PUBLIC ACCOUNTS COMMITTEE

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

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

SIXTH SESSION

Members

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

NADIN, DR CHARLES,
Medical Practitioner
PO Box 1566,
Kalgoorlie, examined:

The CHAIRMAN: The committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Unless otherwise ordered by the committee, witnesses' evidence is public and may be published, including on the Parliament web site, immediately after correction.

The committee has resolved that subject to any evidence given through this public hearing process, if any allegations are made against an individual the committee will give that individual an opportunity to make a formal submission in writing to the committee. It will also give the individual the opportunity to have a formal hearing in front of the committee subject to the committee's approval. Therefore, people will not be able to say they have not had the opportunity to rebut any allegations made against them.

Has the witness completed the "Details for Witnesses" form and has he read and understood it?

Dr Nadin: Yes.

The CHAIRMAN: What is the capacity in which you appear before the committee?

Dr Nadin: I appear as a medical practitioner representing the General Practice Divisions of Western Australia Ltd as well as the rural directors.

The CHAIRMAN: Are you a rural director?

Dr Nadin: Yes.

The CHAIRMAN: Has a written submission been made?

Dr Nadin: Yes.

The CHAIRMAN: Do you want to add anything to the submission?

Dr Nadin: No.

The CHAIRMAN: Do you want the submission incorporated as part of the evidence?

Dr Nadin: Yes, thank you. It is under the name of Dr Parbodh Gogna, a general practitioner from Beverley.

The CHAIRMAN: Would the witness like to take the committee through the submission?

Dr Nadin: We thought it important that the committee receive input from general practitioners who work in this city and that the committee was well informed about to why we work here, why we would not want to work here and all the issues affecting visiting medical practitioner arrangements.

The CHAIRMAN: What are the VMP arrangements here?

Dr Nadin: We are under contract to the hospital - although we have not signed the contracts because they are very much out of date. I am contracted to do anaesthetics and provide an on-call service. I am also contracted to provide general practice duties and attend to any emergencies as required. I am on-call one in every two weekends at the hospital. I am available for my own patients should they turn up before midnight. That is the sort of contract arrangements that most rural general practitioners have. We have visiting rights.

The CHAIRMAN: Let me get this right: if one of your patients is admitted to the emergency department, he would not be treated by a salaried doctor?

Dr Nadin: He would be seen by a resident. The patient would be triaged; the staff would work out what needed to be done. We would be contacted if needed. If the patient did not need treatment or the treatment was so easy that it could be dealt with by a resident, it would be done and the patient would be sent home.

The CHAIRMAN: What about severe cases?

Dr Nadin: If the problem is complicated, doctors such as myself are contacted and we provide advice. I had to go into the hospital the other day to teach. I have done a lot of the resident teaching. I was required to teach a resident how to treat a lumbar puncture. I delayed the lesson by 10 minutes to provide advice on other cases. I am happy to do that until midnight. After midnight, a general practitioner in town is on-call. That is reasonable; we all need a rest.

The CHAIRMAN: What level of income do you generate from this arrangement?

Dr Nadin: It is between $150 000 and $200 000. It is because I am on-call for anaesthetics. I do a lot of anaesthetics work. Half my week is spent doing anaesthetics.

The CHAIRMAN: Half your salary comes from these arrangements?

Dr Nadin: Yes. I also spend a large proportion of my time here because the arrangement is fee-for-service and one does not get paid unless one does something.

Mr HOUSE: Are you on-call on weekends?

Dr Nadin: Yes, every other weekend from Friday afternoon until eight o'clock on Monday morning. It is fairly onerous. The on-call fee arrangement in a place like Kalgoorlie has been agreed because the large industries here create a fair number of trauma cases. Doctors must be available for emergencies and special care if a patient needs intubating and transfer to Perth. Obstetrics and midwifery services must be available to provide epidural services. Doctors must be available for difficult paediatric cases and assistance may be required in neonatal cases. Surgical and gynaecological emergencies also arise. We provide an umbrella of care for a wide range of medical conditions rather than just for orthopaedics. We do not deal only with broken bones; we provide emergency cover.

The CHAIRMAN: Is your role that of an GP anaesthetist?

Dr Nadin: Yes, I am one of them. The town has a specialist anaesthetist and I am one of the general practitioner anaesthetist.

