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

SEVENTH SESSION

Members

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

McCALLUM, DR KEITH ARNOLD,
Obstetrician and Gynaecologist,
examined:

The CHAIRMAN: The 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. Mr McCallum, have you completed the Details of Witness form, and do you understand the notes attached to it?

Dr McCallum: Yes.

The CHAIRMAN: Have you made a written submission?

Dr McCallum: No, I have not. I rang up to inquire about the committee and then I was told to attend so I -

The CHAIRMAN: Can you give us some background about where you are from and how you fit in?

Dr McCallum: Ten years ago, I arrived in Kalgoorlie-Boulder as an obstetrician and gynaecologist. I trained in Western Australia as a medical student and then applied for training at King Edward Memorial Hospital for Women where I was told I was too old. I then went to the United Kingdom for 11 years. I returned to the goldfields as the first obstetrician and gynaecologist in this region. I have brought a map as evidence of the area that we cover in obstetrics and gynaecology. It is not quite true because as we go to the borders and some of the edges are hazed on the map.

The CHAIRMAN: Is it the dark or the light area?

Dr McCallum: The dark area, which is the health and aged care area, is what I covered. I tried to show the area that I covered in relation to other States but it wipes out most of Victoria, part of New South Wales and only a third of Queensland. I arrived here to start an obstetric practice and had been working there until 18 September when I stopped doing obstetrics.

The CHAIRMAN: How long have you been here?

Dr McCallum: For 10 years.

The CHAIRMAN: Did you work here before then?

Dr McCallum: I passed through the area. I did a locum in Kambalda until I got very ill. I was admitted to this hospital and had a rather embarrassing operation on a part of the body that we will not mention, which was my only experience here. I worked here as a specialist for 10 years and last year I was honoured with an award. Last year, the International Federation of Gynaecologists and Obstetricians had an inaugural program and awarded six awards for emergency obstetric care throughout the world. It will be averaging two awards a year from now on. I was one of the fortunate recipients of one of those first awards. I have been a member of the hospital board for three and a half years, and we may touch on that during my evidence.

An attractive aspect of the work here is that anything can come through the door and that is what makes it interesting. Over the last 10 years this area has had the lowest per capita transfer rate to the city for obstetric complications, and we have had amongst the lowest in Caesarean section rates in Australia. The average is about 10 per cent for the last 10 years. The problem with Kalgoorlie and visiting medical practitioners is that our problems are not the same as Perth.

The CHAIRMAN: What do you see as the difference between here and Perth?

Dr McCallum: In my job, the main difference is that I have no junior staff. I see everybody that comes through the hospital. When I am in town I am on call 24 hours a day and I have had every bodily function interrupted by emergency calls to hospitals; I literally mean everything. I have had to leave balls and I have had to attend the hospital in a state when I should not have attended the hospital. However, there is no opportunity for a single-handed specialist to relax and unwind. There must be a compromise. There are times when I should not have been here but there comes a time when you realise that you have the most experience and you have to be there no matter what your condition. I have had to get out of my sick bed and that has been an interesting exercise; that is, to be more incapacitated health-wise than the patient and having to get out of bed and go to the hospital with a roaring fever. What fascinated me about this part of the work is that a patient has never said thank you. I might be a little more sensitive when I am ill but I have never had a thank you for getting out of bed and going to see a patient when I am ill.

Visiting medical practitioners are a very cost-effective way of doing the work here. When I have used specialists from Perth, they have not been able to do the workload that I get through in a four-hour session. Every session I have had in theatre has taken about eight hours. When we have had to employ anaesthetists from Perth, they cannot handle the workload that we do in a two or three-hour session and it usually spreads to a six or eight-hour session if a staff specialist comes up to cover the work. They cannot cope with the obstetric workload. I cover about a 1 000 deliveries and often consult with clients in Esperance, of which there are about 200 a year, with another 600 to 800 clients in Kalgoorlie a year. I have just come back from a course in Melbourne. That same workload is covered in Mildura Base Hospital that has four specialists. They are now appointing a professor of obstetrics and they have a senior registrar and three junior staff to cover that workload. I do that amount of work by myself here. Peel Hospital recently cast an invite to me to review their premises. It has 600 deliveries a year and it is looking for a third obstetrician to do the workload. Kalgoorlie Regional Hospital has an extremely cheap service considering what would happen if it had to employ staff specialists.

The CHAIRMAN: What sort of the salary do you take out of the VMP service here?

