PUBLIC ACCOUNTS COMMITTEE

Visiting Medical Practitioners, Tabling of Papers

MR J.B. D'ORAZIO (Ballajura) [9.27 am]: I present for tabling report No 2 in the Thirty-sixth Parliament of the Public Accounts Committee, entitled "Inquiry into the Use of Visiting Medical Practitioners in the Western Australian Public Hospital System".

[See papers Nos 606 to 608.]

Mr J.B. D'ORAZIO: This morning I report on behalf of the Public Accounts Committee on the inquiry into the use of visiting medical practitioners in the public health system. I thank the doctors of this State who have cooperated with the inquiry. The committee has travelled extensively. The doctors do a fantastic job that requires great skill and training. More importantly, the committee knows of the absolute commitment the doctors give to provide the best health care to the community. The Public Accounts Committee's terms of reference were to look at the use of VMPs in the public hospital system, the terms and conditions of the engagement of VMPs, and compliance and accountabilities within an output-based management framework.

The committee held 42 hearings, saw 77 witnesses and travelled extensively. Not only did the committee talk to people from hospitals in the metropolitan area but also it travelled to Broome, Geraldton, Kalgoorlie, Albany and Bunbury. It also travelled to the eastern States and visited Melbourne, Bacchus Marsh, Sunshine, Bendigo, Wagga Wagga and Sydney. The committee also spoke with the Australian Medical Workforce Advisory Committee, which is a federal-state funded body that looks at the manpower requirements of doctors. As I said, it has been a long inquiry.

The report makes 22 findings and 45 recommendations. It is impossible for me to go through all the findings and recommendations today. However, I will highlight some of the findings. The report can be broken up into four areas. The first area is an audit of the payment systems and claims for payment by visiting medical practitioners. The second area is the structure of the health system and the role of VMPs within the health system. The third area is factors that impinge on the use of VMPs, such as the availability of doctors. The fourth area is a catch-all section that covers the interaction between the Commonwealth Government and the State Government in funding the health system, and the fee structures under the agreement between the health system and the doctors for the payment of VMPs.

I will start with the findings of the committee on the audit of the VMP system. The committee had the benefit of the services of a member of the Auditor General's staff to help us with this process. The committee examined the VMP payments at four public hospitals. Some of the findings were of concern to the committee. The most crucial finding was that most of the hospitals examined did very little checking of the payment systems under the VMP process. In other words, the fees that were being claimed by VMPs were not checked. That was a concern in itself. However, when we examined the payments that were being made, our level of concern increased further. The basic system of verifying VMP payments was against either the computerised total patient admission system, or TOPAS; the health care and related information system, or HCARe; or the theatre management system; and, finally, the patient files. We found that hardly any checking was done, and the checking that was done was on an ad hoc basis and was done manually. Twenty per cent of the claims that were examined against the theatre management system did not support the level of fee being claimed; and when that was checked further against the patient files, some $2.8 million of the payments that had been made to VMPs could not be justified. We need to make it very clear that that does not necessarily mean that those services were not performed. However, it does indicate that there was no paperwork to justify those payments. We need to ensure that that process is fixed. The committee has recommended that an automated process of checking VMP payments be in place in each of the hospitals to ensure that what is claimed is justified and is supported by the appropriate documentation. The process needs to be automated, because it is very difficult to do the checking manually after the event. If the process of checking were automated and integrated across the system, it would solve the problem.

Approximately 25 per cent of the VMPs who are currently employed by the public health system are both salaried and paid on a fee-for-service basis as contractors working in the hospital system. Under the requirements of the Public Sector Management Act, formal approval must be given for this dual employment role. However, in most instances this has not occurred. It is important that these dual arrangements be sanctioned by the Department of Health, because this will allow the health system to control the VMP system and may also avoid any possible conflict of interest for doctors who are working in a salaried situation and also working as VMPs. The VMP system has the potential to have an adverse impact on the capacity of the employing hospitals to deliver quality of care to their patients. It may also have an adverse impact on cost efficiencies. The committee found it astounding that the Department of Health and the former Director of Health