The CHAIRMAN: Do you have a general practice as well?

Dr Nadin: Yes.

The CHAIRMAN: How many hours would you spend at the hospital?

Dr Nadin: On average I conduct about five sessions a week. A session is a morning or an afternoon. That does not include weekends. The last weekend I did, which was two weekends ago, was incredibly busy. We were working 24 hours a day.

The CHAIRMAN: You said that you receive about $175 000 for doing that roster. Is there are cheaper way of providing the service? What about salaried officers?

Dr Nadin: The problem with salaried officers is that they would find it very difficult to cover the amount of on-call work that we currently do. They may not be willing to come in or be available. It may depend on how much they were paid. Practitioners need other people to help them. I deal with the job in hand or the anaesthetics, but other staff are often needed to get a patient ready. Junior staff normally deal with that. Although I am not a specialist, I often do lower-level jobs - that of registrars or interns - at the same time. It would cost a lot more in the end than what I and

others are currently paid. It was set up as a fee-for-service situation. I am paid according to the schedule that previous Governments - presumably including yours - have agreed to for me to come in and do certain work. I do not get paid to sit around from Friday to Monday.

The CHAIRMAN: Is there no on-call payment?

Dr Nadin: None at all. I do not get paid to be available and am able not to travel more than three kilometres from town. I cannot travel more than three kilometres because I must always be available. If a patient in casualty has difficulties, I must be there. It is different to a situation at Royal Perth Hospital in which consultants work on a one-in-10 roster. Junior staff often attend the hospital at the same time. If we are called, we must attend and do the job.

The CHAIRMAN: How many anaesthetists are there?

Dr Nadin: One specialist anaesthetist and three general practitioners who do anaesthetics work. I do the bulk of the general practitioner anaesthetics work. It is because I have a great interest in it.

Mr HOUSE: Do you see many accident traumas because of the mining industry - more than somewhere else?

Dr Nadin: Yes. I do not know whether the committee has seen the workers compensation statistics, but we see a lot of work-related injuries. They are often very serious. Last Wednesday I was playing golf to try to raise money for the Royal Flying Doctor Service when a serious aircraft accident occurred. As soon as I heard, I contacted the hospital to see if I was needed. That is a sort of camaraderie we have. We put down whatever we are doing, get to the hospital and do the job. That is goodwill. Goodwill might not be worth $175 000 a year, but it is worth something. It is often not recognised. I am not talking about goodwill in the sense of selling a business. It is the camaraderie and the ability to say, "Right, that is not a problem" or "No golf - hard luck!"

Mr HOUSE: From what we have heard this morning, the committee would agree. We have been impressed by other people from Kalgoorlie talking about the same things. It is fair to say that most of the country towns we have visited could have similar things said about people's attitudes.

You are unique in having worked in Albany. The committee is visiting it tomorrow. Members are trying to make comparisons between Kalgoorlie and Albany. It is difficult as, for example, Broome is unique and Geraldton and Kalgoorlie are different. When compared to Albany, are there differences in Kalgoorlie that stand out that would result in different decisions or a different process?

Dr Nadin: It is always hard to attract people to work in country areas. Albany is not a difficult place to attract people. One could say that neither is Bunbury, as it is in a nice part of the world. One could say similar things about Broome or even Geraldton, but not places that are more in the outback. It is harder to get people to go to such places. Recruitment is one issue; retention is the other. It is important to keep people who have enjoyed their work and want to continue it. It is important to do anything to help that.

The CHAIRMAN: What about Albany versus Kalgoorlie and the issue of salaried doctors?

Dr Nadin: My honest opinion is that I have no problem with salaried medical officers working in casualty; they are great. They are colleagues and are treated as such. We enjoy teaching them and we enjoy the interaction. They make our lives a lot easier, because we do not have to be there every five minutes. I am busy enough doing what I am doing, as are the rest of my colleagues. It is a very good thing and it makes the life of a general practitioner much easier.

Mr HOUSE: From a general practitioner's point of view, are there things that you would like to say to the committee that would improve the system? If you were asked what could be done to make services better in the country, what would you say?

