EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 27 NOVEMBER 2002

SESSION ONE

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

Committee met at 9.37 am.

QUINLAN, DR MICHAEL FRANCIS
Dean, College of Health,
University of Notre Dame,
examined:

The CHAIRMAN: Good morning and thank you for coming to the hearing. Before we commence, I am required to advise you that a 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?

Dr Quinlan: Yes, I have.

The CHAIRMAN: Do you understand the notes attached?

Dr Quinlan: Yes, I do.

The CHAIRMAN: Have you read the "Information for Witnesses" briefing sheet regarding giving evidence before parliamentary committees?

Dr Quinlan: Yes.

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I take the opportunity to thank you for taking the time to appear today. The committee has written to you and asked you to elaborate on a couple of points pertaining to your submission. The committee members will ask a few question. However, if there is anything that you would like to begin with, then you may by all means.

Dr Quinlan: I was not sure what the title was leading up to; that is, the committee's role and interaction and whether that had any different interpretation on the matter.

Mr M.F. BOARD: The Education and Health Standing Committee is in its second year. Standing committees of the Legislative Assembly are new. They were commenced as a result of a review of the standing orders of the Legislative Assembly. Many issues that were referred to by the Parliament or issues that needed to be dealt with in a bipartisan way to progress things because they had a legislative framework, were dealt with by the select committees of Parliament. To cut down on the number of ad hoc select committees, three standing committees were appointed. In a general sense, those three committees cover all the major portfolios of government. This committee examines the Auditor General's reports and the reports of the various departments under our portfolio, which are health and education. However, because the Minister for Education also has Aboriginal affairs and sport in his portfolio, that comes under our jurisdiction. The committee has great research capacity and, as a result, we are examining in a constructive way the changing models in the delivery of health care around the world. In particular, we are focusing on emerging occupations, the flexibility of those occupations, how they interact within the delivery of health care and whether this State has the right mechanisms and framework, such as education and training programs, and whether they ought to be part generic as well as specialised. It is a matter of examining where other jurisdictions are going, for example, the postgraduate training regime that is now coming on throughout Australia, and what is happening in Britain with the emergence of new occupations in the delivery of health care. With regard to this State the committee is considering nurse practitioner-type arrangements and whether they create more flexibility in the delivery of health care. You have a role at the University of Notre Dame and at St John of God Hospital Health Care. Notre Dame is at the coalface of where we are heading. This committee is interested to know

what is happening there and where the nursing school is headed and, possibly a medical school as well. Perhaps the easiest thing would be for you to elaborate on what is happening at the University of Notre Dame so we can bounce the ball and get some questions flowing.

Dr Quinlan: I am happy to do that. The motivation for mounting courses at the university is to define the need for such courses and not just promote a course or a degree for the sake of doing so. We think that is a waste of time and resources and also unjust to students who may have a difficult career path laid out in front of them unwittingly. In the area of health there are many needs, of which nursing is one. We discussed the possibility of a school of nursing for 10 years before we instituted it. We had two formal inquiries into the possibilities of starting a course. Ten years ago there was concern that there were would be enough nurses and we would not need more in Western Australia, which was, in retrospect, an extraordinary belief at the time. However, it was evident that there was a need and we decided to consult the profession about how we might go about fulfilling that need. It is not a criticism of the existing courses that train nurses in this State or around the country, it is just a matter of looking for different options. That decision was coloured by the experiences in the public and private health system of a number of us and, in my case, my time on the Nurses Board of Western Australia for about a decade. At the time it was decanting nurse training into the tertiary sector, as I mentioned in my submission. I felt that there had been a move towards the more academic training of nurses, not with deliberate neglect but with the gradual erosion of the clinical training that was paramount when there was a hospital-based program. Again, there is no criticism of that type of training; it is just a fact of life. However, in an attempt to address the issue, we focused on trying to combine what we term "the best of the old" with "the best of the new", given that nursing, like medicine and many other health professions, is partly an apprenticeship and not just a form of academic training. We deliberately chose to double the clinical content of the course that pertains to other schools of nursing throughout Australia. For example, our academic year runs for 41 weeks instead of the usual 26 or 27 weeks. Most of that extra time is taken up in formally arranged clinical practice. We believe that that was an approach worth trying and as we approach the graduation of our first cohort, I think it has worked well. We also thought carefully about choosing students and made sure that nursing was their first choice and that they were not doing nursing because they could not get into another course. We wanted them to be committed to caring for and looking after people. Hopefully, through the training that we have provided, they will be "industry ready" by the time of graduation, acknowledging that there has been a large dropout of nursing students throughout nurse training courses and, more worryingly, after registration. There are reasons for that but we wanted to try to redress that problem.

