PUBLIC ACCOUNTS COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON WEDNESDAY, 10 APRIL 2002

Members

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

Committee met at 9.15 am

LANDAU, PROFESSOR LOUIS ISAAC,
Executive Dean, Faculty of Medicine and Dentistry
University of Western Australia,
examined:

The CHAIRMAN: The committee hearing is a proceeding of the Parliament and warrants the same respect that proceedings in the House 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?

Professor Landau: I have.

The CHAIRMAN: Do you understand the notes attached to it?

Professor Landau: Yes.

The CHAIRMAN: We have received your written statement. Do you wish to propose any amendments to it?

Professor Landau: No.

The CHAIRMAN: Is it your wish that the submission be incorporated as part of the transcript of evidence?

Professor Landau: I would be happy for that.

The CHAIRMAN: Is there any statement you would like to make in addition to your submission?

Professor Landau: If I could take two or three minutes to highlight some points in response to the faculty's questions, I would then be happy to answer your questions.

The requested information related to the faculty's processes for entry into medicine and dentistry and the change in the selection process. The reasons for change were that there was some concern about our graduates not necessarily having the appropriate interpersonal skills expected of health professionals and also there was a significant drop-out rate, as you can see from the figures, of about 16 per cent. This was not because of the difficulty of the course, but predominantly because people who had high tertiary entrance examination scores felt that they should study medicine, even though they later discovered they did not have the motivation and felt uncomfortable when confronted with sick people. The aim was to try to change that. We adopted a process that had been available over a number of years in the University of Newcastle and adapted it to the needs of Western Australia. It includes TEE scores, and an assessment test based on logic, reasoning and interactive skills. It is too early to tell whether it has been a success. Certainly students are more involved, interested and articulate, and the drop-out rate due to students changing their minds has fallen. The level of TEE pass to get into the course has varied. The median has dropped from 99.7 to 99 per cent, which is still very high, but it gives an appropriate mix of student intake.

Another objective has been the increase in rural intake from seven to 22 students over the past three years. We are aiming for at least 30 rural students, which would be roughly the proportion of rural residents of the State. They come from all over the State, as can be seen. Interestingly, we are not allowed to include Mandurah because the commonwealth definition of "rural" is 75 kilometres from the General Post Office, and the Mandurah post office is 74 kilometres distant.

Mr WHITELY: It is very good to see that there are rural students, but how many are from rural schools?

Professor Landau: Most of them.

Mr WHITELY: For example, last year there were two students from Albany - were they from the Albany Senior High School and not from Scotch College or Christ Church Grammar School?

Professor Landau: I would have to check, but I think both were from Albany Senior High School.

Mr WHITELY: I would not be surprised if 80 per cent of the students who were listed as rural students were in fact boarders at city schools.

Professor Landau: It would be much less, because the majority would be from rural high schools. In previous years we have been very strict with our selection of rural students. We did not count those who were boarding at city schools until the past couple of years. The definition of "rural" now is that students spent five years of their schooling in a rural school. The number was increasing even when we were not counting rural boarders. We have that data, and we could get the figures to the committee.

Mr WHITELY: Would the figures include the school of origin for year 12?

Professor Landau: Yes. We are certainly continuing with that program.

The CHAIRMAN: How many students from the country are in the course?

Professor Landau: Again, I would have to add them up over the years.

The CHAIRMAN: What is the annual intake out of 130 students?

Professor Landau: There are 22 this year, 14 last year, seven the year before that and probably about seven to 10 in the previous years. I would say that overall that would suggest that we would have about 70 students out of 700.

The CHAIRMAN: Has consideration been given of some sort of onus being put on country students, and metropolitan students who do not have to be from the country, to work in the country?

Professor Landau: Yes.

The CHAIRMAN: I remember when I went through my course that there was a shortage of teachers. We had specific scholarships. We had to work two or three years in the country as part of the process. Is that being done in medicine?

Professor Landau: Yes. There are two answers to the question. The best predicator of a student going to practise in the country is that the student comes from the country. That is one of the reasons we are recruiting them. The numbers are still low but there is double the probability of country students going back to the country as compared with city students. Secondly, we are giving all students a rural experience so that they understand the country, and we hope it will entice them to go to the country. We have included a much greater rural experience in the course. All our medical and dentistry students live in the country for one week in the first year, not concentrating on medicine as such, but experiencing local activities. They visit local industries and talk to local families. They get the feel of living in the country right at the beginning of the course before they become fixed in their ideas. We believe it will have a major impact in the next few years. This year we are developing a rural clinical school funded by the federal Government, so that during the fifth year, by the year 2004, one-quarter of all students will spend a whole year in a rural centre. Rural areas include Kalgoorlie, with an outreach to Esperance, Geraldton, Broome, Derby, Port Hedland and Karratha. We will have students in those centres from 2004. We are trying to get students to have a rural experience to entice them to work in rural areas at least for part of their career. The feedback is that more are considering working there.