Dr Nadin: It would be nice to have guaranteed senior resident medical officers. We are looking at people who have spent a fair amount of time going around the traps within hospitals. Doctors need

to be fairly senior and well experienced. It would be good to have an emergency physician or senior registrar who could keep an eye on junior staff. We have great difficulty in convincing Royal Perth Hospital, which provides our residents, that we need them. The hospital will lose one over Christmas. That means we will all have to do a little bit extra. Royal Perth Hospital does not seem to be short of medical staff and it does not see our hospital as a priority. Working in the country is a great experience for junior doctors. Country service should be a priority for teaching hospitals if they want to have input into country services and to be seen to have such input.

I have worked in Broome and Roebourne. Other staff and I looked to Fremantle Hospital as our base for the north west. We talked to the specialists at Fremantle Hospital and they visited us. That scope is available for the large teaching hospitals. They should be in partnership with country hospitals.

The CHAIRMAN: Yesterday, the committee talked to some general practitioners in Geraldton. They said that by not having salaried staff patients can receive continuity of care.

Dr Nadin: It does not make any difference to me. I am busy enough not to worry about whether continuity is broken by my going on holiday.

The CHAIRMAN: To me it appears as though competition is not welcome.

Dr Nadin: It is a bit like saying that we could do with a paediatrician. That was the feeling about five years ago. I used to do a lot of paediatrics because it was one of my interests. I was grateful when it was suggested we recruit a paediatrician. I do not see a paediatrician as serious competition. I am not worried about competition; I am worried about health outcomes and the health care that is provided in this hospital. If we had one or even two paediatricians, the outcome for the people who live here would be better. When paediatricians leave town, I am left holding the baby again, so to speak. I need to maintain my skill in paediatrics. I would tell a paediatrician as much because when he or she leaves town for a conference or a holiday patients turn to me. I see it as an asset to the community and nothing else. The first thing Albany needs is a paediatrician. I am happy and busy enough in my own job not to worry about competition. I look at the big picture.

The CHAIRMAN: The committee is trying to gauge the scale of things. Geraldton has no emergency doctors or salaried doctors.

Dr Nadin: We have had them historically. They often come back. The majority of general practitioners and specialists - the committee spoke to Mr Skinner this morning - were residents here. Guess what? Doctors who enjoy their country experience often want to return. They realise that they have some independence, yet they will still be looked after. That is very important. Doctors start to do things they have never done before. We have a physician from London who has seen more in terms of pathology in six months than he ever saw in London. He is tired because he is working hard, but he is thrilled about increasing his skills. It is a positive thing. We are about to get involved with the rural clinical school and fifth-year medical students. I have been a senior lecturer here for five years. I have looked after medical students who have come here to do a term of general practice. We are determined to ensure that the students have the time of their life - not down the pub or at Hay Street - working here. They need to understand that Kalgoorlie is a social place and that things happen outside the hospital. If they enjoy life outside medicine, they will be interested in coming here. They spend time in general practice and go out with the Royal Flying Doctor Service. They also spend time with me in theatre. They learn more about anaesthetics in this hospital than they do at Royal Perth Hospital. They get the feel for what it is all about. They do special things. There is nothing better than medical students telling their colleagues or loved ones at the end of the day that they did a difficult procedure successfully. That is part of the training for sixth-year medical students and it has been going on for some time.

The rural clinical school is an initiative of the federal Government. Through an experiment in South Australia, fifth-year students have been sent to country locations for a year. The federal

Government has allocated a significant amount of money to set up a rural clinical school in Australia. Kalgoorlie is one of those locations and Geraldton is another. Broome will probably be the third. Fifth-year medical students will study paediatrics, obstetrics, general practice, general surgery and orthopaedics. They will study those subjects here, a place that is brimming with pathology. The students will not be taught by academics who are more interested in the politics of their department than promoting learning. They will be encouraged. A collegiate feel will encourage them to attend our meetings. It is a very important development. Sixth-year medical students will also spend time here. General practitioner training is also partly controlled by the federal Government. The Royal Australian College of General Practitioners has held the contract for training until recently. It has been advised that the contract is now up for grabs. I am a member of the alliance put together to propose the new training program for general practitioners that will ensure that doctors are part of a regionalised training scheme. Potential general practitioners will be sent to towns similar to Albany and Kalgoorlie. Teachers already involved in teaching sixth-year medical students will also teach postgraduate registrars. It provides vertical integration, which we see as very exciting.