Dr McCallum: I do not take a salary out of the VMP service and I want to make this quite clear to the Minister for Health. It has been reported to me that he has stated my salary throughout Western Australia and quoted my income in Parliament, which I consider to be very rude. From the hospital I earn approximately $350 000. More than 60 per cent of that is consumed in staff, expenses and rooms expenses.

The CHAIRMAN: What per cent of your practice is private and public?

Dr McCallum: About 10 per cent is private. Very little -

The CHAIRMAN: Is 90 per cent of your time spent working for the hospital?

Dr McCallum: No, you asked what percentage of patients are public and private.

The CHAIRMAN: I mean public and private working as a consultant to the hospital; as a VMP and working privately as your own -

Dr McCallum: I do not think I have ever tried to work that out. However, when I was working as an obstetrician, I usually started work at about 7.30 or 8.00 am and would do two hours in the hospital. I would then work in my rooms for about three hours then return to the hospital for about an hour, back in the rooms for three hours and finish at about 6.00 pm in the evening. That is public work. The private work is what happens in the rooms.

The CHAIRMAN: When would you fit the private work in if you were doing that every day?

Dr McCallum: Fit what in?

Mr HOUSE: It is about 50 per cent.

Dr McCallum: I did not say that there is also an all night on-call service and in an average week, I used to attend hospital three nights a week and would have about five or six phone calls to my residence in the evening.

The CHAIRMAN: So the ratio is about 55/45?

Dr McCallum: Something like that. It is hard to work it out. Two sessions of that time are theatre time, so it would be about 60 per cent public to 40 private patients. Much of an obstetric service is charged for using a global fee system. In other words, there is one visit and one fee and it covers everything that happens. Most of my visits to the hospital do not attract a fee. I canvassed several of my colleagues and we forget to charge for many of the items that are raised. I estimate that about 10 per cent of the services that I provide for the hospital are not charged because they happen at 2.00 am; an emergency occurs, the flying doctor comes in and who knows what you have done by 6.00 or 8.00 am when you get out of bed and go back to work. Many items are not charged for and we are all the same here in this town. It is what we consider part of the work. The on-call in the hospital here is voluntary, or has been up until now.

The CHAIRMAN: What does that mean?

Dr McCallum: Being on call is a voluntary service. There are savings for the hospital with it not being staffed because there are quiet times in this town, certainly in the obstetrics and gynaecology areas. There are two periods of heavy work; one is in September, which is nine months after Christmas, and the other is in Christmas, which seems to be nine months after people celebrate the weather getting cold by cuddling up or whatever. The advantage of having VMPs is that if there is no work in the hospital, they do not get paid and they occupy themselves elsewhere. There are no overheads for VMPs. There is no car, no superannuation, no staff, and no holiday. VMPs are not provided with a car, superannuation, staff, holidays, on-call administrative loading or country allowances. Staff specialists are provided with all those things. I believe that the VMPs are vastly under-utilised in this town. They are an educated group of people, some of whom are even wise.

Mr DEAN: You said "under-utilised", yet you are working flat out.

Dr McCallum: I will explain that in a moment. All VMPs have business acumen because they all run their own businesses. Several years ago, somebody arrived in town and organised a day surgery to be built at the hospital. I am not sure whether members understand what a day surgery is, so I will explain it. People who can walk in and walk out of surgery are admitted to a day surgery, so there is no technical bed admission. The day surgery to which I referred was built on the advice of an architect in Perth who built it away from the operating theatre block without requesting any information from the VMPs beforehand. It might be the second biggest white elephant in the hospital. It is certainly a toss up between three or four white elephants currently at the hospital. The day surgery has been a particularly useless device because with some modification and proper management we could have handled twice the current workload. Having specialised in day surgery in Europe before I came here, I have a particular interest in it. It has been a great shame to have such a useless edifice.

Mr BRADSHAW: Was that built by the hospital? Earlier today, somebody talked about the goldfields medical centre. Some hospitals have their own day surgeries.

Dr McCallum: There was some skulduggery involved in the background to its construction. Advisers of the previous Government advised that the day surgery be closed and that a day surgery be opened at the hospital. If the adviser had not been paid by both camps, and if there were not - I am not allowed to say that. I suspect the adviser had a conflict of interest between those two opinions. Am I permitted to say that?

The CHAIRMAN: You are covered by parliamentary privilege.

Mr HOUSE: I do not know what you mean. You can be as silly as you like, but I do not understand what you are talking about.