Mr M.F. BOARD: I have many questions on those points so we might explore that area first. Is that 41 academic weeks throughout the course?

Dr Quinlan: Every year for three years.

Mr M.F. BOARD: Over the course of a three year degree that is -

Dr Quinlan: It is 123 weeks.

Mr M.F. BOARD: Compared to about -

Dr Quinlan: Three times 27 -

Mr M.F. BOARD: That is an amazing amount of additional -

Dr Quinlan: I stand a little corrected on that. The Curtin University of Technology, for example, has a three and a half year course. The extra half year was designed to promote the clinical experience but it is tacked on a little. Again, I am not criticising that course; it is just a different way of doing things.

Mr M.F. BOARD: Do you compare the retention rates of students between the two universities as a result of that program?

Dr Quinlan: Yes, so far retention rates have been very good. We have allowed, as most universities do, for a minimum of 10 to 15 per cent wastage - if you want to use that awful word - but it is certainly no higher than that.

Mr P.W. ANDREWS: Have you done any studies on the period of employment after graduation compared to Curtin University students?

Dr Quinlan: We have not produced our first cohort yet; they come out next month.

The CHAIRMAN: Next month?

Dr Quinlan: Yes, in December.

Mr P.W. ANDREWS: It will be an interesting comparison in five years time.

Dr Quinlan: The point must be proven and these claims must be substantiated by experience. One of the things that young women, and men to a lesser degree, find after they graduate from nursing in some areas is that they are not prepared for the culture shock of working 38 or 40 hours a week. They realise too late that this career is not for them. That is one reason that might explain the high dropout rate after registration; in other words, a year after they have qualified.

The CHAIRMAN: Is that because they do not have the clinical experience in hospital or practicums?

Dr Quinlan: They realise that it is not the career for them. It is a complex issue involving salary rewards and career possibilities, for example. Nursing has always been a travelling profession. In other words, nurses' skills are in demand worldwide and a lot of young people take off and do a stint overseas after their registration year. What is more worrying is those who leave the profession and stay out of it.

The CHAIRMAN: I come from the Kimberley and have been up there for a very long time. My first experience of nursing training was in Derby where nurses got their training at the teaching hospital. They would have up to 80 people from all over the country going there to learn about the profession. Those people were getting hands-on experience plus the formal part of the training program. I have not seen that happening anywhere else. I know that the majority of those people stayed in the profession because they live in the Kimberley. A lot of those women and young men that did the course did not leave.

Dr Quinlan: In part it relates to the duration of the course's clinical practicums. If the students are there for only a week or two and their placement changes from week to week, they do not get the sense of continuity of working in the area they will work as a professional. For that reason, we try to keep our students in the same practicum area for six or seven weeks so that very quickly they become a useful part of the team, or "part of the furniture", and they have a sense of belonging.

The CHAIRMAN: Last weekend or the weekend before I spoke to some nurses from Norway. They were funded by their Government to work in Australia's public health system to get a broader range of experience. They had been all over the place working in intensive care units and found that their theoretical skills were being put into practice. They said that their roles were being expanded. They were intensive care nurses but they were not specialising in one area. The important point is that they were dealing with tropical diseases and things that they would never come in contact with in their homeland. This committee is considering the expansion of the roles of nurses. In most of the submissions we received, professional bodies said that training need to be put into areas like paediatrics, for example. Therefore, there are the nurses and then all these add-ons. Everyone we have spoken to so far believes that they should have more training in their specific area of specialty. We understand their argument that it takes pressure off that part of the specialty for the professionals and the doctors. However, if that were the case, every trained nurse would have to have a huge scope of knowledge and expertise.

Dr Quinlan: They must have experience across the board. However, in-depth study of one particular area may be detrimental if they do not have good general background knowledge. A prime example of that is the trend to have midwifery training separated from nursing training.

The CHAIRMAN: Really?

Dr Quinlan: There is a move around the country to train young people to become midwives without having formal nursing training. That would fall over in remote WA if a nurses did not have generic nursing skills to back up their midwifery training. It is a debatable issue as to whether that is good idea. In other words, a nurse may be specialised in one area but, in doing so, neglect the entire role of nursing otherwise.