Mr HOUSE: Can a committee like this recommend something that would do more to ensure that doctors and students spend time in country areas? Is there a way in which we can help? You are making the point that by having 12 months training in the country, there is more chance of doctors returning to the country.

Dr Nadin: I am not driven by money. That is my honest opinion. It is part of my life, as I have commitments to my practice and family. The thing I love most about this town - and I am happy for it to be published - is the work. I have a medical student from Adelaide at the moment. He assisted me with some paediatrics work this morning. He is having a fantastic time. They are encouraged to return because the work is so good and the support is so good. We currently have a fantastic bunch of physicians, surgeons and general practitioners. It is important that we maintain that calibre of staff here; people who are good at their jobs and interested in teaching. Staff must be kept here and others must be encouraged to come. It is very important. If it becomes no better than being in the city in financial terms, people say it is all too hard and they are better off in the city.

Mr HOUSE: On the basis of what you have just said, is Kalgoorlie a lot better than Geraldton, Broome, Albany, Bunbury or Mandurah?

Dr Nadin: I tend to be biased, but I love the place. But I also loved Broome and Albany. I love the diversity. I really enjoy my work here. The majority of people the committee has met enjoy their work here very much.

Mr HOUSE: What is the catalyst?

Dr Nadin: The catalyst is that, as medical practitioners, we all get on. We are a team. There is the occasional Old Joe who has a blue with somebody, but the majority will jump if someone says "jump". We are always here to help. There is no question of competition between doctors. No-one does not tell someone else about a patient because he is afraid that the other doctor will pinch the patient. We are too busy to worry about that.

I have another job as the medical director for Ngaanyatjarra Health. By the time all the people up there come to this hospital there is a huge amount of pathology to look after. We treat people who are sick and need help. It is a great thrill for us. We do not want to go around creating sickness but if it is there, it is good to know that one is doing something good.

The CHAIRMAN: Do you or the practice bulk-bill? There is obviously a high degree of Aboriginal patients.

Dr Nadin: The Aboriginal Medical Service looks after the majority of people. We bulk-bill people who we consider cannot afford to see us. It is a decision made on the holding of a Health Care Card. We see a lot of ups and downs in this town. I have had paying patients who turn up one day

and say that the drilling rig has gone bust and they cannot afford to pay me. I tell them it is not a problem and I will look after them because I know they will come good. This town has been through a few tough times. We look after people during the tough times. Whether or not we bulk-bill is not a criticism that the committee will find from the majority of people. That is my feeling. My practice in Kalgoorlie may attract a different bunch of people as they come from all over the place.

Mr HOUSE: You have an interest in paediatrics. The committee has also heard from Christine earlier today. She seems like a phenomenal lady. There seems to be some doubts about the paediatrics system, particularly in Aboriginal communities. Are there any solutions?

Dr Nadin: I talked to Rex Henderson about this. He is a travelling paediatrician who I have known for a long time. The Department of Health may need to think about funding two positions. I do not know why but it is difficult to get paediatricians here. It may be that there is more than enough work in the city, and people do not have to bust their guts out here.

The CHAIRMAN: Christine indicated that the salary she generates from hospital work is not enough to pay practice expenses.

Dr Nadin: I find that hard to believe. It is a personal thing. She is not working full-time. A private paediatrician could make a reasonable living in this town. I make a reasonable living and so do my colleagues. It is not an issue. Having said that, for the work that Christine does - which is largely university-based and which contains a great deal of research - and looking after outlying clinics in Laverton and Leonora, it is hard to do bulk-billing because many patients had never been issued Medicare cards. The best way of dealing with that is to provide a salary for that service. Rex Henderson is employed by the rural branch of the Princess Margaret Hospital for Children and is paid a salary to do that. He visits Warburton and looks after Aboriginal lands, some of which I also have to look after. A salary is needed but there has to be some accountability. People have to know how much work is being done, as the money is coming from the public purse. It would have to be written into a contract. It would help the situation. Christine would prefer that because she prefers to do that sort of work rather than go to Esperance or see patients in Perth. She is driven by her interest in paediatrics. She is not worried about running a practice. There is a need for funding for that. One or two positions of that order will attract people who have that sort of interest. Paediatricians in Perth are not short of work. That is the problem. They all have nice niches and nine to five jobs. Their patients are not as sick as those in the outback, who are desperately ill.

