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

THIRD SESSION

Members

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

JARVIS, DR ROBERT BADEN,
Treasurer, Rural Doctors Association of Western Australia,
examined:

Mr HOUSE: Welcome to the committee. This committee hearing is a proceeding of the 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 Jarvis: Yes.

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

Dr Jarvis: Yes, I do.

Mr HOUSE: Did you receive and read an Information for Witnesses briefing sheet regarding evidence before this committee?

Dr Jarvis: Yes, I did.

Mr HOUSE: Will you please state the capacity in which you appear before this committee?

Dr Jarvis: I am a general practitioner in the Dunsborough area. I am appearing here as an individual and a visiting medical practitioner. I am also Treasurer of the Rural Doctors Association of Western Australia.

Mr HOUSE: I understand that you made a submission, which the committee has received. Do you wish to make any amendment to that written submission?

Dr Jarvis: No. I have prepared a statement that is an addendum to that submission.

Mr HOUSE: I will ask you to proceed with that in a minute. Are you happy for the committee to incorporate your original submission as part of the proceedings of this committee?

Dr Jarvis: Definitely.

Mr HOUSE: I apologise that our usual chairman, John D'Orazio, was called back to Perth last night on a family matter, so he is not with us. These proceedings are being recorded. You will receive a transcript of that recording at a later date to check what you said. If you would like to proceed with the addendum to your submission, we would be pleased to hear it.

Dr Jarvis: Have you read my submission?

Mr HOUSE: Yes.

Dr Jarvis: Therefore, you know who I am and of my experience in this area, which goes back to 1974. I have worked through all the various stages of changes in the rural hospitals; that is, in the early stages when we were not paid anything at all and were honorary doctors to the hospitals, and through the Whitlam era when we were paid under Medibank by the federal Government. I was part of the team that negotiated the first non-teaching hospitals agreement with the Government - I was on the Australian Medical Association committee that did that. I am very familiar with what has happened. I am also involved at this stage with the visiting medical practitioners agreement. When I learnt of this committee's sitting, I was a bit puzzled about exactly what the motives were. I would like to hear from the committee so that I can focus somewhat, because it is easy to skirt around issues. If we are out to bash doctors, to cast blame on people or to look for savings or whatever, I can probably help the committee with that. On the other hand, if in fact the committee is looking to assist country towns, doctors and their hospitals, I am here to do that also.

Mr HOUSE: Our terms of reference are in writing, and they have the sanction of the Parliament. In principle, they are to inquire into the use of VMPs in the public hospital system and their terms and conditions of engagement. I think I speak for the chairman and all members of the committee when I say that we, as a group, are very determined to present a positive report that will assist the delivery of services across Western Australia and to do our very best to ensure that everybody is satisfied that that outcome can be achieved. That is not to say that we may not make some recommendations that a few people will not like, of course. However, that is part of being in any responsible position. I can assure you that we are very determined. In informal discussions among ourselves, we have highlighted that we want to make a positive difference. These hearings are not a bashing exercise or a witch-hunt; they are about getting a positive outcome that will benefit everybody. I represent a fairly remote part of Western Australia. It is not as remote as the north west, but it is pretty remote. John Bradshaw represents a country area, Tony Dean represents Bunbury, Martin Whitely is from the outskirts of the metropolitan area, and our chairman comes from within the middle of it. Therefore, we have a fair spread of experience.

From the evidence we have heard from Broome to Kalgoorlie to Albany and places in between, we are also aware that one size does not fit all. There are different circumstances and needs across this State. Therefore, we will not be making sweeping recommendations that are a catch-all. We understand clearly that we cannot do that and that there will be very different needs for doctors, surgeons, hospitals and regions.

Dr Jarvis: I felt that I should speak on behalf of the small to medium towns, because I do not think anybody has spoken on their behave.

Mr HOUSE: That is true.

Dr Jarvis: It is more likely that you have been spoken to by people from the bigger towns, such as Albany, Kalgoorlie and so on, which have different problems from the small towns. My experience came from when I was chairman of the south west health forum, when I did a lot of talking with people, doctors, communities and so on in the south west catchment area, so I am qualified to speak on their behalf. I will perhaps give you a thumbnail sketch of what it means to be a country GP in one of these small towns.