Dr McCallum: The town had a private day surgery that employed a consultant to determine how it could best be serviced. That consultant advised that the private day surgery should close while, at the same time he was employed by the hospital, he advised the hospital to open a day surgery. As strange as might be, the private day surgery closed just as the day surgery at the hospital opened.

The CHAIRMAN: If the private day surgery made money, why should it have closed?

Dr McCallum: It was not making money.

The CHAIRMAN: Why not?

Dr McCallum: That is a difficult issue. The Commonwealth Government has a schedule of fees that can be charged in a private free-standing hospital. The private day surgery had to pay that fee even though it was operating on its own patients from the Goldfield Medical Fund. The patients were much better off going to the hospital to have free day surgery, which is an absolute rort because the hospital made no money out of it. The patients that belong to the Goldfield Medical Fund all come to the hospital to have free treatment. It is an absolute bloody rort that has caused great difficulty in this town. I could not charge obstetric patients above any schedule fee; if there was only a dollar difference, they were treated as public patients. The difficulty for the hospital is that it makes no money out of public patients; they just cost the hospitals money. The hospital makes money only from private patients.

The CHAIRMAN: Is it correct that the VMP payment to you for public patients is higher than the Medicare fee but below the gap fee?

Dr McCallum: Yes; however, not for many patients. Some 75 per cent of my cases involve difficult obstetric patients. I see very few patients who have uncomplicated deliveries. Most of them are Aboriginal or have high-risk pregnancies, all of whom are now going down to Perth for their deliveries.

Mr HOUSE: What percentage of them go to Perth?

Dr McCallum: About 25 per cent of obstetric patients go to Perth to have their deliveries. I am on the ward, but I have not seen the figures since I stopped -.

The CHAIRMAN: Who does the obstetrics at the hospital now?

Dr McCallum: The six GPs. I will refer to that later. During the three and a half years I spent on the hospital board, I was desperate for the opinion of a doctor. Some very silly decisions were made because nobody on the board had any medical knowledge about the result of the decisions it made.

VMPs also provide staff training at no cost. To my knowledge, no VMP has ever been paid for education sessions. I may be wrong, but I certainly was not paid, and I have regularly run training sessions for GPs, nursing staff and midwives, and I teach medical students. We all conduct training that is all done gratis. The result is that GPs in the town do obstetrics. They are highly motivated, with very good skills and they achieve a high level of job satisfaction. One of my colleagues mentioned that those things are important. When visiting specialists come to town, they are amazed at what we do here. The two visiting specialists that come to mind are the oncologist from Royal Perth Hospital, and Craig Waters, the urologist from Joondalup. Another thing that impressed me when I was on the hospital board - this might be more in the members' line of business - was the lovely meeting culture of the Health Department. I find it very difficult to contact people in the hospital establishment because they are always at meetings. VMPs cut meetings short because they have other businesses and other work to attend to. Generally, they hold their meetings at reasonable hours, and those meetings do not drag on. VMPs in Kalgoorlie play an important role in cutting down the meeting culture.

The next issue I will raise is important to VMPs but is not in any job description. It is important for them to just be at the hospitals with the patients. I do not know how many members have been to a

hospital recently, but I have been at this hospital for 10 years. In the first couple of years, I used to see the senior nursing staff on the wards, but now I do not see them on the wards very often. That is an important issue for morale. As members would be aware, in the past few years nursing morale has been low. The doctors in this town are part of the glue that keeps the hospitals together. They provide an avenue of morale for their staff. I believe that the doctors in this town provide continuity of care at the hospital. The turnover of administrative staff occurs fairly frequently and the turnover of nursing staff is almost as frequent. However, the turnover of doctors does not occur as frequently. The doctors provide the continuity of care in this town.

Doctors are important because they communicate to patients all the time; they speak the same language as the patients. Patients even like to be called patients, but the administration calls them clients, which might be appropriate because that is what is referred to as a legal customer. Often we must interpret for the patients and the staff what the administration wants to happen.

The CHAIRMAN: What do you mean when you say that it must be interpreted?

Dr McCallum: Some of the rules that are handed down from the Health Department are uninterpretable by ordinary people.

The CHAIRMAN: Would you provide an example?

Dr McCallum: How many dictums are handed down each year by the Health Department?

The CHAIRMAN: I have no idea, but tell me some of them so we are at least informed of what they might be.