Thank God the Government is going to spend some money on the Warburton hospital. I am trying to get general practice registrars to go to Warburton hospital to get some serious experience of Aboriginal health. We find it very difficult to get medical officers to work on Aboriginal lands.

The CHAIRMAN: Referring to visiting medical practitioner payments, are there any safeguards and checks?

Dr Nadin: I stated in my submission that I would be the first and happiest to see serious accountability measures, because we are being paid through the public purse. Measures exist but they are only what the Department of Health has decided. We keep notes of our work and there is obvious evidence that, for example, an operation has taken place. Treatment notes prove that. The computer system of this hospital records what we do in respect of procedural work. No medical practitioner here would have problems with the word “accountability”. That is very important as we are talking about the public purse. Authorities want to go to the public and say that staff have been audited and everything is straight. Inevitably, some people will try to get away with things. That happens in all walks of life including politics, but not in this State, of course.

The CHAIRMAN: Not in the Labor Party either.

Mr HOUSE: Not since the last member went to jail!

The CHAIRMAN: Can you see any accountability process that could be put in place that will safeguard things? There will always be examples of a doctor working solo but getting a three-quarters of a million dollars salary.

Dr Nadin: I am glad you mentioned that. You would have to ask to see what that person had done. Doctors are paid on a fee-for-service basis and that must be how that income was generated. The person must be questioned as to what he was doing to generate the money. I would be expected to explain.

The CHAIRMAN: That was just from the public purse.

Dr Nadin: There is no problem with that. The person would have to have done the work and not doing things that did not need to be done. Crooks can be found anywhere. Assuming it could be done, I do not foresee a problem. They would have to show what they did. Some visiting medical practitioners are high earners because they do an enormous amount of work. That is the other thing that must be considered. What is the capacity of a place like Kalgoorlie to look after patients who need operations? The majority of the time we do not go around looking for work.

The CHAIRMAN: From the point of view of the public purse, is there a better way of paying the big earners? If a doctor is doing six knee reconstructions or hip replacements in a row, should that doctor receive a fee-for-service or a sessional rate?

Dr Nadin: The question is what can be accommodated physically on a day's surgery list. I have worked under a fee-for-service system. The out spin of that is, for example, when considering a knee operation a doctor could decide to do the operation in an hour or take three hours. If the doctor took three hours that would be his session done. That is what happens when doctors are paid sessional payments. Doctors may decide not to do the next case because it may be half an hour before the end of finishing time and he may prefer not to rush it. It is not a perverse incentive, but I think it would be perverse to try to do six. There must be balance about what is a reasonable number to list. If doctors and hospitals have waiting lists of patients who definitively need operations, then this is a measure of getting them done if they must be done. Teaching hospitals are fantastic places for very complex medicine. They are very big institutions. Perth has three. That represents a lot of duplication, even triplication. Perth has three cardiac units but it only needs one. It needs centres of excellence. A lot of bread and butter stuff that doctors see in their surgeries - hips and hernias - can be done in the non-teaching hospitals in and around Perth. Even Kalgoorlie has the capacity to deal with the wait list. The General Practice Divisions of Western Australia Ltd is the organisation for which I have made a submission. It has been involved in the wait list program. It has handed it back to general practitioners so they can review the list and determine what needs to be done and what could be done somewhere else if facilities existed. In other words, patients do not necessarily have to have an operation in the area in which they live. It may be convenient, but if the nearest place to have an operation is a teaching hospital it might not be able to be done in that teaching hospital because it is too busy. It is much better to do it in satellite locations.

Mr HOUSE: How many teaching hospitals do you think Perth needs?

Dr Nadin: Perth has a population of about 1.8 million. It needs at least one teaching hospital - although they will probably crucify me if they hear me.

Mr HOUSE: We should not forget that this is on the record.

Dr Nadin: I do not have a problem with that. For this population we need a teaching hospital and probably a district general hospital that is not part of the teaching hospital; therefore, we would need Royal Perth Hospital and a Fremantle-type place to deal with the common-or-garden cases. We need centres of excellence to focus on specialist areas, such as heart and lung units, neurological units, the endocrine units, a children's hospital and an obstetric-gynaecological hospital.