Mr HOUSE: You might also like to recommend to us two, three or four towns that you think it would be beneficial for us to visit. Your summation is accurate, and we are aware of that. We were talking about it last night informally, when we spoke about where we should go. Therefore, if you have some recommendations about that, we would be pleased to hear them.

Dr Jarvis: In the wheatbelt, perhaps you could look at Corrigin and Bruce Rock, and in the northern wheatbelt, Three Springs. Those places are problem areas, because some of them do not have the population to support more than one doctor. The poor guys there find themselves on 24-hour call, seven days a week, and they support other towns. There is now some cooperation between towns. However, generally speaking, this means that either doctors or patients are travelling long distances so that the patients can see the doctor who is looking after them that night.

However, I will give you this thumbnail sketch, because I thought you might be interested. Generally speaking, the rural GP in the small to medium country town is a private practitioner. He has always been a private practitioner, although perhaps his income has been underwritten by the shire. That has occurred in many areas. He might be in shire-subsidised housing or accommodation. Many of them these days have been recruited from overseas and have been resident in Australia for only a few years or even a few months. He is quite a stranger to the nightmare of the forms and paperwork entailed in running a medical practice in Australia. He is busy because, as you know, everywhere in the country is under-doctored. He has a lot of pressure on him. He must organise his own premises, his staff and all the Medicare and Health Insurance Commission paperwork, which is a real nightmare. There are practice-incentive programs with which he must comply, and there is accreditation. He must keep up his continuing medical

education to continue his vocational registration. All this is going on. He must deal with the local hospital bureaucracy as well. The paperwork from the local hospital has been increasing. His running costs for the practice are in the vicinity of almost $100 000 per annum per GP. He has a significant amount of overheads. He pays more than $7 000 a year for professional indemnity insurance alone, and that is increasing every year. He is on call 24 hours a day, seven days a week. Perhaps in cooperation with other doctors, he might be on a better roster, but he will be responsible for all the accidents and emergencies that arise in the area. These may include motor vehicle accidents, domestic crises, mental illness, suicide and seriously ill children. They can occur at any time of the day or night, and during his usual surgery hours he might be called away - women have their babies at any time. Therefore, he will be up all night doing all this, and then have to be at the surgery the next morning at nine o'clock because his patients will arrive then. There are long hours for some.

He will also be very reliant on the goodwill and skills of the hospital staff. This relationship between the nursing staff at the hospital and the doctor is a unique relationship in many little country towns. They must get along. He must rely on them to sort out the sheep from the goats - triage, we call it. You will come across "triage" as a word. There are five categories of triage. He must rely on them to triage the patients presenting at the hospital. It is a relationship that cannot go wrong. If there is a falling-out between the hospital and the doctor, his time in that town will be limited. He works on a fee-for-service basis at the hospital and is paid for the work he does, and not for standing around drinking cups of coffee. There is no allowance in that for sick leave, holidays, study leave or superannuation, or for the continued running of his practice. He participates in hospital committees. He might be on a number of different committees and on the hospital executive, and be involved in community health projects and pregnancy education. He attends all the inpatients under his care in the hospital, and also probably the local nursing home, the day care centre and so on. He does not mind any of this, because he believes in the philosophy of caring for the community from the cradle to the grave, and the community loves him for it. It is a very satisfactory relationship, and, sadly, it is seen less and less these days. He is running a very efficient and cost-effective service. The Western Australian Department of Health, in the running of its hospitals, should appreciate that it is cost-effective. There is continuity of care when people are seen in the surgery first, then at the hospital and perhaps are then referred to Royal Perth Hospital or somewhere else, and are seen again in the surgery. That is very valuable and cost-effective, because investigations are not being duplicated, prescriptions are always up to date, and there is no confusion about what the person is on. The coordination of that care can be seamless. This kind of continuity of care is not seen in urban regions. The degree of satisfaction for both the patient and the community is lessened by that. Rural general practitioners need to be rewarded for their dedication, perseverance and courage, because sometimes it takes courage to be out there when they are faced with mangled youths in car wrecks, difficult labours and other things that country GPs see and city GPs do not. They need to be rewarded. They need hospitals that support them and they need hospitals to continue in their communities. They need secure funding and staffing levels in those hospitals. They need hospitals that listen to what they say and what they request. They need hospitals that have established channels of dialogue and problem-solving methods with them. Built into any agreement which has gone before, and which should continue, is some mechanism for doctors to be involved in the day-to-day running of the hospital and in the established channels of dialogue with the hospital and the hospital executive. They need reasonable and secure payment for the services they provide. This means a secure contract negotiated on their behalf by those with the time and the expertise to do it. At the moment we are faced with the involvement of the Trade Practices Act in the negotiation of our agreements. I have been told - I think it has been the case in New South Wales - that the Trade Practices Act has been circumvented. There has been a negotiation between the president of the Rural Doctors Association and the Government, and one contract is then used as a pro forma for subsequent contracts throughout that State. There is documentation about that.