Dr McCallum: I wish to table a document later and I will use it as a broad illustration of what the Health Department is doing. On Monday, I rang to inquire about this issue and I was told to attend the committee, so I have not had a great deal of time to prepare. I will provide members with some examples.

The CHAIRMAN: You can provide the committee with a written submission later.

Dr McCallum: Doctors are advocates for patients' needs and they interface with the administration. For example, this year a specialist back service has started because the service we provided here could not cope with the workload. A chronic pain service was also started. The VMPs initiated those programs - not the Health Department or anyone else - because the VMPs saw the need to have them. In emergencies, we all cover each other. At times, I have had to perform outside of my specialty. I have performed appendectomies when there was no one else available. GPs and specialists throughout this town work and cooperate together. That cooperation is unique to this town. They might not all be best friends, but in this town the VMPs get on and work together. As I said, all of the VMPs in town and I teach medical students. As members know, the rural clinical school is about to open here, which is important. There has been an enormous amount of goodwill between VMPs and the Health Department. I have every reason to believe that this goodwill is rapidly disappearing.

The CHAIRMAN: Why do you say that?

Dr McCallum: I will discuss that when I refer to the conditions of service of VMPs. Three years ago, the per capita cost to Medicare in this town was the lowest rate in Australia. It is important that that be recognised. In the terms and conditions, which is the second point of this inquiry -

The CHAIRMAN: You said it was the lowest Medicare rate in Australia. Why did you consider that important?

Dr McCallum: If all of Australia could operate at the per capita cost of Kalgoorlie -

The CHAIRMAN: The problem is that if Medicare is low, the state payments are high.

Dr McCallum: Not necessarily.

The CHAIRMAN: That is the impression. I would prefer it if the Medicare payment was higher and the state payment was less, because the onus should be on the federal system, not the state system.

Dr McCallum: I understand that and I understand the transfer that occurs between those two systems. However, 90 per cent of my patients are public patients, and Medicare also includes doctors' surgery visits. Generally, the Health Department does not consider that that item should be added to the conditions of VMPs. The total health care cost of this town is still one of the lowest in Australia because there is no duplication of services and people do not hunt around from doctor to doctor. Anyone who knows anything about drug abuse will know that doctor hunting is a favourite past time of some patients.

The CHAIRMAN: As a long-time pharmacist, I know those problems quite well.

In regard to terms and conditions, when I arrived in Kalgoorlie I refused to sign the contract from the Department of Health because it did not recognise my status as a specialist. I found that difficult because I had trained overseas for 11 years on what I considered to be very little money. When I arrived in Kalgoorlie, I could not get a mortgage or even an advance from the bank to start my business because there had never before been an obstetrician there and nobody would make money available. When I started here life was very difficult. The only reason my wife and I got started in this town was because I imported two vehicles, which I subsequently sold to my own company. I was able to use the money raised from that as a deposit at the bank to get a mortgage. I refused to sign the contract because I was paid the same rate as a general practitioner. That is more or less what I still get paid. I spent another 11 years getting my qualifications and I felt - and still feel - that it was unfair especially because, until recently, I was paying five times more insurance than a GP pays and the risk that I take as an obstetrician lasts for 27 years. In fact, after my death my family can be sued if it is considered there is a problem; that is a fairly onerous responsibility.

Mr WHITELY: Could you explain why the risk lasts for 27 years?

Dr McCallum: Any legal writ can be issued six years after an incident and up to the age of 21 in the case of childbirth. The committee would have heard of a recent case in Sydney involving a 22-year-old woman.

The CHAIRMAN: You say that, but the figures presented to us indicate that you are the highest paid visiting medical practitioner at the hospital.

Dr McCallum: I do not believe that is true, but I do not know.

The CHAIRMAN: The figure of $350 000 for you is the highest VMP payment.

Dr McCallum: Nobody else in this town, apart from the orthopaedic surgeon, works 24 hours a day. He does not get anywhere near the number of call outs that I get and he does not have an insurance policy that costs $54 000 a year.

The CHAIRMAN: Why do the other four other obstetricians, who also have their own medical practice -

Dr McCallum: What four obstetricians? There are not another four obstetricians in town. I beg your pardon.

The CHAIRMAN: GP obstetricians; I apologise for the terminology.

Dr McCallum: Thank you.

The CHAIRMAN: Their salaries are nowhere near this scale.

Dr McCallum: Yes, but how many weekends a year do they get off?