were not aware of the scale of payments to individual VMPs. The reason this problem has arisen is that there is no integration of the financial systems of the hospitals, and each hospital acts as an individual and independent unit. That generates all sorts of arguments about whether, because those payments are so high, VMPs are working such an enormous number of hours that it may have an impact on the type of health care being provided to patients. The committee strongly supports the Health Administrative Review Committee recommendation that area health services be established. However, we have gone one step further and have recommended that, from a financial point of view, there be an integration of the financial processes and that that be answerable directly to the Director of Health so that the Director of Health can have direct control of the payments processes and financial structures of the various institutions.

The committee found also that Western Australia has the lowest ratio of clinicians per 100 000 population of any State or Territory in this country. When we consider the vast size of Western Australia and the diversity and location of its population, that statistic is absolutely diabolical. The committee found also that funding for undergraduate places at the University of Western Australia school of medicine has significantly failed to meet the increased demand for doctors in this State. It is astonishing that in 1990 there were 120 medical students at UWA and in 2002 there were 134, of which three were overseas students. The shortfall of doctors in Western Australia is such that since 1999, 240 overseas-trained doctors have been recruited into the state system. It is interesting that in 1990, 340 students were fully qualified and eligible to get into 120 places at the UWA medical school, and in 2002, 1 040 fully qualified students wanted to get into medicine but only 130 were accepted. It is an absolute indictment and a national disgrace that students who want to get into medicine and who will be great doctors in the future are being denied that opportunity because the number of places at UWA has gone up by only 10 in 10 years. We are importing doctors from overseas at the rate of approximately 60 a year. The current capacity for medical students at UWA is 180 students. Therefore, tomorrow we could increase the number of places at UWA to 180. However, that has not occurred. Worse than that, the doctors that we are recruiting are coming from countries that can ill afford to lose their doctors, such as South Africa. We, as one of the supposedly learned countries, need to make sure that this national disgrace is rectified immediately. This situation has a flow-on effect through the profession. It takes approximately 10 years to train a doctor. Under this scenario, it will take 10 years to reap the benefits. It also flows on to the training of specialists. Although specialists are approved under the federal system, the training of specialists is a state responsibility. The number of specialists being trained in Western Australia is also a problem. In 1991 there were 163 graduate specialists in general surgery. In 2002 the number was only 74. Those figures speak for themselves. This State has the lowest number of doctors per 100 000 population and almost the lowest number of specialists per 100 000 population in the country. I will quote some of the numbers. There are 255 clinicians per 100 000 population in New South Wales and 220 in Western Australia. There are 90 specialists per 100 000 population in New South Wales, 96 in Victoria and 78 in Western Australia. Those figures, in themselves, indicate the problem. However, the problem goes a step further. The current structure of the health system does not permit the training of any more specialists. The number of specialists training is almost at saturation point. The committee recommends a change to the training structure to allow training to occur in secondary hospitals and hospitals that are publicly owned and privately managed, such as Joondalup Health Campus, and asks that that matter be looked at. In conjunction with that, the committee also recommends consideration be given to the creation of centres of excellence. The community must understand that the provision of all services and facilities at secondary hospitals is a thing of the past. The creation of centres of excellence with specialists located at those centres performing certain specialties would, to a degree, eliminate the need for services by visiting medical practitioners. Those centres would provide more support for specialists and could provide training for doctors who want to specialise to alleviate the shortfall that we are experiencing in Western Australia.

The committee acknowledges that in country areas VMP services work very well. The system of supplying VMP services in country areas must be supported. Incentives to general practitioners and specialists in the system who currently provide services in remote areas must also be supported. I acknowledge the hard work of those doctors in remote places and the conditions under which they work.