The CHAIRMAN: I am a country member and I spend a lot of time in remote areas of my electorate. Some communities all year around have only an Aboriginal health worker. These people are completely dedicated to their community. They get a minimal wages - say community development employment program with top up or whatever - they are on call 24 hours, they live in their community and they are there seven days a week. However, for their medical training I think they go to Broome at the moment with camps. They are removed from their community for that time and no other service is provided while they are away. Yet, without these women, and some men, there would be more fatalities in the community if they did not have that level of skill. Some Aboriginal health workers specialise in environmental health and others are generic - they do dressings and that sort of thing - and some give injections because that has been their training; therefore, they have different levels of accreditation. Some workers have delivered babies and have provided a midwifery service but they do not have the qualification per se, just the fact that there was a need and they came up trumps. However, they were the lucky ones as there were no complications. My concern is how do we service the communities? Those people are never going to live in towns; they choose not to. How will we continue to provide those communities with a service because many of these people will not leave their community to receive formal training? Many women in the Kimberley did their training in Derby Regional Hospital; they have never been registered but they have done the training and have the skill. In recognising prior learning, do we try to get them back in? Do you see what I mean?

Dr Quinlan: I agree and if the education opportunity can be taken closer to the environment, so much the better. We are endeavouring to do that in Broome but it is difficult. We have a nursing school up there and we were careful from the outset that we were not adopting a double standard; in other words, the qualifications we wanted for our Broome nurses were of the same standing - academically and experientially - as those in Fremantle or Perth. We fully acknowledged that for them to get clinical experience and travel beyond the Kimberley with family commitments and so on was extremely difficult and off-putting in terms of being attracted to doing a nursing course. Therefore, there must be imaginative ways around that to give them clinical experience in their local area but not deny that they must have a broader experience, even if it means coming outside the local area to a big regional centre, such as Perth, for some time.

The CHAIRMAN: Take the old Derby leprosarium at Bungarun for instance. I was at a meeting with a number of Aboriginal health workers about the medical facility or the old hospital for the leprosarium. There are accommodation units at this facility and these women were saying that they would be quite happy to move their families in and undertake their training on-site. They could have their family system with them and be close enough to a town whilst using a disused facility for their training. Those are an example of the creative ideas that have been put on the agenda but are rarely taken up because it all seems so hard. That is an ideal solution, but I am only considering the north of the State, which is a little suss.

Dr Quinlan: I agree that that matter must be addressed and provision made for the special needs of the area in terms of accommodating the desire for the woman, for example, to have her family with her while doing her training and not being removed from a remote part of the north west to do it.

The university would also like to expose Fremantle students to the north west area and we will get them to volunteer and take the full course, or most of the course, in the north west. We also have volunteer students going to Third World areas, such as East Timor, as an accredited part of their course. Equally, we want to do the same with other health professionals, for example, in the areas of health and physical education. If the medical school gets going we would certainly use the Broome campus as an important part of that clinical exposure.

Mr M.F. BOARD: The University of Notre Dame is providing a slightly different model that we would like to explore. One of the criticisms of the existing set-up is the lack of transitional arrangements between the university and the workplace. What will Notre Dame be doing with its first cohort in that regard?

Dr Quinlan: There is provision in the public and the private sector for post-graduate professional training. In the year following graduation an intensive transitional educational program is provided to enable new graduates to become confident and competent in dealing with a full-on nursing career. That has been in place for some time. We have tried to lessen the need for that by making sure that they have enough exposure to the industry so that they feel confident on entering their career after graduation. We have even negotiated with places such as Fremantle Hospital, which will employ some of our graduates from last year, to reduce the time they spend in that program. They will be given credit for the experience they have already had. We hope that that will also reduce the cost to the individual hospital. I mentioned in my submission that the 1998 costs to fulfil that transitional role came to $3 000 per graduate after graduation and on top of the salary. The proof will be in the pudding. For example, when the students are in a practicum setting, as I mentioned, we ask for volunteer registered nurses working in that particular facility to take on board a student nurse during their practicum time. They work as mentors and the student nurse works alongside them day and night and over weekends for 32 hours a week on average during that period. If the student is not exposed to a working environment by the time that experience has finished, then something is missing. We hope that that transitional phase will be a natural one rather than a sudden exposure to a 38-hour week that the student has never experienced before. Nursing is a demanding profession and the more the student is attuned from the start to where he will be working, the better.