The CHAIRMAN: I have no idea; that is why I am asking the question. I am not having a go at you.

Dr McCallum: Perhaps you do not understand how a specialist works. I cover everyone else; when they get problems they call me. That is why my insurance is so high; I have to carry the risks they take.

The CHAIRMAN: I am not talking about insurance. You are saying that is the cover you provide.

Dr McCallum: Yes.

The CHAIRMAN: That is great, but if you are getting only the same amount as they are getting, why is yours higher? Is it because you have extra patients or patients come from somewhere else? If you are covering only excess patients who they cannot handle, how come your payment is high compared with theirs?

Dr McCallum: I am sorry, I am confused between payments and payments.

Mr BRADSHAW: No, the chairman is talking about the insurance costs and why yours is $54 000.

The CHAIRMAN: No, I was not talking about that.

Dr McCallum: No, I did not think he was, but that is what was said.

The CHAIRMAN: I did not call it salary because you objected to its being called salary. I am talking about the payment for your VMP service.

Dr McCallum: Hold on, it is not bloody salary! I beg your pardon.

The CHAIRMAN: That is why I just said it was the payment for your VMP service.

Dr McCallum: More than 60 per cent of that disappears in costs.

The CHAIRMAN: I am not arguing about that. I am talking about the total amount you received from the Department of Health, whatever we call it. Why is it high when, as you said, your fees are exactly the same as the other GPs' fees?

Dr McCallum: This is not just about obstetrics.

The CHAIRMAN: What is the answer?

Dr McCallum: I take responsibility for about 800 operations a year. I cover about a quarter of the surgical workload of the hospital by myself with no assistance whatever.

Mr WHITELY: When you say 800 operations, do you actually perform those operations every year yourself?

Dr McCallum: Yes, about 800. That is why I am interested in day surgery. With a properly designed day surgery I could cut by half the length of time I spend in theatre. Guess what I would like to do? The most expensive item in the hospital is surgery and I would like to cut in half my surgery costs. You can go to the hospital and ask anyone there: I am its most economical surgeon.

Mr WHITELY: Pardon my ignorance, but how would day surgery cut the costs? Is it because patients would be there for a shorter time?

Dr McCallum: Yes. The hospital I worked at in the United Kingdom had a dedicated unit, part of which I helped to design. I also helped to design part of the equipment. In a three-hour operating session, I handled 16 cases.

The CHAIRMAN: Were they gynaecological cases?

Dr McCallum: Yes. In Kalgoorlie I can average about three cases an hour.

The CHAIRMAN: I am completely ignorant and have no idea of the difference between an operation in day surgery and one in hospital.

Dr McCallum: The difference is the way in which it is organised. In day surgery patients walk in, get on a table and the table goes out with the patients. The handover and theatre times are

dramatically reduced. The only aspect that matters is the time taken for the anaesthetic, for which patients need ultimate care. In Kalgoorlie Regional Hospital a porter must be sent off with a trolley. The porters or orderlies - or whatever they are called now, the name changes every year - are always late. It takes time to transfer patients to theatre and transfer them onto a table by two to three people. The increased workload is enormous. That is why theatre is the highest single cost in this hospital.

Mr BRADSHAW: Was day surgery mentioned when you were on the board?

Dr McCallum: That was organised before I sat on the board. We were given the new hospital plan when I sat on the board and told we had 15 minutes to vote on it. We were told, "If you don't vote on the plan and you don't get the money in the next five years, it will go to Geraldton or Bunbury or somewhere else. You have to vote on it now."

The CHAIRMAN: Is there a day clinic operating there now?

Dr McCallum: Yes, there is a day surgery there.

The CHAIRMAN: So, why can it not get the throughput?

Dr McCallum: Because it is built away from the theatre, the patients have to get on a trolley to go to theatre, they come back on a trolley and they are transferred across on a trolley.

The CHAIRMAN: Surely that does not waste that much time for you because you are the surgeon.

Dr McCallum: It does. I have to wait while the orderlies transfer the patients in and out.

The CHAIRMAN: Surely they know when you are going to finish and have the next one ready.

Dr McCallum: The average time for most operations I do is about five minutes.

Mr WHITELY: Pardon my ignorance. There is obviously a very simple answer, but I would like to hear it. Why can they not have the patients waiting for you if it is a matter of transporting a trolley?

Dr McCallum: They are not allowed to do that. That is simple theatre policy. You cannot have that.

The CHAIRMAN: What is the logic behind that? Right or wrong, there must be a rationale behind that.