Mr HOUSE: We will track down that information, because it would be very useful.

Dr Jarvis: I have been told also that there could be state legislation to exclude the Trade Practices Act for contracts of labour only, and particularly including independent contractual arrangements between doctors and the Department of Health.

Mr HOUSE: State legislation cannot override federal legislation. The presence of federal legislation is sacrosanct. It would not matter what State Parliament did; it cannot override federal legislation. We will track down the New South Wales example. Obviously it is an issue that the federal Government needs to tangle with, and we can make representations to it if need be.

Dr Jarvis: You should also recommend that there be subsidies for obstetrical practising and procedural general practitioners so that they can afford their professional indemnity insurance, which is necessary for them as private contractors. Indemnity insurance is not required by the Government in salaried positions because the Government takes the brunt of any indemnification in a salaried position. However, these doctors must be private contractors. They must bear that cost in any case if they are to continue to practise obstetrics, anaesthetics or surgery.

Mr WHITELY: Typically, how much would an isolated GP in the wheatbelt who delivers the odd baby pay for his medical indemnity insurance?

Dr Jarvis: It is the same amount as that paid by any general practitioner who practises obstetrics anywhere; it is in the vicinity of $7 500.

Mr WHITELY: Is that just for obstetrics? How much is the marginal cost of insurance for country GPs practising obstetrics? I imagine it could be a real barrier.

Dr Jarvis: It is a huge barrier. I have the figures, and I can give you the exact figures down to the last dollar.

Mr HOUSE: If you could provide us with that information at a later date, that would be great.

Mr WHITELY: In your experience, are there many isolated country GPs who simply say that they will not deliver any more babies because of the cost of the indemnity insurance? If that is happening, there is a huge problem.

Dr Jarvis: There is. Rural areas are being de-skilled in obstetrics. Very soon doctors will not be able to afford to deliver 50 babies a year. Fifty babies a year is a lot; it is one a week. Even if a doctor delivers 20 babies a year, he will not be able to afford it with the fees that he receives and the cost of indemnity insurance.

Mr WHITELY: As I understand it, it is done on the basis whereby doctors pay a figure; it is not done on a per-delivery basis. If it were done on a per-delivery basis, the doctor could wear the cost if he delivered only two babies a year.

Mr HOUSE: It is not just a cost and insurance issue; it is a responsibility that some doctors do not want. I live in a small country town and a baby has not been delivered there for 10 or 15 years. It is fairly typical of a lot of country towns of that size with a small hospital. It is more complex than that.

Dr Jarvis: It is more complex. Doctors are leaving obstetrics for that reason. The Government, through its subsidy scheme, has subsidised indemnity insurance to this year. Only this year have we had doubts about whether we will be subsidised. Even though I have delivered only 20 or 30 babies in the past three years, I have continued to practise in obstetrics because I have skills in that area and I can use them in the jobs that I do.

Mr BRADSHAW: When you give us the figures for the indemnity insurance, can you let us know the difference between what a GP pays and what a GP-obstetrician pays?