The committee recommends the phasing out of VMP services at secondary hospitals in the metropolitan area. That cannot occur immediately because of the obvious shortage of specialist doctors. It is impossible to replace the services that are currently being provided by those VMPs. However, the use of these doctors must be in conjunction with a total health outcome. Visiting medical practitioners provide specific services. When we as a community examine the issues surrounding those services we must acknowledge that there is more to health care than providing specific services; there are opportunities to provide support structures and for specialists to share learning by training others. In the establishment of that process a cost-benefit analysis must be undertaken. The committee was concerned throughout the whole inquiry that nobody was able to provide a cost-benefit analysis of VMP services at secondary hospitals. A cost-benefit analysis is very important when one considers the method of delivering health services. When that analysis is undertaken, the committee would like taken into consideration not only the cost of specific services at hospitals, but also the wider cost ramifications that are built

into those services; for example, the 24-hour availability of staff, the flexibility in the rostering of staff, the ability to change rosters - which is not necessarily possible with VMPs - and the ability of staff to impart knowledge to others who are not qualified specialists but are doctors who need exposure to specialists so that they can learn and gain experience from them. That matter must be looked at in the overall context of the health system. Victoria moved away from VMP services on a whole-of-health outcome basis; that is, providing the best health outcome rather than a service based only on cost.

Another recommendation of the committee is the collocation of GP clinics next to emergency departments in public hospital sites, which appears to be reasonably widespread in Victoria. The notion is that patients in the four and five triage category, who are now turning up at emergency departments, consult a GP. This will provide a far better outcome. First, it will take the pressure off emergency departments; secondly, it will allow patients to be seen more quickly; and thirdly, and more importantly, it will provide a better health outcome because it will remove from the state system the enormous pressure that has been created. Medicare rebates in the past 10 years have not kept up with inflation - in fact, they are well below inflation - and that, in itself, has created a problem. The statistics on bulk billing are referred to in the committee's report. Members will see on one hand that bulk billing has decreased severely and, on the other hand, the attendance at emergency departments in state hospitals has risen exponentially. That, in itself, is a telltale sign. Basically, people who should consult a GP under the federal Medicare system are being seen in emergency departments and are creating a huge pressure on the state system. Also, aged care patients occupying beds in the state system could be better accommodated elsewhere. The committee recommends an examination of that problem. The Sunshine Hospital in Victoria is dealing with that problem quite well by shifting people out, not necessarily to aged care accommodation but to private accommodation, thus allowing beds in the public hospital system to be used. It is far cheaper to deal with aged care patients in that way than have them occupy public hospital beds.

I have only two minutes left and I want to thank a number of people. First, I thank all the members of the committee. This has been a huge, in-depth inquiry that has taken a long time. I thank the deputy chairman, Monty House, the member for Stirling; Mr Bradshaw, the member for Murray-Wellington; Martin Whitely, the member for Roleystone; and Tony Dean, the member for Bunbury. Interestingly, it is a unanimous report. When the committee sat down as a group and looked at the issues, the answers appeared to come out in a fairly sensible way. I believe that is the outcome of this report.

I also thank Andrew Young, who is sitting in the front of the Chamber. When we got almost to the end of the report we had a staff change, which created enormous problems for the committee; however, Andrew stepped in fantastically well and helped us compile the report to this point. I thank Jovita Hogan, who is sitting at the back of the Chamber, for what she did. Towards the end of the inquiry she was thrown into the deep end but managed to help us bring the report together. I thank also the new Director General of Health, Mike Daube, and all his staff for their support, cooperation and input. The committee was quite happy to note that a number of initiatives that I have spoken about today have been undertaken already or are in the process of being developed.

Some issues in the report are controversial and will be difficult to implement, but it is important that an effort be made to implement them. If some recommendations are adopted, at least in respect of training, some students in the community will have an opportunity in the future to become doctors. It is an indictment on all members on all sides of the political fence that they have prevented students from practising medicine in this State because they have been unable to find the dollars to make those positions available.

As I said, the report is lengthy and a number of recommendations have been made. I again thank all the people involved for their support in compiling the report. I look forward to hearing the minister's response to the committee's recommendations.

MR A.J. DEAN (Bunbury) [9.48 am]: I will not take all the time available to me because the chairman has, effectively, dealt with most of the report.

