. VMPs area pretty good option for us. We know that it is a cheaper option in some respects than others because it enables us to incur costs for medical services that are flexible and reflect our needs. If we have salaried people, that is helpful in that they are part of the organisation, so we can manage them in a different way. However, that incurs high fixed costs that sometimes mean we carry that as an inefficient cost when there is low volume. A good example of that currently is that we had to engage a full-time locum physician because we have been unable to get a private practitioner to cover in a locum capacity a physician who is off on sick leave. We have only three physicians. It is difficult to cover the needs of a hospital like this with only three part-time people. We had to engage someone full time and we know that is an added cost and that it would have been cheaper had we been able to get a VMP.

We have just about run out of time. Please provide additional information that has arisen as a consequence of our discussions this morning or on any other matters you would like the committee to consider. This committee will be gathering evidence until the new year. There will be other opportunities to provide additional information if you think it would be useful. Members are determined to provide a positive report that contains practical and sensible recommendations to improve the system. Anything you can add to assist in that regard would be appreciated.

Ms Donaldson: We have focused very much on Bunbury. However, many referrals come from the rest of the south west. An area structure, without contravening the trade practices law or any other legislation, would enable us to consider how referral patterns might be established with doctors across the south west region, what the clinical pathways might be for treatment and how we can support them. That was one of the aims of setting up an emergency service for the whole of the south west, starting with Busselton and Bunbury. There is a need for us to examine the patterns and

to become a lot more cognisant of what gives an indication of change. As we start to do more trauma work, we need to know what that means for doctors working on a fee-for-service basis and how to deal with that. We need to be able to compare the nature of the work in one regional centre as against that in another regional centre, and how that alters the cost structures. A salaried structure is expensive. It is a different expense. We are paying for time and service, because a fee for service provides a full service.

Mr HOUSE: We understand that. I am probably not telling you anything you do not know, but to the committee members the difference has been dramatic. Obviously it is not possible to compare Kalgoorlie with Broome or Albany with Bunbury. There is a huge difference in the way you must manage. Members are aware of and concerned about that, and we want to ensure that we do not do anything to hinder your ability to manage in that sense. However, it is a moving feast.

Mr DEAN: I would like to compare the accident and emergency sections in Albany and Bunbury. The costings appear to be remarkably similar.

Ms Donaldson: You would need to examine the patients who are airlifted from Albany to Perth. One of the hidden costs is how much work goes to Perth. What is the cost of an air ambulance and the service in Perth? That is only one dimension. We are looking at what gets done in a regional centre not at the true cost of providing services because we most look at -

Mr HOUSE: We are acutely aware of that. That why I asked earlier whether you knew of the cases that bypass Bunbury, because that is a concern to the committee. The issue is even more accentuated in a place like Albany, where one of the surgeons has three and a half days work a week. Does he stay or go? Is something missing? If hospital beds are overloaded and people are going somewhere else when they need servicing, they will clog up the system in that other place. That is a problem for all of us and the committee is aware of it. It is hard to compare two places.

Ms Donaldson: It is difficult. Probably one of the things we need is transparency of information. How do we track the cost of a health service in one area? We can say that a service is expensive but it may be relatively lower than the cost of providing the service by moving people out of their region. All those other factors come into it.