Dr McCallum: Patients going to the wrong theatre. Having a leg off is a very expensive procedure if you wanted a mole removed. That is what happens. If you have patients waiting next to the theatre, they go into the wrong theatre and the surgeon says, "Remove his spectacles, not his -

Mr DEAN: Testicles!

The CHAIRMAN: Is there demand for 16 operations a day?

Dr McCallum: No. What I am trying to say is that in the UK, where I trained, which had proper day surgery, instead of taking two operating lists a week, I could do my operating in one list a week. That halves the standing costs of the operations. I think that is important. All that I have ever tried to do in this hospital is cut down the operating costs of the hospital, so much so that I have my own ultrasound scan on the maternity ward because this hospital has never had enough bloody money to pay for it.

The CHAIRMAN: What is the difference between the day surgery process you had in Scotland and here? Is it the fact of the queuing business?

Dr McCallum: Just that it is properly organised. Patients get onto an operating table that is wheeled into the theatre and it is not cleaned in theatre. One can therefore go from one operation to the next with no cleaning or transfer time. All those things take as long as an operation, or longer.

The CHAIRMAN: Is that not built into the fee that is built into the cost of the operation?

Dr McCallum: Yes, but the point I am trying to make -

The CHAIRMAN: If someone takes a day to recover from day surgery, no matter what you chop out, it will take a day whether that it is in day surgery or in the hospital.

Dr McCallum: No. What I am trying to say is that I can cut in half the costs for the hospital. All the costs for day surgery are the standing costs and the equipment costs, all of which can be cut in half if we can double the turnover. Would you not agree?

The CHAIRMAN: Yes. You are not cutting in half the costs, just getting twice the productivity.

Dr McCallum: Yes, I am sorry, but the unit cost is reduced.

The CHAIRMAN: The argument about day surgery versus hospital surgery obviously relates to the length of stay in hospital for the patient.

Dr McCallum: No, I am not comparing it with hospital surgery. I brought that up as an example of how the hospital is poorly organised, poorly funded and poorly thought out.

The CHAIRMAN: You are saying that you prefer to use day surgery, but you cannot because of the hospital. The only difference I can see is that you are doing three as opposed to 16 operations. However, the fact that the patients stay only a day should not change.

Dr McCallum: It does not.

The CHAIRMAN: Therefore, the only extra cost is a productivity cost. However, productivity is only there if you have enough processes to continue performing operations. You must have 16 operations to perform. You might do only three a day because you have only three to do.

Dr McCallum: No, that is not true, because of the way in which theatres are staffed. There are morning, afternoon and on-call shifts. It is about twice as expensive for the hospital if staff are called in for an on-call shift because the theatre list has gone over time. The standing costs of a theatre block are enormous. The less time one can take in an operation, with safety in mind, the less cost to the hospital. That is why day surgery has been popular throughout Australia.

Mr HOUSE: Did you say that it was poor organisation by the hospital that created this problem?

Dr McCallum: It would not be fair to say that it was the hospital. It is probably the fault of the Department of Health.

The CHAIRMAN: How can it be the department's fault when the board approves what is going on?

Dr McCallum: That is a very good question.

The CHAIRMAN: What is the answer?

Dr McCallum: From what I have seen in this town, the questions and answers are generated in Perth.

Mr HOUSE: Let us simplify the issue. If your problem is replicated in every operating theatre in Western Australia, are you suggesting that the answer is greater productivity with very little increase in costs - because those are the facts - which would eliminate waiting lists, deliver a better health care service and solve people's problems?

Dr McCallum: I am sure. If I could take Dr Braimbridge to Perth and get a properly designed unit, I think it would make a significant imprint on the Perth waiting lists.

Mr HOUSE: Are you suggesting that the Department of Health prevents that simple solution from occurring?

Dr McCallum: No, I did not say it prevented it. It did not have the foresight and it did not ask advice on the matter.

The CHAIRMAN: How could it alter that building to satisfy your requirements?

Mr DEAN: Knock it down?

Dr McCallum: Thank you so much.

The CHAIRMAN: It has nothing to do with the building.

Dr McCallum: It has got to do with the building. It is the organisation. The building is separate, in another corridor. There are four corners to go around.

The CHAIRMAN: Can a corridor to it not be built? You have said there is a problem, but I still do not have an answer to the problem.