The CHAIRMAN: What about the fact that already two or three teaching hospitals are under enormous pressure and have huge problems?

Mr HOUSE: They create their own pressure .

Dr Nadin: There is a degree of that sort of thing. As I said, we do not have huge waiting lists here because we work very hard in theatre. I probably earn $175 000 because I work very hard; not perversely but because we can include people in the list and it is reasonable to try to work hard to ensure that the people who live in the goldfields are looked after and that they have their operations. The surgeons do that. The paediatric surgeon sees the patients who have been sent to Perth to see him and who are on the Fremantle list. We do them here. The money comes from the Fremantle paediatric unit here. Andrew Barker and I see those patients. There is capacity in many of these places. That would probably be a funding issue. It is a question of moving funds around to solve the waiting list problem from a political basis.

Mr WHITELY: Is it possible to have a model whereby Fremantle Hospital would be teaching certain aspects and Royal Perth Hospital would be teaching other aspects? Breaking down empires is a very difficult thing to do.

Dr Nadin: Yes. If you think you have trouble with one thing, you have seen nothing until you confront a bunch of medics politically. I think there should be centres of excellence. Royal Perth Hospital could be the neurological centre, Sir Charles Gairdner could be the cardiovascular unit and Fremantle could focus on something else. That would be a very useful way of dealing with the situation. Hospitals sometimes get tied up dealing with things that they do not need to deal with. Much of their work could be farmed out to the non-teaching hospitals, of which there are many in this State, and within the metropolitan area where you are paying visiting medical practitioners now. The productivity of those hospitals is probably very high. The productivity of this hospital is very high. We do not turn over patients unnecessarily, but we get on with the work that is necessary. That is an issue for the waiting list problem. Teaching hospitals are concerned about operating as centres of excellence and focusing on very rare things in medicine rather than the average. They do not want to operate on hernias, for instance.

The CHAIRMAN: Are you suggesting that we introduce a fee for service at our teaching hospitals?

Dr Nadin: You would not have a waiting list if you did.

The CHAIRMAN: Another administrator suggested that if we introduced a fee for service we would not have a waiting list at metropolitan hospitals.

Dr Nadin: I think you would have a smaller waiting list. I do not want to sound as though it is a perverse incentive because we need to have a balance between over-paying and not paying anything at all or underpaying. The Government must try to strike the balance and decide whether people who work in the country are paid more - this is only an idea, it is not necessarily what I suggest - than those who work in the teaching hospitals. There must be some form of carrot to create greater productivity and efficiency. Those very valuable non-teaching hospitals are a great asset to deal with the bread and butter waiting lists.

The CHAIRMAN: Are there any processes you can suggest to solve the accountability issue for the procedures done by visiting medical officers?

Dr Nadin: It is difficult to know how to do that. We prove that we have done the work by writing notes and confirming that operations have taken place. It is recorded on a computer. In a sense I do not know whether we need to photograph each operation as it takes place. I am not sure how that could be done at a procedural level.

The CHAIRMAN: The operation is not a problem; it is the VMO service, for example, for patients in hospital.

Dr Nadin: Again they must write in the notes. In Albany the notes are checked for content before people are paid. It involves a high degree of labour to thumb through all the notes. Threats are always a good thing. If I do not complete the sequence of events of not only seeing the patient but also writing about the patient and doing a discharge summary, I do not get paid.

The CHAIRMAN: That is an incentive.

Dr Nadin: It is as easy as that.

The CHAIRMAN: Is that what happens here too?

Dr Nadin: It does not, but it could. We have talked about it on a medical advisory committee level. We do not get paid unless everything is codified from a diagnostic related group point of view. If a discharge summary is not completed, so that the clerks downstairs can check it, submit it and send the information back to the health department, we miss out on being paid vital dollars.

The CHAIRMAN: What about the other premise of trying to shift some of the stuff to the Medibank system by having categories 3 and 4 seen at a private clinic on the hospital site?