The CHAIRMAN: Is there some commitment that they contribute two or three years of their career to rural areas?

Professor Landau: I am getting to that. It is my third point. It is not part of the previous program, which is purely to encourage them.

The third strategy is the medical rural bonded scholarship introduced by the federal Government. A requirement is that a bonded student make a commitment to spend six years in the country after completing training. This is a long-term commitment because before they get to that stage they do six years of internship and probably four to six years of general practice training and then six years in the country. It is really a 20-year program. That started last year. We had seven rural-bonded scholarship students last year and nine this year. They are committed for that six-year period.

The CHAIRMAN: Will it be 10 years before we get anything from those bonded students?

Professor Landau: Yes, and even more. It will be 10 years as the absolute minimum, and more likely 12.

The CHAIRMAN: Do you see a place in the medical profession for bonded specialists, not necessarily for country areas but for the public health system generally?

Professor Landau: It is a difficult question. The rural-bonded scholarships that we have can be for specialists, not just for general practitioners.

The CHAIRMAN: The public health system has a huge shortage of specialists. They are trained there and then disappear into the private sector because the salaries there are so significant. Students are bonded for the country. Why not do that with specialists; in other words, why not bond them so that they do three, four or five years service in exchange for their training?

Professor Landau: Those programs do not always work very well. It would probably be better to get people into the public system by making it more attractive for them and providing the correct environment.

[9.30 am]

It is not just financial. They do contribute to the public system while training. We need to allow them to practice in a way that stimulates and excites them. We get the best people to stay in the public system because they are the ones who want to do more and have the opportunity to train others to do research. My preference would be to promote that, because with the other types of programs there is not a lot of evidence of great success in getting the right people to stay within the system.

Mr BRADSHAW: One of the problems is the lack of training that is available for those doctors who wish to become specialists. Do you agree that that may be an inhibitor as well?

Professor Landau: That is an inhibitor, because the numbers that the colleges admit into a training program depend upon the positions that are available, and they will accredit positions only if they have adequate experience in that speciality. That is a problem; so I agree.

The CHAIRMAN: Does the faculty of medicine play any role in the training of specialists?

Professor Landau: We do, but it is all informal. Although the members of the faculty - the academic staff - are the people who do most of the training and run the exams, we do not actually run the training programs. The reason for that is historical. Over the years a process has evolved in which the universities train undergraduates in Australia, and as soon as they graduate they become interns. They are then left in limbo for a while. They then became involved in college training programs. We are trying to change that, and we now have a pre-vocational training committee that takes them through from their undergraduate years to their vocational training. That is a combination of the medical board and the university. I am trying to set up a medical council that will bring all of those groups together with the university to be involved in that vocational training.

That has not happened in the past, but it is something that we are trying to develop. The other States are doing similar things. It certainly has worked in New South Wales and Queensland, and we are trying to get it going here.

Mr BRADSHAW: Is there an opportunity in Western Australia to train more specialists, or is the capacity limited?

Professor Landau: The capacity is there. However, we would need to change the way we run the services. We would also need to adapt to the changing requirements of the community. We need to integrate the community-based services, the secondary hospitals and the tertiary hospitals, because the tertiary hospitals are becoming more specialised, and a lot of other care is occurring at the secondary hospitals and also within the community. Once we can integrate that, we can then organise the teaching positions that are now not available because there are limited numbers in the teaching hospitals, and we can then have them spread throughout the whole of the health service so that they are in the secondary hospitals and also in the community, and we would then have more positions and be able to train more specialists.

Mr DEAN: Is that work under way? Will we see some of the fruits of that work within the next 12 months?

Professor Landau: Certainly the Health Department is very much aware of it and wants to move in that direction.

Mr DEAN: Yes, but being aware and actually doing something are two different matters.

Professor Landau: I will be keen to maintain contact with Dr Lloyd, the deputy director general, who is very much in favour of progressing it.

Mr BRADSHAW: So someone is driving it to train more specialists? It is not just a matter of someone saying it is a good idea, but nothing is happening because no-one is driving it? Normally you need someone to drive it. Is money available to put that in place as well, because that can be another inhibiting factor?

Professor Landau: It can be, but again it is more a matter of redistribution of funds rather than of new funds. If we can change the structure of the health service to allow more training positions, then we can provide that opportunity, and hopefully it will not be a significant extra cost.

Mr DEAN: It is a restructuring rather than additional funding - within reason?

Professor Landau: Within reason, yes, because everyone will say they do not have enough funds. At the moment we cannot run the services that are required. It is a balancing act, too. It is working out what we can provide, and then working out how best to provide it across the whole service. Some of it is restructuring. It is not all just extra funds.

Mr DEAN: Do you have an opinion on the various professional colleges and their stranglehold on the number of professionals who are coming out, or is that just too political?

Professor Landau: It is. It is also something that we cannot generalise about. I do not think the colleges have had any intention of having a stranglehold on positions. Most of them consist of people who are genuinely interested in maintaining standards and ensuring that the training positions are appropriate.