I put on record my appreciation of the committee members. It was a fairly lengthy report and was 18 months in the making. The 45 recommendations in the report enjoyed bipartisan support in this House. Perhaps the members for Murray-Wellington and Stirling will reiterate that point when they speak. However, the recommendations in the report will go a long way to providing solutions to the current impasse in the visiting medical practitioner system in Western Australia. The 45 recommendations are fairly wide ranging and exciting. The chairman, in his introduction to the report, refers to the committee's terms of reference. In my eyes, the original terms of reference for the committee ballooned out, because once we started inquiring into the three items listed in the terms of reference it became obvious that there was much more to be considered in the visiting medical practitioner system than just the audited reports of some accounts. That has been dealt with. The solutions the committee came up with, if implemented, will provide a concrete way of analysing payments to doctors.

I will concentrate more on the other key parts of this report. The chairman said we visited a number of regional hospitals in Western Australia - Geraldton, Broome, Kalgoorlie, Albany and Bunbury. What amazed me was the dedication, particularly in the outlying areas, displayed by the VMPs and the specialists who were working an enormous number of hours and were also receiving enormous amounts of money. The committee reached the conclusion that they deserved every red, raw cent they were getting - in Kalgoorlie, Broome and Albany in particular. One of the recommendations of the committee was that the system operating in country areas should prevail. Obviously, there is a shortage of doctors willing to go to country areas, and the solution the committee has earmarked for the metropolitan area, with the gradual phasing out of VMPs, will not work in country areas because of the undersupply of doctors.

I said this report contained some exciting recommendations and I will mention three of them that could go a long way to improving the health system in Western Australia. The first is that the department should introduce collocated general practitioner clinics at secondary hospitals. Obviously, this will require a bit of argy-bargy with the federal Government, but it would solve a lot of problems in emergency departments. In Bunbury, for example, the number of people fronting up to the emergency departments in triage categories 4 and 5 has escalated over the past two years. My report into the Bunbury Health Service highlighted that point. A lot of the people in triage categories 4 and 5 should not be at the emergency departments; they should be visiting their local GP. In Bunbury only one GP bulk-bills, and the remainder do not. The message in Bunbury is that if a person gets sick, he will need to make an appointment two weeks ahead; he will have to finetune his body to get sick when it is convenient.

The other exciting recommendation is No 23 involving the further use of secondary hospitals as teaching institutions. If we are to increase the number of students participating in undergraduate courses - the committee has recommended 180 - they will need more patients to work on. If those students are to follow through into specialist positions - the general practitioner profession or surgery - more patients will be required in those hospitals.

The other exciting recommendation is particularly relevant to country areas. I am not sure where this suggestion came from, but it resulted from committee discussions. Recommendation No 29 states that the federal Government should be asked to allocate specific provider numbers to geographic locations. If a GP wishes to go to Merredin, for example, the general practitioner number he is allocated should stay in that geographical area. If that GP relocates out of Merredin, that number should remain in Merredin. GPs currently take their provider numbers around the State, and often country areas are well short of their quota of GPs. Bunbury is not exactly an area of unmet need, but it is 12 GPs short at the moment.

One of the committee's recommendations concerning training is to increase the number of entry level places at the University of Western Australia to 180 students. Professor Landau, the Dean of Medicine at the university, said that the university could accommodate 180 students tomorrow, with no problems. The training of undergraduates is a federal government responsibility. The federal Government should provide sufficient funding to allow that recommendation to be taken up. The University of Notre Dame Australia wants to start its own medical school, and it suggested it could start next year by offering 40 places. We have heard nothing from the university since and I am not sure where that proposition lies; however, there was some competition between Notre Dame University and the University of Western Australia about those extra 40 places. I have some reservations about Notre Dame University duplicating the UWA medical school, which is under-utilised at the moment. There is provision for between 130 and 140 medical students to begin training this year, from between 1 000 and 1 100 applications. I know from personal experience in a previous life that the vast majority of those applicants - not all of them, because some people apply for university courses that exceed their capabilities - could take up university places in first-year medicine. There is a pool of qualified students in the community with the necessary ability and we should tap into that.