Dr Jarvis: I can provide all the different levels.

Mr HOUSE: I asked a question before about insurance premiums being funded by the doctors. You have been involved with a number of groups. Rather than outsource to a traditional insurance company, I understand that some countries in the world have a self-insurance process. Have you looked at that in Australia?

Dr Jarvis: We have always been self-funded. The Medical Defence Association of Western Australia is a self-funded insurance association that indemnifies us.

Mr HOUSE: Do you not outsource it at all?

Dr Jarvis: It is outsourced. It does reinsure. For instance, it reinsured with HIH Insurance. Fortunately our indemnity association here was not badly hit. However, United Medical Protection in the eastern States was badly hit by the collapse of HIH.

Mr HOUSE: We might get some more details about that ourselves to understand how it works.

Dr Jarvis: United Medical Protection of Western Australia Ltd has been going for years.

Mr HOUSE: Is there a peer group review of that? In other words, if a case occurs, does a peer review make a recommendation before it goes to litigation?

Dr Jarvis: Absolutely. I do not want to deviate, but I think that the annual report of the Medical Defence Association of Western Australia outlines all of this. It has just been published.

Mr HOUSE: We will get a copy of that. I apologise for sidetracking you. Perhaps you will go back to where you were.

Dr Jarvis: I had finished.

Mr HOUSE: Are you comfortable with tabling that submission, or do you want us to take it as transcribed?

Dr Jarvis: I would prefer you to take it as transcribed. I have skipped a few things and added others.

Mr BRADSHAW: Someone said that a doctor still has responsibility for a baby up to 26 or 27 years after the delivery. Are you continually covered? If you stop practising tomorrow, and you stop indemnifying yourself, will you still be covered after that time?

Dr Jarvis: That is an interesting point. Our medical indemnity companies have changed the way they look at it. Once upon a time we were covered for life, but now we are covered only if we keep up our dues. When we retire, we must continue to pay a premium. We will not be covered for events that have occurred and are not reported. There are a lot of intricacies about events that have occurred and are reported, and events that have occurred and are not reported. The report would make interesting reading for you because it covers all of that issue.

Our indemnity society in Western Australia now does not cover doctors unless they continue to pay their subs. The subs go down when doctors retire. Unfortunately, the insurance policy is based on how much money a doctor earns. Because I retired three and a half years ago, and I have been working part time, my income has fallen. My insurance premium went down a level. That is why I cannot give you an exact figure, because I pay only about $5 000 a year. I am still covered for anaesthetics and obstetrics. If a doctor's patient billings are over $120 000 a year, he must pay the maximum premium.

Mr WHITELY: I am a little confused. Monty asked whether you were self-insured and you said that you are.

Dr Jarvis: Yes.

Mr WHITELY: Could some of these problems be sorted out by the medical profession changing the way it self-insures?

Dr Jarvis: A number of private companies have gone into medical indemnity insurance, but there are deficiencies in their policies. Their policies do not match the kind of cover we get from our defence organisation. Besides that, the premiums are not much different.

Mr WHITELY: How does your defence organisation work? As I said, I am still a little confused. I thought you would put into a pool and then draw from that pool.

Dr Jarvis: That is right.

Mr WHITELY: The group would determine how the insurance is administered.

Dr Jarvis: Yes.

Mr WHITELY: Why can doctors not take those anomalies out of the system? Why can they not change the way they self-insure?

Dr Jarvis: They have made some changes over the years. At one stage every doctor in the State paid the same amount. Now there is inequity because some groups get sued more often than others; for instance, neurosurgeons and obstetricians now pay up to $30 000 a year. GPs who do not practise obstetrics ask why they should pay for other people's obstetric insurance. That is the case. On the other hand, it is too difficult at the moment. The day may come when doctors insure for each case; for example, if a doctor is to deliver Mrs Jones' baby next week, he will take out an insurance policy for her. However, that has not occurred yet. It is still a mutual society with cross-subsidisation to some extent.