Mr DEAN: That can often be a smokescreen.

Professor Landau: It can. Individuals may behave in that way and use that as a smokescreen, but I do not think I have any evidence to say that colleges have done it intentionally.

The CHAIRMAN: But there has been a shortage of specialists, not just this year but for the past few years. It takes up to 12 years to train a specialist. Why have we not done anything about it until now, to the point that we are now crying out for specialists in almost every category and in every hospital, yet training positions have not been made available to alleviate the problem? The

number of specialities is governed by the Australian Medical Workforce Advisory Committee, which is independent and made up of representatives of each State, yet it has not recognised or recommended that we increase the number of training positions in the specialties.

Professor Landau: It has recommended small increases. The only speciality in which it has recommended no increase is my own - paediatrics - because it believes on its numbers that there are excesses. However, that is wrong, even in Western Australia.

Mr DEAN: Go to Kalgoorlie, Albany or Bunbury.

Professor Landau: Exactly. There is a problem, and AMWAC has realised now that its statistics do not adequately reflect what is happening at the coalface. It tried as hard as possible to make the numbers it has used valid, but there are many other variables in it, including the range of practice; the increasing female work force, which means shorter hours worked per week; and the distribution of specialists in individual towns as well as within States. AMWAC was not able to include those variables in its formula, so when it did its numbers, the numbers per head of population fitted what was internationally accepted, and it said the numbers are reasonable. However, it has recommended for most specialties a slight increase, but nowhere near enough to address the issues that you say are a problem. It has recognised that and it is trying to change its analysis to reflect it. However, what has happened in the past is that on the basis of the data it had, AMWAC has suggested that only small increases were needed in most specialties.

The CHAIRMAN: This year there is a huge shortage. AMWAC has made some recommendations for minor increases. In this case, one and one does not make two. Why are we not addressing the problem of the massive shortage of specialists and making positions available, knowing that it will be 10 years before we get those people on the ground? People such as you in the decision-making process are not making a noise about it, yet to us as laypersons the problem is obvious: If you have a shortage of specialists, the cost of the health system will go up, and it will be a never ending cycle.

Mr DEAN: I am intrigued by one of the comments you just made, which I will not repeat because it is very politically incorrect, but it is a theme that we picked up on our travels around the countryside. AMWAC looks at the figures and says that in paediatrics, for example, you do have the required numbers. Is any allowance made, or is, say, a 50 per cent loading given because of the number of females who are taken into the profession? You have just talked about the shorter working hours and the drop-out rate. It may appear that you have the appropriate number of paediatricians or specialists. However, because of the female component - and it is very politically incorrect to say this - it gives the illusion that we are well serviced when we are not. Has anyone made submissions to AMWAC about giving a loading based on the female intake?

Professor Landau: Again, it is something AMWAC is addressing. It has produced its own paper on the female work force, and that is where those numbers come from. I do not think it is politically incorrect, because it is a fact and the data shows that more women will move out of medicine and will work shorter hours per week; and it is not wrong that they make that choice, so long as we recognise it in our calculations. It is interesting that the surveys that have been taken in the past few years show that males are now doing the same thing.

Mr DEAN: Yes. We have had specialists tell us that because of lifestyle choices -

Professor Landau: That is now a major factor, but it was not until probably the past five years.

The CHAIRMAN: According to the numbers that you have presented to us with regard to the intake for ordinary medicine, not specialists, in the past 10 years we have gone from about 120 students to 130 students, yet there is now a huge shortage of general practitioners in the community. To make matters worse, the proportion of male students to female students has reversed. Ten years ago you had a majority of male students. You now have a majority of female students. In light of your comment that female students tend to work shorter hours and to drop out after they become

qualified, why have we not increased the student intake to allow for that change in mix? More importantly, we are far behind in the number of GPs being trained. The intake number today is only 10 above what it was 10 years ago. It will take a minimum of six years, and for general practice 10 years, to get a doctor on the ground. We have a massive problem between now and the next 10 years, and no-one seems to have done anything about it.

Professor Landau: We have not achieved a lot at this stage, but we have certainly been trying.

The CHAIRMAN: I have noticed that!

Professor Landau: We have certainly been trying. The quota for medical students is strictly controlled by the federal Government. We cannot take any extra numbers, and we have not been given any increase. All of the increase that we have been able to bring in has been by initiative programs for which we have been supported, such as for rural and indigenous students.

The CHAIRMAN: In other words, other organisations are paying for them?

Professor Landau: Yes. Some of those the federal Government has funded as special programs too, so it is a mixture of others and the federal Government. It is a tight quota, and that is what has restricted us. I think we have to accept the proportion of female to male students. It would be incorrect of us to have any other arrangement.

The CHAIRMAN: I am not critical of the ratio. I am saying the reality is that there will be fewer hours worked because of the ratio change, and we need to increase the number of positions available to cover the demand from the community. I am not commenting on whether the female students are more clever or deserve a place, but we need to understand that more students need to be trained, because we already have a huge shortage. We have the highest ratio in Australia of overseas-trained doctors, yet we cannot get doctors where they are needed.