One of the most important committee recommendations is recommendation No 36, which is a call by this and, hopefully, other State Governments for the federal Government to convene a national summit on medical training and work force requirements in Australia. The committee met with the Australian Medical Workforce Advisory Committee when in Sydney and, quite frankly, the people in that organisation had no idea what was going on in Western Australia. They need gelding and should be put out to pasture, because that organisation is detrimental to health care in Western Australia. This is not in the report, but I call on the federal Government to revamp AMWAC; it should be abolished and another body established that at least has a Western Australian practitioner representative. More importantly, this House, the State Government and the federal Government should commence that national summit as soon as possible, because anything we do today will not have any benefit for 10 to 13 years down the track because of our system of training. The actions we take in 2003 will not have an impact until 2013 or 2014. In anyone's language, that is a long-term approach.

It was a pleasure working on the committee. The 45 findings of the committee are relevant and, if implemented, will have a substantial effect on the health system in Western Australia. I commend the report to the House.

MR J.L. BRADSHAW (Murray-Wellington) [9.58 am]: I welcome to the Speaker's gallery Robert and RoseMarie Vojakovic from the Asbestos Diseases Society of Australia. They do a great job looking after people who have problems with either asbestosis or asbestos-related diseases.

The inquiry into the use of visiting medical practitioners in Western Australia started as an investigation into visiting medical practitioners, but it branched off into other health-related issues, doctors and services that are provided throughout the public health system in Western Australia. It was not a simple matter of considering whether there should be paid medical staff in the hospitals or whether doctors should be employed on a fee-for-service basis. I do not know whether it is fortunate or unfortunate, but the system must have a mixture of both to make it work. For example, country areas cannot afford to have paid staff or paid doctors in hospitals, because there is not enough work and, therefore, it is not justified. Therefore, country areas rely on visiting medical practitioners. One of the recommendations of the committee is that in busier areas, paid staff should be placed in hospitals to provide services. I agree with that recommendation. However, until we reach the stage at which there are enough doctors to fill those positions and enough money to pay doctors to provide those services, a combination of paid staff and visiting medical practitioners is needed for the system to work in Western Australia. From my experience in my electorate of Murray-Wellington, which takes in the Harvey, Yarloop and Pinjarra hospitals, that system has worked adequately. It does not place a great impost on the health system and it is probably the most efficient way to provide those services. However, this system could be improved in the city if full-time doctors were put into those services.

Of course, there are advantages and disadvantages in having fully paid medical staff rather than fee-for-service staff. Fee-for-service staff get in, do the job and get out, whereas doctors who are paid on an hourly basis have no incentive to do jobs quicker or get through a bigger workload. There is an incentive for fee-for-service staff to work harder and faster, and many do. One reason the investigation was set up was that a couple of large payments to doctors came to light. When the committee investigated those doctors, it discovered that they were very hard workers who were keen to work at any time, whereas other doctors would say that they could not attend. The doctors who made a lot of money would come at the drop of a hat. Certainly in the Bunbury area, the doctor who was being paid a large amount was held in high regard because he could be called when needed. That is very important, particularly if someone has been in a car accident and needs patching up; somebody is needed right away to do those jobs. Even though these people are being paid large amounts of money, they are doing the work and probably deserve what they are being paid, because if they do not do the job, someone else will, so the same amount of money will be paid. There are some concerns about whether some of the work being done needs to be done, or whether people are working the system so that they can have a throughput of patients. That needs to be clarified. We need to know whether the work is justified, or even if it is being done, because there seems to be a shortfall.

The gravest conclusion of the committee is that there is a shortage of doctors in Western Australia. The way the system currently works will mean that the shortage will get worse and worse. As was pointed out by the chairman of the committee, it takes 10 years to get a student from day one through to becoming a fully-fledged doctor. To become a specialist takes even longer; it takes years and years. It takes something like 14 years for a person to become a specialist. The system needs to change quickly. The throughput of today is roughly the same as it was 10 years ago, but our population has grown dramatically and has aged in that time. Therefore, we need more doctors. Of course, it suits the federal Government to have a shortage of doctors, because the more doctors there are, the higher the throughput and costs will be. If more doctors are around, health costs will rise in Western Australia and Australia. Those are the main points that need to be made. We need a system that combines paid doctors in the system and visiting medical practitioners. It is an efficient way to use the services in Western Australia, particularly in country areas. The main point to address right now is to put more medical students into the system, and to increase the amount of specialist training. If those things do not happen, there will be a major problem in the next 10 to 20 years, because it takes so long for those people to be fully trained.