Dr McCallum: I shall walk you through the problem. I simply illustrated one of my frustrations. I shall continue on the terms and conditions. I do not believe that any other doctor in this town signed the previous contract that was available; we have worked under goodwill.

The CHAIRMAN: They have not signed a contract, but they are getting paid the fees in the contract schedule.

Dr McCallum: I know it is a contract and I want to refer to this matter now. In 1998, the federal Government agreed to a complex delivery fee, which is item 16522. There was considerable improvement, including a prescribed list of obstetric complications and an increased fee. The hospital agreed to pay that fee as at April 2000 and paid it retrospectively for cases back to November 1999, when the fee was first promulgated. In April 1999, the federal Government agreed to pay the new fee. Four general practitioners and I claimed that fee in the appropriate accounts, and the hospital paid it fee and the retrospective fees. In April 2000, I was called to an office two doors down from mine and told that I had mistakenly claimed the fee. I was told that I owed the hospital $40 000 and that I should pay it there and then. I applied for arbitration in the matter, as I was entitled to under the terms and conditions that we then had, and my work was audited. I was called into the head office again in February and informed that at that time the hospital would not pursue repayment. I emphasise “at that time”. I had used every process available to clear up this matter. I had a legal contract. I had been paid for 15 months and the Department of Health reneged on it. Since that time, the department has issued a new contract.

The CHAIRMAN: Has it been agreed to?

Dr McCallum: No. Has any member seen this document?

The CHAIRMAN: We will have it tabled.

Mr DEAN: The health service board is your employer, not the Department of Health.

Dr McCallum: Monkeys! There is not a decision in this place that does not go to Perth first. After three and a half years of working with the board, I have found that it is a waste of time.

Mr DEAN: Why have a board and a general manager?

Dr McCallum: Because it is imposed on us by St Elsewhere. It is a waste of time. Everything has to go to the board for approval, and then it goes to a committee for a decision. It has a meeting about it and it goes to the board. The board cannot meet that month and it is put off until the next month. I am sure members know how these political processes work.

The CHAIRMAN: I refer again to the complex fee. The Commonwealth might have agreed to it, but it is not incumbent upon the State -

Dr McCallum: I do not mean to be niggardly, but fair play has always been central to the Australian culture. That fee is paid across the border. If someone from Dr River goes to Alice Springs for treatment, that fee is paid. However, because they come this way, I do not get the fee. All of my colleagues in South Australia and Victoria -

The CHAIRMAN: It could also be argued that the commonwealth sets the Medicare fee and that it is not paid here either for VMP services.

Dr McCallum: Generally speaking, whenever there was a new Medicare fee, it was incorporated in the Western Australian schedule within the following year.

The CHAIRMAN: But the VMP service fees are much greater than the Medicare fees.

Dr McCallum: At the moment they may be, but they were not originally. I do not believe that they were in 1996.

The CHAIRMAN: We will have both listed.

Dr McCallum: They may be now, but in 1996 they were not. It was less than that at that time.

The new contract is very difficult, to say the least. It calls doctors "contractors". I am not sure why, but I have been ashamed that people keep talking about my income and my salary. I suspect that there is a witch-hunt under way involving rich doctors. That is my opinion. I am not sure whether members understand the wages some people in this town take home. Bogger drivers can earn up to $200 000 a year for a 50-hour week.

The CHAIRMAN: What is a bogger?

Dr McCallum: It is a big machine that is worked underground. It pushes muck along to a decline. The muck then falls into a crusher and is taken to the surface. It is heavy equipment and the drivers undergo three weeks' training.

The new contract states that doctors should take out indemnity insurance for the hospital. That is public indemnity insurance, not medical indemnity insurance. That is a farce. I believe that is included in the new contract. We have made inquiries and discovered that no insurance company in Australia will provide it.

Mr WHITELY: Please explain the difference.

Dr McCallum: I have asked the Department of Health to explain it because we could not work out the difference. The example it gave us last year was that if I were to leave my briefcase on the floor in a ward and someone tripped over it and broke his leg, the hospital would be covered because that involved a member of the public. Each doctor in this town would be required to take out $10 million of cover for the hospital. That works out at about $200 million of cover for the hospital. We would be able to get a new one for that!

Mr WHITELY: Is that instead of paying $65 000?

Dr McCallum: I am the only one who pays that.

Mr WHITELY: Do you have to make another payment on behalf of the hospital to cover its liability?.

Dr McCallum: It covers the hospital, the board and the Department of Health.