Mr M.F. BOARD: A number of people from the Nurses Board of WA, the Australian Nursing Federation, Edith Cowan University and Curtin University of Technology and a number of other groups, have indicated that they feel that the career structure for nursing in this State is not appropriate. There was also a feeling that the gradual specialisation of nursing, whilst it is good in itself, is also leading to difficulties in terms of career structure; people are becoming isolated in their own cell, as it were. Have you some thoughts on that issue and where you might see things going into the future?
[10.04 am]

Dr Quinlan: I hope that nurses want to remain nurses throughout most of their career rather than aspire to an administrative role, which is the ultimate in a nurse's career. If a career structure so designed allows nurses to practise hands-on while they advance up the ladder, so much the better. The recognition that clinical skills are as important, if not more important, than administrative skills must be embedded in the whole situation. Good generic general training must be the basis of it all. General experience must come before speciality training.

Mr M.F. BOARD: At the moment people are paid or awarded according to their position rather than their achievements; that is, people can undertake postgraduate study but unless they are a level three, four or five they are not paid accordingly. Do you support a program that awards people for their advancement in terms of their personal development?

Dr Quinlan: Yes, because a lot of nurses who undertake graduate courses find that they do not enhance their award. They undertake the courses more for altruistic reasons rather than career advancement. That should be redressed.

Mr M.F. BOARD: I am interested to learn your thoughts about the nurse practitioner legislation that is currently before Parliament. If a person becomes a nurse practitioner through additional study they hold that title only while they work in a nurse practitioner position. If a person moves away from that position they are no longer a nurse practitioner unless they hold another position that has been designated as such.

Dr Quinlan: The Australian Medical Association's stance is a bit hesitant about nurse practitioners. Personally, I believe that Western Australia has peculiar requirements for nurse practitioners. As we explain to people from Victoria, rural and remote Western Australia means a three-and-a-half-hour plane trip whereas rural and remote Victoria is two-and-a-half hours by car and almost in the next State. That mindset, which is peculiar to Western Australia, must be overcome. To my mind nurse practitioners in Western Australia are a thoroughly good idea.

Mr M.F. BOARD: What about the utilisation of nurse practitioners in after-hours emergency triage in the metropolitan area and in aged-care situations?

Dr Quinlan: I do not think that a nurse practitioner would want to assume the role of a doctor if doctors are around. That is not their desire. In conjunction with other health professionals working side by side and training side by side, they can slot into such roles very well and it would give them more interest and incentive for doing so.

Mr M.F. BOARD: I refer to your medical school. What is the status of your submission to the Commonwealth?

Dr Quinlan: Our first proposal was considered by the Australian Medical Council's accreditation subcommittee in October, and it wishes to consider parts of the proposal in more depth. To that extent, an agreement was made at the council meeting last week, which was held in Launceston, that we will meet with members of the accreditation committee and secretariat early in the new year. Medical education and the lead-up to accreditation is a long process. It takes an average of one and a half to three years from the first proposal to the final tick. That is the nature of the game. In that way the public should be reassured that the recognition of a medical course is so thoroughly supervised that the public is protected in due course. In terms of standards, of all professions it is the most thoroughly controlled in Australia. All being well, we want to open in late 2004 or 2005. We are on the way. It is a matter of having the curriculum approved and the ability to deliver it secured in the mind of the Australian Medical Council. On the other hand, the political issue of whether the Commonwealth is happy for us to start a school of medicine is a separate but partly related issue. The Australian Medical Council has no say in the number of doctors that are produced in Australia. That is the role of the Department of Health, which is jealously controlled. For obvious reasons the tax payer must see that his or her money is being spent wisely.

Mr P.W. ANDREWS: Will the courses be full-fee paying courses?

Dr Quinlan: They will be but under the PELS arrangement - the postgraduate educational loan scheme - which was introduced by the Commonwealth Government in January of this year and which applies to all universities, including the University of Notre Dame Australia. It allows a student who has already completed a degree in any field to apply to do a second degree of a postgraduate nature - not of a research nature - and to borrow from the Commonwealth, interest free, the course fees. Like the higher education contribution scheme subsidy, they have to repay the money after they have finished the course and when they reach a certain tax threshold. That redresses many equity issues that hitherto made it difficult for people to undertake further study in many disciplines in Australia. We will use PELS to allow that to happen.