Professor Landau: We are with Queensland in having the highest number of overseas-trained doctors.

Mr DEAN: Attachment A of your submission is headed "TISC Applicants, Cut-off Tertiary Entrance Rank, Commencing Students and Mean Score". Last year your total number of applicants was 1 119, of which you took approximately 145 or 146, or about eight or nine per cent of applicants. How many of those students would satisfy the tertiary cut-off score; and from your ranking with your interviews and so forth, how many would fall 10 per cent outside the criteria of your interviews?
[9.45 am]

As the Chairman said, 1 100 students - a massive number - applied but you have taken only 146. Obviously the quality will vary. In your normal curve, given that your funding has been trebled, how many students could you take while being confident of maintaining the quality of applicants?

Professor Landau: I would have to examine the exact details. We could easily double our intake and remain within the selection criteria for medicine or dentistry. The undergraduate medicine and health sciences admission test and interview scores give us a ranking only.

Mr DEAN: Do you feel confident that you could double the student intake and maintain a high standard of applicant?

Professor Landau: Their TEE results would still be above a TER of 96 and they would all have done well in the undergraduate medical admissions test. Those are the students that we interviewed - more than 400 did well in UMAT - and many would have got a good interview score. There is no doubt that an intake of 250 would easily satisfy our criteria.

Mr DEAN: Is this not a federal funding issue ?

Professor Landau: We have been trying to increase the federal quota. However, the federal Government has been using Australian Medical Workforce Advisory Committee data to say that we

do not need any more doctors and, therefore, no more intake. John O'Donnell, a consultant, undertook a study of the number of students we can take. The Department of Health is helping by giving us its figures, and we will submit the data to the federal Government this year. We want to seek an increase of between 40 and 60 students. We have put together a case to show that, for the benefit of Western Australia, it would be better if we had a combined undergraduate/graduate intake. The case we are preparing, which will go to government and the Australian Medical Council in May, suggests that we retain our school leaver intake of around 100 and have 40 to 60 graduate entry students who could get into medicine based on a shorter course because of their previous experience in the basic sciences.

The CHAIRMAN: In 1990, 760 students wanted to do medicine. Out of that we took 120. This year 2 200 students applied and we have taken 141.

Mr DEAN: Where did you get 700 from?

The CHAIRMAN: I added 402 and 340.

Mr DEAN: The total number of applicants is only 402.

The CHAIRMAN: Okay. That is almost treble the number, yet the school took only 120 students. On the one hand, there is a huge shortage of doctors and, on the other hand, there are many students who have met the requirements but cannot be accepted. The nexus in this equation appears to be lack of university places for training in medicine, yet no-one in the health system, the education system, or the political system, has publicly said this is wrong and needs to be addressed for the sake of the community as well as the students and the health system.

Professor Landau: We are keen to address the problem and would welcome any support in that. A small part of the increase is artificial, but it is at least double the previous number. Until 1999 students knew that they would get in only if they were in the top one to two per cent of TEE scores; therefore, many students did not indicate medicine as a preference for study. Once we changed the selection criteria there was a marked increase of almost 500 students, who then realised they had a chance and therefore put it down as a preference. The early numbers do not recognise the number who would have liked to do medicine. The figure is somewhat artificial but the argument is still very valid. As I say, we are putting the case to the federal Government and we would appreciate any extra support.

The CHAIRMAN: This process will highlight the issue. How many students is the faculty capable of taking? You said that you would like to take up to 40 or 60. Realistically, how many can be trained through the faculty?

Professor Landau: We had a business case prepared by another consultant who has shown us that if we take 40 local students, we would then need 20 international fee-paying students to cover the costs, so that we can do it. If we accepted 175 students we would need to take more international students to break even. The best combination is the one I gave in which there would be 100 undergraduate entries, 40 graduate entries and 20 international students. If we take more local students, either graduate or undergraduate, we would need to take more fee-paying students to break even. We can cope with anything from 140 up. However, we could readily accept that number. On top of the 140 would be the number in the current special entry program, so we would still be looking at between 150 and 160 total. If we added 20 international students that would equal between 170 and 180, and we know that we have the facilities and resources to work with them. Once we get above that we would require a fairly major investment.

The CHAIRMAN: The overseas students will not help our health system because they go back to where they came from.

Professor Landau: They help us financially.

The CHAIRMAN: How much money is required from both the feds and the State to enable the faculty to train 160 or 170 doctors?

Professor Landau: If the feds fund the positions, that will give us the basic higher education contributory scheme funding for HECS-liable places.

The CHAIRMAN: What amount are we talking about?

Professor Landau: The cost per student is roughly around $30 000 per year. The deficit is around $500 000 with 140 students, which we make up from international fee-paying students. If we take in more students than that, the amount would be closer to $1 million for each year enrolled and the gap would increase between that and what we would receive from HECS funding.