Mr WHITELY: Are you saying that it is cost shifting from them to you?

The CHAIRMAN: We are not talking about the final agreement.

Dr McCallum: That is what we were hit with one evening. We had not heard about it previously. No company in Australia will provide that cover. What is the point of including it in the contract?

The CHAIRMAN: The contract has not been finalised yet. The committee has been told that it is still being negotiated.

Dr McCallum: It is. Last week -

The CHAIRMAN: Are we talking about your picking up some public liability that the hospital would otherwise pick up?

Dr McCallum: This is a new policy. We do not know what it means. It has come out of left field.

The CHAIRMAN: Is it over and above your medical insurance?

Dr McCallum: Yes. We do not know what it covers. That has been included in our contract, or it will be in the contract.

Mr WHITELY: Is it in the draft contract?

Dr McCallum: Yes. The arbitration system outlined in the non-existent contract is most unfair. All our lawyers - we have all taken the document to a lawyer - have said that it is an unworkable document. There is also no sensible dispute resolution in the proposed contract.

The CHAIRMAN: Did you sign the previous contract?

Dr McCallum: No, I did not sign it.

The CHAIRMAN: Presumably other people did.

Dr McCallum: No-one in this town signed it. There was an agreement between the Australian Medical Association, which did the negotiations, and the Department of Health. The Australian Competition and Consumer Commission deemed that it was not workable. This new contract was drafted by the Department of Health to cover the previous contract. It has taken five years to draft this document. In that time, there has been no change in the fee structure.

The CHAIRMAN: Have the negotiations about this draft contract been between the AMA and the Department of Health?

Dr McCallum: No.

The CHAIRMAN: Has it been sent to you individually for signing?

Dr McCallum: I have been told that it is essentially the same as the one I have tabled here today, which was last year's contract. Our lawyers have advised us not to sign this new contract because it involves a loss of legal rights. That is what has happened to me over the past two years. I have realised that to be a specialist doctor in this town I must sacrifice my legal rights. No-one will represent me in this dispute with the hospital or with regard to the new contract. The final insult in this proposed contract is that, as a contractor, I must sign over the intellectual rights for anything I discover while I am in this town. That is wrong.

The contract also imposes a compulsory on-call arrangement rather than a voluntary arrangement. I believe that that contravenes several Acts of Parliament. It is totally unworkable. This is a very good way to lose any goodwill that may have existed between the Department of Health, the hospital and the VMPs.

A fortnight ago I was invited to meet with the general manager of this region to discuss providing obstetric services. I am happy to provide them, but not under the existing arrangement. I have discovered a new life not having to get out of bed every night. I am able to go home and not come back to the hospital in the evening. It has been exciting. I was invited to discuss the matter and agreements were reached. The local board agreed, pending approval by Perth. That goes back to the question asked about Perth: as long as Perth approves it, the board will agree that I can start work again providing obstetric services. I was asked to put my signature on the contract, but I was not allowed to read it. I am now very bitter and twisted. That would have been the seventh meeting I had had about the issue. It is entirely inappropriate for doctors to have to negotiate their own contracts, especially country doctors who have much better things to do - like work. I feel very sad about what has happened.

Mr BRADSHAW: I find it hard to believe that someone would ask you to sign a contract that you were not allowed to read.

Dr McCallum: They were the exact words.

Mr BRADSHAW: No-one in their right mind would ask someone to -

Dr McCallum: Apparently, once one becomes an obstetrician, questions are asked about sanity.

Mr HOUSE: Your evidence is on the record. That will be taken into account.

Dr McCallum: I was uncertain about what was meant by "client accountability and compliance in an output-based management system", so I asked several people who are involved in management systems what it meant. They could not interpret it.

Mr WHITELY: It refers to getting value for money for service delivery. That is straightforward.

Dr McCallum: If that is the case, that should have been said. My management colleagues have told me that an output-based management system is nonsensical. It is an output-based system or a management-based system. An output-based management system does not make sense.

Mr HOUSE: This committee is not responsible for the wording of the contract. I understand why you have raised it and the issue is on the record.

Dr McCallum: I would like to add to that. On several occasions during my time here I have seen discrepancies within the system, and they have alarmed me. I do not know how to correct them, and I would like to address that matter. Again, I did not have much time to consider this. I have audited my own work and I have found a 10 per cent discrepancy rate.

Mr HOUSE: If you want to add to this submission, you are welcome to do so.

Committee adjourned at 4.15 pm