Mr HOUSE: I understand your general comments. I think we share many of those views. Are there any other areas in which you think the system for visiting medical practitioners needs to be improved? I appreciate what you have said, and that you concentrated on the smaller country towns - one doctor, one hospital.

Dr Jarvis: My submission dealt with two things: cost shifting or attempts to shift costs, and compliance and accountability. The latter is straightforward. Our practices are open and transparent. Doctors must record and document their work. That documentation is correlated with the fees they charge or submit. If there is any difference in opinion or in the documentation, that application is rejected. Only the applications that are substantiated are accepted. A doctor cannot perform surgery without the problem being confirmed by histology. I think that is transparent.

Cost shifting is a grey area. We experienced this in Busselton. When things got tight, the hospital thought one of the ways they could save money was by not paying the VMOs. They wanted us to run private clinics in the hospital so that we could see all the triage category 4 and 5 patients and bill them through Medicare. Many of us were uneasy about that because we understood that under the state-federal agreement, people who fronted up at the hospital were to be treated free of charge, even if it were their first port of call for medical care. When people fronted up to the hospital on a weekend for free medical care, the hospital would give out the doctor's phone number and tell the patient to ring him. The patients were rather irate when they then received a bill. We did not think that was very fair. We asked our federal member of Parliament to clarify the issue. That was done over the course of several months. I am afraid I misplaced my letter when I moved. I am sure Michael Peterkin, who was then chairman of the medical advisory committee, has copies of the letters he received from the federal member that stated that such a practice is seen as cost shifting and doctors can be fined up to $50 000 under the Act relating to Medicare.

Mr HOUSE: You outline those two things in your submission. The commonwealth-state relationship is a major issue with health. You would appreciate that we are only one part of that equation, and the other part is bigger and uglier than us. We must work out how we should deal with that.

I go back to your comments about country doctors. You have obviously had a lot of experience. How can we encourage more young doctors to work in country areas? Is there anything that a committee like ours can recommend the Government do to encourage more people into the bush?

Dr Jarvis: I think some things are under way. They are being facilitated. We will see many more doctors going to the country. I do not think the committee should worry. Things have become reoriented, and I am very optimistic about what is happening. I see many young doctors who are enthusiastic about doing things in the country that they cannot do in urban areas. They see the country as the place for them.

I do not know whether I should tell you this, but I believe that the training program for general practitioners got carried away. It was taken into the realms of urban general practice by one particular doctor was in charge of the training program in its very formative years. He unfortunately went on to be in charge of the training program at a federal level. This particular person had no concept about what it meant to be a general practitioner in the country.

Mr HOUSE: Medical students used to be actively discouraged. They would be told to not go to the country.

Dr Jarvis: It was terrible. Our practice in Busselton took GP trainees from the outset. That was in the first stages of the family medicine program. We were one of first practices - with Kevin Cullen, who was a great GP - to take on the family medicine program trainees, which is what they were called then. We came to blows with the trainers because they were much more interested in teaching doctors to be psychological counsellors rather than being able to face a difficult motor car accident or delivery by themselves at four o'clock in the morning. They were not taught to have the fortitude to do that. Of course, many young doctors went out to the country, had one bad experience and went back into the city.

Mr HOUSE: What caused the change? You say you are confident and not worried. That is not the sort of feeling I get when I move among the small country towns in my electorate. Everybody is concerned about where the next doctor will come from. In fact, we are pinching them from other countries.

Dr Jarvis: It takes six years to train a doctor, and almost seven years to have them vocationally registered and able to cope in a country area. That is a gap of about 13 years - if the doctor does not take time off in between.

Mr HOUSE: I understand that. What caused the change?

Dr Jarvis: That change has been driven by the country people themselves. The Western Australian Municipal Association, the Rural Doctors Association of Western Australia and the Western Australian College of Rural and Remote Medicine argued for the training program and shook a few people by the collar. WACRRM was an important catalyst in this through people like its founding fathers, such as the chap from Northampton who has since passed away. These people changed the thinking. They said that country kids would go back to the country, but they must be trained properly and equipped to go to the country and have experience in the country areas. More than 80 per cent of the trainees now spend six to 12 months in country general practice posts.