I congratulate the committee staff, particularly Jovita Hogan, who was one of the main people who helped prepare this report, and Stefanie Dobro and Linlee Davies. I thank those people for the work they did and the assistance they provided. I also thank the members of the committee.

MR M.P. WHITELY (Roleystone) [10.05 am]: I endorse the comments of the previous speakers and congratulate them on their participation in this committee. This committee is one of the highlights of my time in Parliament. The work done in committee is very constructive. We approached this issue in a bipartisan way and have delivered a unanimous report. We had our disagreements along the way, but we swapped ideas, shared information and came up with a report that we all support. I commend my fellow members for their efforts. I also commend Andrew Young and Jovita Hogan, who took a central role in the preparation of this report and did a great job. Stefanie Dobro and Linlee Davies also did a great job in their time with the committee. I also thank Alf Opie and Andrea McCallum for their assistance, mainly with the other inquiry that the committee is dealing with. They have all done tremendous work, and in a very professional manner.

I will add my thoughts to the topic that has already been covered in some detail today; that is, the fact that we must quickly do something to address the chronic shortage of doctors in Western Australia. Some actions that we will take now will not show benefits for a decade. We need to address the training numbers immediately so that in 10 years we will be able to see some improvements in the system. It is clear from our deliberations that there is an Australia-wide shortage of clinicians and specialists. Finding 11 in the report states that Western Australia has the lowest ratio of clinicians to population in Australia. If one thinks about Western Australia's isolation, it simply does not make sense that this Australia-wide problem is even more acute in Western Australia. Recommendation 24 deals with the need to increase clinician numbers, at least to the national average, by 2010. That would require an immediate 10 per cent increase in the number of clinicians in Western Australia. That indicates the magnitude of the problem. Even to get to the inadequate Australia-wide average, Western Australia would need a 10 per cent increase.

I will pick up on something the member for Bunbury raised; that is, the inadequacies of the Australian Medical Workforce Advisory Committee. That was one of the more fiery encounters the committee had with people who provided evidence. Perhaps part of that was the fact that we were out of our own State and did not feel that we had to be too kind to anybody. We were all absolutely unimpressed by the work AMWAC does and the way in which it accounts for regionality or isolation in its calculation of the need for training places for doctors. It applies a simple formula, which uses the percentage of the population living outside major cities to make adjustments for isolation and regionality. Obviously, that system goes against the need for training places in Western Australia, because, of all the States, Western Australia has the largest concentration of population in its major city. This formula favours States such as Queensland and, to a lesser degree, New South Wales, which have large regional centres away from their capital cities. It is too naive. It does not take into account that Western Australia has many small communities dotted over a very large geographical area, which places increased demands on our system and increases the demand for doctors, and, therefore, training places. The representative from AMWAC failed to understand that, even when it was explained to him in fairly forceful terms by several members of the committee, including me. That was of great concern. When I did a little research on the make-up of AMWAC, I found that Western Australia was grossly under-represented. Of the 12 to 15 people on that committee, there is no representative from Western Australia. That showed. There previously had been one representative from Western Australia, but the current committee does not include a Western Australian representative. Had there been a Western Australian representative on that committee, I am sure the index for isolation would have been adjusted to reflect the unique circumstances of Western Australia. We need to focus on that. Recommendation No 25, which states that the Department of Health should insist that AMWAC give consideration to the special circumstances in Western Australia when forecasting medical labour requirements, and that the State Government should insist that there be a representative from Western Australia on the AMWAC board, is absolutely crucial to that problem. There should probably be even more than one Western Australian representative on that body. While Queensland has problems with doctor numbers - it is the second worst State after Western Australia - it is well represented on that committee, and I am sure the benefits of that will flow through to Queensland in the coming years. We have already missed the boat, but if we do not get on it now, we will be really neglecting our duties.