Dr Nadin: It is a great idea. There is enough private health cover in this town and people are responsible enough. The majority of people in this town are hardworking. They are here because they want to get somewhere. A few people spend as much as they earn and do not get anywhere. However, the majority of people here are happy to look after their health care and insurance etc. If they were offered something on this site that provided them with a private health situation, that would be great and money would be generated within this hospital. We do that now. We are pushing hard for people with private insurance to be treated privately because, as we all know, our budget is not what it used to be, but we are not allowed to record that.

The CHAIRMAN: What do you do, tell them to use their private cover?

Dr Nadin: We ask them to. Most people do not have a problem with it.

The CHAIRMAN: What happens about the gap payment?

Dr Nadin: Some of us are lucky to be HBF Health Insurance or GMF Health approved doctors or whatever. It is a question of working with funds to try to reach an agreement that is friendly and useable by both parties. The problem with health insurance companies is that they have been at a distance and said a doctor is either approved or not, but they do not know why. It would be better if we all sat around a table, as we can with a group like GMF, and said that we want to look after the people who are privately insured and find out whether we can come to a reasonable agreement without breaking Australian Competition and Consumer Commission laws. That is another obstacle to overcome.

If someone is brought to this hospital as a private patient and he is put into a four-bed ward he will ask what is the point of coming in privately. There must be an incentive. It would be best to build a separate facility that has access to the facilities here such as theatres etc; then we will begin to generate money.

The CHAIRMAN: I was referring more to the GP services in emergency - categories 4 and 5 - having some sort of clinic.

Dr Nadin: Were you talking about a GP clinic? We are already on call for the hospital.

The CHAIRMAN: That is through the State paying for it. I am referring to a concept that was referred to in Geraldton; that is, develop a clinic that could take private patients, but not be considered to be a private clinic.

Dr Nadin: I do not have a problem with that. However, in the light of the work doctors do in this town, there would be problems working there as well. We are already stretched in our general practices without having to find time in the evening or on weekends to work in a clinic like that.

Some of us try to work a little bit later in the evenings. Most of us do surgery on Saturdays and we need to put our feet up if we are not on call.

Mr BRADSHAW: You indicated earlier that if we introduced fee for service at the teaching hospitals it might help reduce the waiting lists. The problem with teaching hospitals is that while people are learning they slow down the process. Operations in teaching hospitals are probably done more slowly so that interns can learn the process.

Dr Nadin: That is a very important point. However, much of the bread and butter stuff should not be done in the central hospitals. More should be done at the peripheral hospitals, where surgeons can get on with it. However, the State must have a teaching responsibility. They need a balance. I am not suggesting that we change from sessional completely. There must be something to get the whole process moving. I think a degree of chronic inertia is causing the problems the committee is faced with. People are probably a bit cheesed off. Everybody is feeling a bit sad and asking what is happening. We wonder what we have done wrong as doctors.

The CHAIRMAN: If you were the chief surgeon earning $130 000 at Royal Perth Hospital, and a VMO was earning from $350 000 to $600 000 and in one case $700 000, would that be a problem?

Dr Nadin: That is potentially a problem. Some people are not driven by income. Some people love being a professor of surgery working in a teaching hospital because of the facilities provided. They like the academic work.

The CHAIRMAN: There is a dichotomy when someone is earning only $130 000, yet someone who is not even a third qualified is earning three times the salary.

Dr Nadin: I do not know whether we can use that analogy. I know what you are trying to say. If that were true, that would probably be the case. However, I do not think it is, because many of the people who work in the teaching hospitals are very committed to their work and love their job because they can do the research and teaching. It is much more difficult.

The CHAIRMAN: Is there anything else you want to tell us that you have not told us?

Dr Nadin: No, I do not think so. Is the amount of $64 million your figure for VMP payments?

The CHAIRMAN: For total payments, yes.

Dr Nadin: The health service may not be the best value for money in certain areas, but the majority of people, certainly in rural Western Australia, get pretty good value for money and a great deal of goodwill. It would be a great shame - I am not asking for more money - to remove that. We are wondering what we have done wrong. While we see some of our political colleagues, it is easy to see what is going on. We are all feeling a bit thrashed at the moment. The amount of $64 million out of Western Australia's budget to provide health care for people who live in rural Western Australia is not bad value for money. I would be the first person to say accountability is important as long as we can talk about any problems with it, and if we disagree set in place a process. I do not think there is a problem with it.