Mr P.W. ANDREWS: In terms of the curriculum, will there be common first-year courses with nurses?

Dr Quinlan: The school of medicine will be in the same college, and counselling students, nursing students, physiotherapist students and health and physical education students will train side by side. I hope that the cross-fertilisation, which has already started in nursing and counselling, will allow students to see that they can work side by side with each other and contribute.

Mr P.W. ANDREWS: I know that you have not been successful in the tender for nurse practitioners at this stage, but in 10 years time do you think Notre Dame will do down the path of training nurse practitioners or other postgraduates?

Dr Quinlan: We are looking for the opportunity to do that sooner. Next year we will start graduate diploma courses, and, if necessary, masters courses, in nurse education, aged care, mental health and orthopaedic nursing, just to name four. They will be funded under PELS or by way of a scholarship. Nurse practitioners is one area we would like to consider.

Mr P.W. ANDREWS: At this stage have you identified the entrance requirement for school leavers?

Dr Quinlan: Not for nurse practitioners.

Mr P.W. ANDREWS: What about training in the medical school?

Dr Quinlan: It will be a graduate entry medical school, which is the same model as pertains in Flinders, Sydney and Queensland, which have converted from a six-year undergraduate course to a four-year graduate course.

Mr P.W. ANDREWS: Will school leavers be accepted into the course in the future?

Dr Quinlan: If we move to a graduate model, probably not - because the University of Western Australia already has an undergraduate model. Although there are piggy-back models around the world - that is, there are graduate students on top of undergraduate students - it is questionable debate whether that system works. The options would exist if UWA persisted with its undergraduate course. If we get the acknowledgment and the nod to go ahead with the graduate course, young Western Australians will have a choice between the two.

Mr P.W. ANDREWS: What are the fees likely to be?

Dr Quinlan: At the moment we are predicting an annual fee of about $25 000, which is $100 000 over a four-year course. The HECS fee for an undergraduate and a graduate course at Flinders is approximately $6 000 a year. Therefore, a six-year course will cost $36 000. I am told that the actual cost is $55 000 a student for a standard six-year undergraduate course Australia. In other words, the Commonwealth picks up some of the tab - the State contributes a fair amount of that in either direct or indirect terms. It is a very expensive exercise.

Mr M.F. BOARD: I am interested in the relationship between the private and public sector and the sector to which nurses are likely to go. Is there any relationship between the two sectors in terms of experience, training or shared opportunities?

Dr Quinlan: The actual undergraduate training program incorporates experience in both the private and public sector in not only the acute hospital setting but also the aged-care setting and beyond. The aged-care setting has proven to be an absolute boon. When Professor Doreen McCarthy, the head of the school of nursing, decided that the first clinical practicums that first-year students would undertake would be in an aged-care setting, she was criticised. She was told that exposing student nurses to a lot of sick and aged people in nursing homes and hostels would turn them off nursing. However, she persisted. We asked our students to keep a diary of their experiences throughout their three-year course. To read the diaries of the first group who undertook the seven-week aged-care nursing experience at the end of the first semester in the first year is quite amazing. The experience did not turn them off nursing; rather, it turned them onto the whole

concept of nursing. We were delighted with that feedback, which was quite spontaneous. Having young people around also added to the aged-care setting and they became useful pairs of hands. The aged-care experience is absolutely critical in training a nurse, or a doctor for that matter.

Mr M.F. BOARD: I am interested to learn about your experience as a result of your work at St John of God Health Care, and your involvement in the administrative area of the public health system. Do you think there should be - or is there the opportunity for - a greater cooperation between the two sectors? If so, in what area could the private sector assist the public sector? Would it be in additional training, education or in helping to relieve the pressure points within the public health system?

Dr Quinlan: There could be assistance in all those areas. Assistance started in education because the State had a vested interest in the independent school system, as well as supporting and promoting the public school system. If the people of Western Australia can elect their politicians, I do not see why Parliament cannot consider that the interests of all Western Australians should be pursued when looking at delivering standards and services, such as education and health. There is a big health resource in the private sector, ranging from acute care right down to aged care, which should be incorporated in the planning and delivery of services by the State. Traditionally that has not been the case. Maybe there are political reasons for that; maybe it is the instruction given to the various departments running the delivery of health care. There is such a wealth of experience - let alone resources - in the private sector that it should be taken into account when planning for the delivery of health care to all Western Australians.