The CHAIRMAN: Are you telling me that only $1 million would solve our problem?

Professor Landau: It would increase the intake and help towards solving the problem.

The CHAIRMAN: It seems absurd that $1 million a year will help solve the health problem of a shortage of doctors and no-one has bitten that bullet in all the years we have been suffering as a result of the shortage.

Professor Landau: The issue may be a bit more complex than that. That would help one area, which would be to increase our intake. However, we must then have the training positions. That may be achieved through not only increasing the number of positions but also restructuring the service. We must then provide the subsequent employment for them. The total cost of solving the problem would be a bit more than $1 million for each year enrolled. However, it would be a start.

The CHAIRMAN: A 10 per cent saving on the visiting medical practitioners' payments of $7 million would enable us to train all the doctors, increase the training positions and have money left over to provide a better system.

Professor Landau: Notwithstanding all the variables, that would improve the system.

Mr BRADSHAW: I notice that the fee-paying students vary greatly in number from three to 11. Do you have capacity for more fee-paying students or is the number limited? Is there not a demand from fee-paying students?

Professor Landau: The demand varies tremendously. If we had an active program we could attract them, and we could cope with up to 20 fee-paying students. The difficulty is getting good students who have the ability to complete the course, because many applicants do not have the skills or the ability to do that. We can get them if needed and we can cope with approximately 20.

The CHAIRMAN: Rather than a scholarship, what is the scope for a local country council to pay for a student to train in medicine? Has that been canvassed through the school of medicine? There is a huge shortage of doctors, especially in the smaller country towns despite the many overtures they have made to provide free housing etc. Has consideration ever been given to the prospect of a town sponsoring a student on the basis that when the student qualifies, he would service the town for a period? On a number of occasions the Western Australian Local Government Association looked at all sorts of ways of enticing doctors to work in country towns.

Professor Landau: Absolutely.

The CHAIRMAN: You mentioned international fee-paying students. Rather than accept them from overseas why not get them from Western Australia?

Professor Landau: Although the idea is good, there is a problem with that. I totally agree with you; I was talking to a person from the Bruce Rock Shire Council a couple of weekends ago when we had our rural surgical weekend there. That shire has just spent $600 000 building a new practice and a house and providing a car to attract a doctor. The shire knows it will be an overseas-trained doctor because they will not get a local doctor. The enthusiasm and motivation exists to do that. It is worth pursuing. I would like to follow that up with country shires. The only problem is that we

cannot take Australian fee-paying students into medicine. They are restricted by federal government requirements. They would not be able to pay the fees. They would still have to fill HECS places, but we could provide scholarships. It is a good idea if a shire wants to promote it. It is a difficult initiative for a shire to take because it will not see value from a student for 10 to 12 years. However, it is something we should at least follow up.

Mr HOUSE: What do you do as the senior person in the medical faculty to encourage students to go to the country?

Professor Landau: We try to promote rural practice as much possible. When I meet them on their orientation day, before they even start their training, I explain the rural initiatives in place to encourage them to think of rural practice as a career option. We have developed the Spinrphex Rural Students Club, which is the strongest rural students club in the country. It is very active and helps about 300 students develop an interest in rural activities. Last year one of our students did a survey for us of the third and fourth-year students to ascertain how many of them would consider a career in rural practice. That has increased to 60 per cent of students who are prepared to spend part of their career in rural areas. We have a very strong rural program in the course. We are trying also to make rural practice more attractive. We hope to achieve this with the rural clinical schools. When we have set up the academic posts in the rural centres I mentioned, that will provide a focus for people to continue to interact with their colleagues to avoid the difficulties facing isolated rural practitioners. We are very conscious of the need to do that. We are trying very hard from every point at the very beginning for students entering medicine.

Mr DEAN: I know you will give me the schools of origin. Of the 22 students listed as country students, 10 are either from interstate or from towns that do not have senior high schools; therefore, there is a boarding aspect. I feel the number of students is dominated by students at city boarding schools.

The CHAIRMAN: Although they appear to be country people they are metropolitan people who live in Perth?

Mr DEAN: Ten out of 22 is a significant proportion.

Mr HOUSE: Is there a tolerance level to encourage more students into country practice? I know you must have a base mark, but if you had a commitment from a potential student to practice in the country, would you allow a tolerance level within an acceptable range because that would fill a need?
[10.00 am]

Professor Landau: We already do that directly in two ways. We go below the cut off with rural scholarships to fill those positions with people who commit themselves to working in the country. We take places from other parts of the university to fund a minimum of six extra rural places for people who are below the cut off. There is already a significant tolerance level to take in rural students.

Mr HOUSE: Is there any merit in allocating a doctor's Medicare number to a specific rural posting and not allowing it to be transferred?

Professor Landau: That is not a popular argument within the profession.

The CHAIRMAN: That is understandable but at least it would ensure a doctor stayed in a town.