Mr BRADSHAW: When I went to Harvey in 1968, the local doctors, who had not been out all that long, were doing anaesthetics and things like adenoidectomies and tonsillectomies. That practice seemed later to be discouraged by the specialists, who applied pressure by saying that only specialists should perform those procedures. Has that also been turned around, or do the specialists still try to dictate the sorts of procedures that should be done by specialists ?

Dr Jarvis: There is still a group of specialists that supports country GPs. Those people are around. The medical school itself is run by a group of specialists who are so up in the clouds that they have no idea about what happens in country areas. To some extent, those people are driving the medical school. However, things have changed. A lot of pressure has been applied and Professor Landour

is now having to give way to things like this and the John Flynn scheme. Much is happening that is encouraging country GPs.

Mr WHITELY: You say the solution in the pipeline. How far down the pipeline is that solution, and can things be done in the interim to help solve the problem?

Dr Jarvis: The use of overseas-trained doctors is good. Some of those doctors are very well equipped. They have worked in places like South Africa and central Africa, and they are well equipped for coping with rural practice. Good agreements and relationships between hospitals and doctors are important to encourage people to go to the country. It would be a daunting task for someone just out of training to go to the country and be faced with establishing a practice and the associated paperwork, particularly if the hospitals were not onside and people were not sympathetic.

Mr WHITELY: Are you generally in favour of the concept of VMPs providing service in country areas through a fee-for-service arrangement that is based on a good working relationship between the hospital and the local doctor?

Dr Jarvis: Doctors should be rewarded for being on call. Being on call means that we cannot go to a party that we would otherwise go to or on a weekend trip away with the kids. Doctors should be rewarded for being on call. Some payment for that should be built into the next agreement. There should also be payment for rurality. I think that is in the pipeline. The idea is that the further away one is from the support mechanisms that big towns offer, the more one is rewarded.

Mr WHITELY: One suggestion in Albany related to a general surgeon who is often on call but rarely called in. However, it is essential that he be available. Most of the time there is no reward for that. Some GPs are also on call, but they generally pick up a decent income because they are frequently called in. Out of that came the suggestion of an on-call fee that is payable if the doctor does not earn sufficient income from on-call work. That would involve a sliding scale, whereby the on-call fee would decrease as income went up. Would that be an acceptable compromise?

Dr Jarvis: I am sure it would. That could be negotiated. People want to feel that they are rewarded for being on call. There is a range of different formulas. The Mandurah hospital introduced one - I am not completely familiar with it - to create some balance of amounts.

Mr WHITELY: This suggestion was put up in Albany yesterday, and there was a divergence of opinion. Some of the doctors said they should all get an on-call allowance as a matter of principle, and that giving it to one doctor would create a precedent. That would obviously create a problem for the health budget. My personal opinion at this stage is for a more individualised system. Do you think that is something that should be considered, rather than a practice that is based on precedent elsewhere? Otherwise, such a scheme would be robbed of its flexibility, and the regions would not be able to find their own solutions. What is your slant on that?

Dr Jarvis: I am not sure. I am not an expert in remuneration. I would be happy if someone paid me a nominal sum for being on call, knowing that if I were called in and the payment for my services was more than what I was getting for being on call, the on-call fee would be cut back to a certain extent. A doctor in a country town might not get called out. The chances are that the nurses in the hospital will take care of most things, although the doctor will sometimes get called. However, in a bigger town, the guy on call might get called out four or five times a night. He would not get any sleep. Therefore, he would need some sort of income to cover the next day so he could write off his patients and go home to bed.

Mr HOUSE: Do you accept that the on-call component is built into the fee payable when you are called?

Dr Jarvis: It could be.

Mr HOUSE: No, it is now.

Dr Jarvis: It is now.

Mr HOUSE: Do you accept that?

Dr Jarvis: I accept that there is a premium for working after hours and between midnight and 5.00 am.

Mr WHITELY: That does not help solve the problem of the general surgeon in Albany who does not get called out.