My colleagues have also commented on the need for an approach to visiting medical practitioners that is peculiar to the particular circumstances of the area that is being serviced. Recommendation No 11 states that there is a role for VMPs in country areas, while recommendation No 12 states that we should be looking at phasing them out in the metropolitan area. Recommendation No 13 states that in an examination of the issue in the metropolitan area, a cost-benefit analysis should be conducted by the Department of Health. That reflects the impression we gained. When we began this inquiry, some quite stunning information was presented about the amount being paid to VMPs. It rang alarm bells, but examination of the details revealed that a VMP system worked appropriately in certain locations, typically in country areas, where there is a shortage of specialist services, and people cannot necessarily be employed full time in the health system. In the metropolitan area, it would seem to be less appropriate. I echo the thoughts of the previous speakers on that issue. I was concerned not so much about the operations of the VMP system itself, but with the amount of accountability and control in the system. Finding No 10 states -

> The Department of Health was not aware of the scale of payments being made to some high earning Visiting Medical Practitioners.

In fact, early evidence the committee heard was that the highest paid visiting medical practitioner earned about $450 000 or $460 000 in the 2001 financial year. However, when the figures were consolidated across the different hospitals, that figure ballooned out to $770 000. It was a great concern that, at a global, system-wide level, at that time, the Department of Health was unable to identify the scale of these payments. These problems were reflected down the system.

Findings Nos 2 to 5 refer to accountability concerns for individual payments. Finding No 2 states -

> Most hospitals examined were not undertaking procedures to verify that, prior to payment of a VMPs account, the fees claimed by the VMP were commensurate with the service provided.

Even more alarmingly, finding No 5 states -

- In 20 per cent of the claims examined, documentation on the hospitals' theatre management system or Total Patient Admissions System (TOPAS) did not support the level of fee claimed.

Lack of accountability at the top end - being unable to identify how much individual practitioners were being paid under the VMP system - was reflected all the way down. This evidence came to light early in the committee's deliberations, and early in the term of this Government. I am sure that, over time, these things have been addressed. I am sure that having the spotlight of the Public Accounts Committee on the issue has led to improvements in that area. However, it was of great concern that this was how the current system operated.

There are some systemic problems with the use of VMPs. Finding No 8 highlights that 25 per cent of all VMPs are currently employed by the public health system on salaries, as well as acting as VMPs. There is an obvious potential for conflict of interest and for shifting the lucrative part of the job. In country areas, doctors refer patients to the health service at which they operate as VMPs. There is an obvious problem with accountability there, but there is no easy solution.

MR M.G. HOUSE (Stirling) [10.15 am]: I acknowledge the work done by my fellow committee members, as well as the staff. I pay particular regard to the efforts of Andrew Young and Jovita Hogan. Without Andrew, this report would not have been pulled together as well as it has been. I acknowledge his hard work. I apologise to the committee chairman, the member for Ballajura, for arriving a bit late in the House and missing the beginning of his speech. Last night he told me he would start speaking at 10.10 am. My other committee members would reflect, accurately, that this would be the first time he has ever been early for a meeting. We attended many meetings, and he has certainly never been that early, and has definitely been a bit late a few times. I do apologise to him. My fellow committee members have accurately summed up in their remarks the feelings of the committee. We worked well together as a committee. If the report has any deficiency at all, it is that the committee did not explore any of the overseas systems. It would be the first committee with which I have been associated that did not undertake an overseas trip in order to have a full and factual report tabled in the Parliament. We will rectify that with the next report.

I was a bit like the member for Roleystone - I did not have much knowledge of the workings of the health system. Some of the things that came to light were extraordinary and interesting. All members of Parliament should read the report and gain a good understanding of the workings of the health system. It is an eye-opener. As we moved around our communities, particularly those of us who work in rural areas, it was rather enlightening to see the effort and energy put in by health professionals - not just doctors or visiting medical practitioners. Health professionals right through the system do an amazingly good job. They are really dedicated people who put in much extra time, energy and effort, much of which goes unrecognised. They could do with a lot more support.