Mr HOUSE: I assure you that none of us went into politics to become popular. We are aiming to solve some of the problems in rural areas. My family and I live and work there. We must resolve this problem somehow and we want to find more creative ways of doing that. We have explored all the easy options.

Professor Landau: Yes.

Mr HOUSE: Do you think the scheme of allocating a Medicare number to a region might work?

Professor Landau: It may help a little but it is unlikely to solve the problem. It has been tried in many countries. Many people sign up and then find all sorts of ways of avoiding the system. Those people are not happy working in the country so they are not the people the country needs. We want good people who are motivated to go to the country. It is preferable to get people to go on their own initiative because they know they will enjoy it, will be satisfied and will provide a better service to the country. Tying people who do not want to be there is not what the country needs.

Mr HOUSE: There is merit in that argument. Do you recall the old dental bonding scheme to which students were bonded for two years service?

Professor Landau: Yes.

Mr HOUSE: There was a similar scheme in teaching.

Professor Landau: Yes. The federal Government has introduced such a scheme of 100 rural-bonded places in medicine and we have distributed nine of them this year.

The CHAIRMAN: Has consideration been given to having a medical school outside Perth? The suggestion is that one location for a medical school in Perth tends to drag students here and those studying medicine will be here all the time. Has consideration been given to having a small medical school in Bunbury to provide training for country doctors in their environment rather than their having to come to Perth?

Professor Landau: Our current compromise is probably a better way to go. It will provide rural clinical schools so that students will spend all of their fifth year in one area.

The CHAIRMAN: That is only one year?

Professor Landau: Yes.

The CHAIRMAN: Facilities are there in a large regional centre like Bunbury.

Professor Landau: No, the facilities are not there; that is our problem. We could not set up a rural clinical school in one city in Western Australia, as our cities are not large enough. We need the infrastructure of at least half a million people to have all the facilities that are needed to run a medical school because towns are just too small; even larger places like Geelong in Victoria and Wagga Wagga in New South Wales are too small. The only rural medical school that has developed in that way is at James Cook University in Townsville. Even Townsville is not big enough; it also draws students from Cairns and the hinterland. I do not believe a totally rural medical school would be sustainable in Western Australia because we do not have a large enough city.

Mr HOUSE: In that vein, is it valuable to get people to spend some time in Bruce Rock, Albany, Wongan Hills or wherever as part of their training?

Professor Landau: Yes.

Mr HOUSE: The more we can do with that and the more we can expose them to a range of places would surely create a more positive atmosphere about such a scheme?

Professor Landau: I totally agree. That is why we are developing the scheme. When we first introduced rural week, all the students lived for a week in the country. As mentioned before, all first year medical and dental students are living in the country this week. Many students have come back to Perth and said that was the first time they stayed anywhere in the country, apart from having stopped at a service station, which was their previous experience of rural Western Australia.

Mr HOUSE: There are a few members of Parliament like that!

Professor Landau: That is having a major impact. When the rural clinical school gets going, 30 students will spend all their fifth year in rural centres and we will even add to that number. We are commencing a pilot in June this year in which seven students will spend the latter half of the year in

rural centres. We will increase that number to 30 by 2004. The experience will be voluntary but we hope to have excited enough students to want to do it. We know from our surveys that we should achieve that figure. However, five years ago there was no way we would get 30 students to say they would spend a year in the country.

Mr BRADSHAW: Are the rural students that you have taken on board the ones who are going to the rural areas?

Professor Landau: No; two from rural centres are going back but not all of them.

The CHAIRMAN: Do you have statistics on the shorter working hours of doctors because of the female-male mix problem that you highlighted?

Professor Landau: The Australian Medical Workforce Advisory Committee produced a report on that.

The CHAIRMAN: I know from my experience as a pharmacist that there was a real difficulty in getting women to work after hours at night because of the danger of pharmacists working alone. Has there been a reduction of five per cent or 10 per cent in the number of hours worked?

Professor Landau: It is more than that. I think it is around 20 per cent but I can send the committee the AMWAC report.

Mr HOUSE: I shall add a positive comment to that. One town that I represent, Mt Barker, has three part-time women doctors who are all married to local farmers. They might work part-time but they are a tremendously valuable resource in that community. They stay there because they are married to local people.

The CHAIRMAN: I asked that question because there has been a change since 1990 when the ratio was 60 males to 40 females. Now there are more females than males who are working reduced hours, yet the intake figure has not changed.

Mr HOUSE: What you need is a program to get them married to farmers!

The CHAIRMAN: That is a really sexist remark; we will scrub that.

Professor Landau: They do provide a fantastic service in the country but we must recognise in our calculations that they are part time and adjust for that. That is certainly not a negative comment.

The CHAIRMAN: Reference has been made to setting up a medical school at the University of Notre Dame Australia. How would that affect the system and how would it work if it came to fruition?

Professor Landau: It depends on what evolves in the next couple of months; we should know by the end of this year. Basically, Notre Dame's submission is no different to ours. The extra 40 places in graduate medical school that I said we have asked for are the same 40 places in Notre Dame's submission.