Dr Jarvis: No.

Mr WHITELY: That is the dilemma.

Dr Jarvis: The premium is for the inconvenience of getting out of bed and driving to the hospital.

Mr HOUSE: I play the devil's advocate: why as a doctor are you different from me as a farmer who has to be on the farm 24 hours a day, seven days a week during seeding or harvest, or a businessman who runs a business and who works around the clock?

Dr Jarvis: We are no different; we are businesspeople. However, the average GP in these areas are businesspeople who are under particular pressure.

Mr HOUSE: Are you referring to the pressure to save lives?

Dr Jarvis: Yes. That is the difference between businesspeople and us. A farmer does not have to get up in the middle of the night because his crops are on fire; he can get up the next day and collect the insurance. However, a doctor cannot ignore a patient.

Mr HOUSE: Are you familiar with the visiting medical practitioner service that was run in country towns on a fly in, fly out basis and was started by Tony House?

Dr Jarvis: Yes.

Mr HOUSE: Was that a useful and beneficial service? Should we support that service?

Dr Jarvis: That service is a bit like the general practice in Perth that closes its doors at five o'clock and means sick patients must go to the hospital and wait in the accident and emergency department. That is not good for the patient.

Mr HOUSE: Wongan Hills, for example, has no specialists, although it has a GP. The fly in, fly out service would conduct minor surgery procedures and the after-care was left to the local hospitals, which meant that the nursing skills were developed. It was advantageous that the surgery was done because, as I understand it, some of its patients might not otherwise have presented themselves to hospital. That system operated by reversing the patient assisted transport scheme. In my view, members of that fly in, fly out service were visiting medical practitioners. Was that a useful service?

Dr Jarvis: Basically, it was a good service. I am enthusiastic about doctors and specialists who visit country areas. That means, for example, that patients in a small town would know that in a month's time an eye doctor would visit the town; therefore, the patients knew how long they would have to wait before they could be treated. There was also a link with that specialist. If something went wrong with a patient, the GP could ring the specialist who could provide some good advice over the phone. The doctor would know the specialist and the specialist would know the situation in which the doctor was working. It is an ideal situation for continuity of care. That type of service is terrific and should be encouraged. Specialists who operate in those rural areas take an anaesthetist with them if they know that one is not available. It is good for the hospitals because the nursing staff maintain their skills and remain interested in the job. Although there may be some instances around this State where these services are good, for example, flying a well woman's clinic to isolated areas and conducting pap smears on 50 women in a day is fine if that is all it pretends to do. However, that is no way to look after the whole patient. Sometimes those clinics can be worthwhile and sometimes they will not be welcome because they can interfere with the doctor-patient relationship.

Mr HOUSE: That is an interesting point. Would you like to add anything to what has been interesting evidence?

Dr Jarvis: No, but thank you for listening.

Mr HOUSE: The committee intends to visit some small country towns and it will follow up on some of those issues. You are quite right when you said that the committee has visited some of the larger towns. In summary, in the past few weeks, members of the committee have developed a huge amount of respect for country doctors, nurses and associated health professionals. Although they perform very different roles in very different places, we have not come across anybody for whom one could not have a tremendous amount of respect considering the difficult situations in which they work - professional as well as geographical isolation. The committee is aware that those medical practitioners do a huge and demanding job, and it is likely to provide positive recommendations. We will not finalise this report until early in the new year; therefore, we are happy to take any supplementary evidence that can be addressed to us at Parliament House. If you think of something on the way home that you wanted to say -

Dr Jarvis: I have just thought of something. Mr Whitely asked about some other way to pay peak doctors to be on call. The salaried medical officers in this state are paid a 25 per cent on-call and call-back allowance, which is not inconsiderable, on top their salary. That is something for the committee to consider.

Mr WHITELY: It could possibly still leave a problem if it is in addition for the doctor who is on call and rarely gets called but essentially must be on call because -

Mr BRADSHAW: Twenty per cent of nothing does not add up to a lot.

Dr Jarvis: Exactly.

Mr HOUSE: Thank you very much for taking the time to appear before the committee.