Mr M.F. BOARD: I assume that you would have read the report of the Health Administrative Review Committee. Should the private sector and the total delivery of health be considered in a total health plan? Should there be interaction at the administrative level between the two sectors?

Dr Quinlan: I think there should. I am sensitive to the profit motive, and, as a result of my experience, I am persuaded that the not-for-profit private sector is much more able over a long period to cooperate with the Government in the delivery of services. I am not denigrating the profit motive, which is correct in our society. However, in health care I have my reservations about it, because the delivery of health care in the profit motive is basically driven by the dividends to the shareholders. I do not like that being the prime driver of the delivery of health care. For example, the St John of God Health Care system in which I had the privilege to work has been going since 1898 - well before federation - and is still contributing like many other similar organisations in Australia. Although it has to make its way, the profits are turned back into the maintenance of its standards and services. If we can capture that idealism and altruism and incorporate it into the public sector on a sharing basis, it will be to everyone's benefit. There is probably a recognition that it needs support from, but not dependence upon the public system. There is a lot of goodwill out there that needs to be tapped.

Mr M.F. BOARD: If we are going to explore that, and it is critical to some degree if we are to share or utilise health professional in both sectors - some do now of course - or in training, can the not-for-profit sector deliver to the State cost-effective care and beds, for example, at a similar or cheaper level than is being delivered in the public health system? In other words, dollar for dollar if the State wanted to purchase services or beds from the private sector, would it be in front or behind in terms of its financial commitment?

Dr Quinlan: That depends upon what administrative structure is superimposed on the delivery of public services by the private and even the not-for-profit group. Because the private sector has had to make its way, whether it be for profit or not-for-profit - otherwise it would have gone out of business - it has learnt many managerial skills. At the same time, that sector promotes its skills and standards by offering an extremely good health care delivery. If we can use those managerial skills to offset costs then we should have equivalent costs at least, if not somewhat lower costs. I am

confident that given the right structure, savings could be achieved. It also uses the resources that are there.

Mr M.F. BOARD: Do you envisage a situation in which the State might become involved in a joint-tendering arrangement with various independent sectors to be cost effective in the purchase of capital equipment and the like?

Dr Quinlan: Yes, I do. I am aware of the experiment at Murdoch. The St John of God system tendered for the right to construct a hospital on that site, which was government-owned land, many years ago. We had to purchase the land at commercial rates. One of the provisions in the tender was to open an emergency department, which we did. We planned for X number of attendances in the first year. I think it was 7 000. It turned out to be 14 000 and not 7 000, and it has grown exponentially since. It has received no significant help from the Government and runs at a loss of somewhere near $2 million a year. That cost is absorbed in the overall St John of God Health Care system, because we believe that the service to the community is so important that it should be maintained. It certainly takes the pressure off other emergency departments in the metropolitan area, even as far away as Joondalup, at which patients are often told to front up to Murdoch. It is a bit quicker down there for reasons that I will not go into at the moment because of the lack of time. There should be a recognition by the Department of Health that that department is fulfilling a function and that it should be supported. The other issue that arises is that it is possible for us in the St John of God Health Care system in that situation to triage patients at the front door, which is not possible at Sir Charles Gairdner Hospital or Royal Perth Hospital. Primary care units at Royal Perth or Sir Charles Gairdner cannot be opened and manned by general practitioners because the Commonwealth gets upset about cost shifting. In other words, many people who front up to emergency departments in the metropolitan teaching hospitals are not emergency cases. They are after-hour primary cares issues that should be dealt with at a different level. As I have said many times, there should be a better way of the Commonwealth and the States coming to an agreement so that the barriers can be removed and commonsense should prevail

The CHAIRMAN: It has been fascinating listening to what you have had to say. The committee appreciates your time. Could we visit you at some stage at Notre Dame?

Dr Quinlan: We would be most delighted to have you visit any time. I will make the necessary arrangements.

The CHAIRMAN: That would be wonderful. We talked about it before but it did not happen.

You will be sent a transcript of the oral evidence you have presented here today. Any corrections to the transcript must be made within 10 working days. Thank very much for appearing before the committee.

Dr Quinlan: Thank you for giving me the opportunity.