The CHAIRMAN: Its submission is not in addition to yours. A decision will be made for one or the other.

Professor Landau: Yes. Initially I hoped that we could do it together. We had discussions to progress it together but Notre Dame decided it wanted to go alone because it did not want the restrictions that people involved with the development had with various issues. Therefore, Notre Dame felt it was easier to go alone which meant that we are now both making a submission. The federal Government will either say no to both of us or one of us will be given the go ahead. There is no way it will grant both submissions and I believe it will ask us to collaborate. I have asked the ministers for education and health to try to get us together to work out a submission that we could put to Government for the whole State. I believe that it will be detrimental to the State for Notre Dame to go it alone. The federal Government might not bother with either of us if we make competing submissions; whereas if we went together with a coordinated program we would be more

likely to be successful. I have asked the ministers for education and health to facilitate that program and they have asked the Director General of Health to do that. I hope we can do that in the next few weeks. I believe that will lead to the best possible outcome for the State because the State will be disadvantaged by our competing.

The CHAIRMAN: You have obviously a pile of statistics to justify the increase. Is it possible for the committee to have access to those statistics to support our case? All we have heard from day one is the claim of a massive shortage of doctors and specialists and nobody doing anything about it. We have some statistics to support the case for an increase in the intake number but are there any others that you could give us?

Professor Landau: Yes, but they are not strong. We have asked the Department of Health to give us their numbers and Brian Lloyd is putting that together for us. I can send you the consultancy report that suggested two outcomes. One was the need for an increase in the number of graduates and a better option was a gradual entry alternative. That report gives the initial figures and the Department of Health will give us its figures.

The CHAIRMAN: I refer now to the massive shortage of general practitioners. It takes six to seven years to train a normal doctor.

Professor Landau: Yes.

The CHAIRMAN: Then to get to general practice takes another four years of speciality training?

Professor Landau: Yes.

The CHAIRMAN: Is it necessary to have a 10-year course for general practitioners? You will obviously make some comments, but as an outsider who has been involved in this matter, I believe 10 years is a helluva long time to train somebody for general practice. Has consideration been given in the profession to the requirement for training at that level?

Professor Landau: Yes, the requirements for training are continually examined.

The CHAIRMAN: It does not take that long in other countries.

Professor Landau: Not many countries in the developed world. It depends on how the years of training are counted. If the first degree in a graduate entry course is not counted, students do only four years of medicine and internship and four years of general practice; that training is, therefore, cut down to nine years. Other countries have variations of that, such as four, one and three years training. However, we are considering the same level of training. There may be a difference of a year or two but that difference is not dramatic. Again, we must look at the difference in those years. For example, the amount of actual study the students do in a graduate course of four years is not much different from an undergraduate course of six years. Undergraduates do a typical university course in which their early years are 26-week years of two 13-week semesters. They then do more as they get into the clinical years; whereas the graduate course does 40-week years right through. Therefore, there is a difference of only about 10 to 20 weeks between the four-year and six-year courses.

[10.15 am]

The actual amount of medical training is not very different, no matter what course they do.

The CHAIRMAN: I am trying to get more people on the ground.

Professor Landau: I know. The same applies to general practice. The important thing is not to see general practice as less of a speciality than the specialities. In fact, in many ways it is more of a speciality because people must be able to address the whole of medicine to recognise problems. They do not have to provide high-tech treatment for complex conditions, but they must be very aware of all the possible presentations of illnesses. They need to know how to manage long-term, complex psychosocial issues as well as the physical problems. It takes a lot of training to get the

experience to do that, particularly as members of the community expect more of their general practitioners now. They cannot be the paternalistic, well-meaning doctors of the 1950s who just told patients what they believed the patients should know, wrote a prescription and that was it. Members of the community expect more; they expect doctors to understand their needs, discuss them with them and provide physical care. Training for all of that takes time. If it were possible to do it in a shorter period, I am sure they would try. People who undertake general practice training now still do about a year of their training in a teaching hospital to get to know the range of diseases. Then they have to do six months of obstetric training and six months of paediatric training, which takes another year. Then they must have experience in practices to know the types of things they must do in practice. All of that very quickly builds up to four years. There is not much that we could take out of that and say was unnecessary.

The CHAIRMAN: Returning to your earlier comment that part of the solution to the problem with the specialities is to combine the secondary and tertiary training, how do you see that physically happening? I know it is easy to say that this is what should happen. However, when we started this inquiry, different elements of the health system were competing with each other, and the left hand did not know what the right hand was doing. How do you see that physically happening to achieve the end result of an integrated system? To do that will require a total restructure of the health system, which will not be able to be done very easily in the short term.