As has been outlined by others speakers, the key parts of this report refer to the fact that Western Australia faces a critical shortage of doctors and specialists in the future. It is so critical and it is amazing that it has been allowed to get to this stage. The facts and the figures are there to speak for themselves. Members need to read the report to extract those facts. Even if we started to correct it today, it would take a decade to restore that critical shortage to some sort of equilibrium. That is rather frightening for the future of the delivery of health services.

I particularly want to talk about rural areas in that respect. The recommendations in chapter 6 of the report, while they are general recommendations, will also help to rectify some of the health problems of rural Western Australia. If all the recommendations in chapter 6 were implemented, we would get a better service delivery in rural Western Australia. It revolves around the number of practitioners, and support for those practitioners in a way that allows them to have professional development, holidays, and a break on weekends. Increasing the number of practitioners will allow those things to happen. I think that is vitally important. If they are not implemented, I would go so far as to say that the health system in much of rural Western Australia will collapse. People will not be prepared to practise under the conditions they have today. The alternatives will be such that they will practise elsewhere and receive more financial reward. More importantly, they will have time for their families and peace of mind through professional support. That is an important part of the medical profession. It is also a very important part of the system that needs to be implemented.

The report discusses the commonwealth-state relationship. That is another area in which we must do things differently. Historically, federal Governments have blamed the States and the States have blamed federal Governments. That is an easy thing to do and it gets people through the moment. At the end of all that, the delivery of services does not improve. We have to change that system somehow. The States all have different arrangements; it is almost an "as much as you can get away with" option. It is how much they can push one way

or the other. The States try to shift the costs to the Commonwealth and the Commonwealth tries to shift them back. At the end of the day, it is the people receiving the services who miss out, particularly in country areas. As the member for Bunbury quite rightly said, even places like Bunbury - which is not normally regarded as an area of unmet need - are suffering a shortage of health professionals because of that sort of attitude and because we have not allocated enough resources to train new people. The figures in the report that show the number of people who apply for medical school and the number accepted are startling. As a State, we can do something about that.

I want to talk about the implementation of the report. I have been around long enough to have seen many reports tabled in this Parliament. I have heard a lot of speeches like those made today about great cooperative arrangements, how well the committee got on together, and the knowledge accumulated. If members go back through *Hansard,* they will see them year after year - through all the years I have been a member and before. Not too many recommendations of reports get implemented. I have had the privilege of chairing two select committees of this Parliament that made substantial recommendations. However, the number of recommendations implemented is quite small. It will not surprise me to be here in six months facing the health bureaucrats who will be saying that the recommendations are too hard, they cannot do it, it is too difficult, there is not enough money, and that we did not get it right. They will have all the excuses a person can think of and the Government of the day will probably allow that to happen. I am not blaming this Government; that happened under the previous Government as well. As a Parliament and a community, let us try to get behind this report and implement the recommendations.

Health, like education, is one of the key things that controls and affects our life. If we do not get this right, we will have failed the communities that we represent. The crisis is upon us now. I do not use the word "crisis" lightly. It is a crisis, and the projected figures are frightening. Every member of Parliament should read this report and do his or her very best politically and bureaucratically with their communities and federal colleagues to have the recommendations implemented. It is a good report and provides answers that are practical and sensible, but not hugely expensive. The problems just need a bit of commonsense applied to them. We can fix some of the problems with health that have dogged Governments. The health issue certainly dogged the previous Government and it is dogging this Government. Whether members think that or not, that is the community's view. If this report were implemented, we could take away a lot of the pain. My plea is, for once, let us get behind the report and implement its recommendations.

I congratulate our chairman. He put a lot of work and effort into getting the report together. As has been said, the committee worked well, but there is a need for a chairman who pulls everything together and keeps everyone moving in the right direction. The member for Ballajura certainly did that and I commend him for it.