Professor Landau: No, not easily. However, it is certainly the direction that everyone is moving towards. It was the direction of the previous Government, and it is the direction of this Government. It has set up processes to try to improve the communication between the various components of the system. The Government is now advertising the positions to manage the regions rather than just the hospitals. It is already having an effect. There is less competition between the teaching hospitals than there was five years ago. The teaching hospitals are now integrating better with other hospitals like Swan District Hospital, Osborne Park Hospital and Joondalup Health Campus and those in the south such as Fremantle Hospital, Armadale-Kelmscott Memorial Hospital and Rockingham-Kwinana District Hospital. It has a long way to go, but at least we have started. We have already started to make appointments across the hospitals, so that specialists from the teaching hospitals are appointed at the secondary hospitals.

The CHAIRMAN: Are you saying that in the previous situation, a person could go to a hospital and make an appointment and no-one would know that that person had made an appointment at another hospital? That could result in an artificially increased waiting list because the person was listed at four different hospitals.

Professor Landau: That was shown to be the case when the central wait list was started.

The CHAIRMAN: It seems amazing that in this health system, which costs us so much and which has such sophisticated computer systems, we cannot tell that one person has appointments at four different hospitals.

Professor Landau: Indeed.

The CHAIRMAN: Is there anything you want to tell us about how we could improve the training process? As I have said numerous times, there seems to be a huge shortage of general practitioners and specialists, which increases the cost of the health system; yet we do not seem to be addressing the training end of it. Is there something that we can do or recommend as a change of process that will facilitate an improvement in the number of professionals coming out of the system?

Professor Landau: You have highlighted the two areas that need to be addressed: the increased number of graduates needed for the State and the integration of the health service so that there are more training positions across the system. If both of those issues are addressed, that will put a big dent in the problem.

The CHAIRMAN: Even if both those things were adopted tomorrow, it would take five years in the case of GPs and probably 10 years in the case of specialists. What can we do, if anything, to improve the shortage of specialists and doctors?

Professor Landau: Again, it is basically attracting people back to the State. We lose a lot of our graduates interstate and some overseas. There is not an easy answer, other than getting our own graduates back or attracting well-trained overseas people in the short term. The only problem is that we are competing with all the other well-developed countries in the world. The United States has a shortage of doctors. The United Kingdom has a program to bring in 1 000 doctors a year from overseas to fill its needs. It is trying to attract people because it has exactly the same problem.

The CHAIRMAN: It seems that everyone wants doctors, but no-one wants to train them.

Professor Landau: Yes. Once again, the same problem is recognised in the UK. Tony Blair has started to develop 10 new medical schools throughout England to fill that need.

Mr HOUSE: The chairman has made a valid point. I find it immoral that we can rob South Africa of doctors. I have been to South Africa a couple of times and I have a particular interest in the issue. To take doctors away from a country that desperately needs them is immoral. It is terrible. We must face our own responsibilities and obligations. A country like ours should train more doctors.

The CHAIRMAN: The training costs only $1 million a year.

Professor Landau: That is just the gap for each year cohort, and assumes that the federal Government funds its HECS number of places as well.

The CHAIRMAN: It is not a huge sum of money if the $30 000 a year cost of training is multiplied by 10 or 20 students. Training for 10 students costs $300 000 a year and training for 20 students costs $600 000 a year. The numbers are insignificant in relation to the $2.2 billion that is spent on health, and $1 billion is given to the health fund to supplement its fees. It is crazy that we are not training students to a point at which the need is satisfied. Is there anything else you want to tell us?

Professor Landau: You have highlighted most of the important points. I want to make one point. The issue of rural students at boarding schools was raised. The assumption is that they will not go back to the country, which is not necessarily true.

Mr DEAN: I am not assuming that. I am just saying that it is very difficult once they have been seduced by the city lights.

Professor Landau: It is another barrier.

Mr DEAN: Yes. It is less attractive, particularly if their parents have accommodation in the city for them.

The CHAIRMAN: There are three country members on this committee, so I am slightly outnumbered.

Professor Landau: That is good.

Mr HOUSE: What about mature-age students? I apologise if you have spoken about this.

Professor Landau: No, we have not.

Mr HOUSE: What percentage of mature-age students do you take? Is there an encouragement to take them on? Is there a possibility that if you saw people from country areas, more of them might go back to the area?

Professor Landau: Yes, and we do. We have a minimum quota of mature-age students, but it is a small number. We have four extra mature-age student entries for rural mature-age students. At the moment, we take 99 school leavers and 21 non-standard students, which is a mixture of those who

started another course and mature-age students; that is, those who have completed or graduated from some other training. It is only 21 out of 120. On top of that are the rural positions, so there are a few more. We recognise that, and they are more likely to go back to the country. That is why we want extra numbers so that there is a greater number of graduate entry, because they will be mature-age students and they will be more committed to rural practice. I totally agree that that is a good way to go because that will help towards overcoming the problem.

The CHAIRMAN: Thank you very much for your evidence. It has been very enlightening and will be a very integral part of our report.

Professor Landau: Thank you for the opportunity. I will send those three bits of information you requested: information on the school of origin and the rural students, the Australian Medical Workforce Advisory Committee report on the female work force and our Kadmos report on the increased needs for Western Australia.

Committee adjourned at 10.26 am