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Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 25/08/200

..DAY 49

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THE COMMISSION RESUMED AT 9.33 A.M.

MR R GOTTERSON QC with MR M O'SULLIVAN (instructed by Crown Law) for Mr Nuttal

MR S COUPER SC (instructed by Tresscox) for Professor Stable

MR T MARTIN SC (instructed by Gilshenan & Luton) for Mrs Edmond

COMMISSIONER: Mr Gotterson.

MR GOTTERSON: If the Commission pleases, I seek leave to appear. I appear with Mr Mark O'Sullivan for Mr Nuttall.

COMMISSIONER: Such leave is granted. And welcome aboard.

MR GOTTERSON: Thank you.

COMMISSIONER: Mr Couper.

MR COUPER: I seek leave to appear for Professor Robert Stable.

COMMISSIONER: Such leave is granted and, likewise, welcome aboard. Mr Douglas.

MR DOUGLAS: If it please the Commission, it's proposed to call this morning Ms Edmond. Mr Martin of senior counsel instructed by Mr Quinn are appearing for Ms Edmond.

MR MARTIN: Sorry.

COMMISSIONER: Not at all, Mr Martin. We try to surprise everyone by being punctual occasionally.

MR MARTIN: Yes, well, you surprised me. If the Commission pleases, my name is Martin, initials T D. I'm instructed by Michael Quinn of Gilshenan and Luton and I seek leave to appear on behalf of Mrs Wendy Edmond.

COMMISSIONER: Thank you, Mr Martin, such leave is granted and welcome aboard.

MR MARTIN: Thank you.

COMMISSIONER: Mr Douglas.

MR DOUGLAS: If it please the Commission, I call Ms Edmond. While Ms Edmond is coming, Mr Commissioner, the original Ms Edmond statement has already been given to the Commission, to Mr Groth.

COMMISSIONER: Thank you.

MR DOUGLAS: As a matter of formality.

COMMISSIONER: While Ms Edmond is coming, can I ask Mr Martin, Mr Gotterson and Mr Couper, following some confusion or misunderstanding yesterday involving Mr Applegarth on behalf of Dr Buckland, I issued a statement making it clear why we regard evidence of matters outside Bundaberg as having some relevance but the limited use which we would propose to make of such evidence. I trust that you have both received a copy of that?

MR GOTTERSON: Yes.

MR MARTIN: Yes, thank you, we have.

MR COUPER: I have, thank you, Commissioner.

COMMISSIONER: Is there anything you wish to raise from that?

MR MARTIN: No, not from my perspective.

MR GOTTERSON: Or me either.

MR COUPER: Commissioner, I should say something.

COMMISSIONER: Yes.

MR COUPER: One matter which it is necessary for Professor Stable to address when he gives evidence goes not to the Bundaberg inquiry but what was said by you about him on that occasion. I don't seek to amplify at this stage.

The other matter I should place on the record is that Professor Stable of course wishes to assist the Commission of Inquiry, as he has made clear on a number of occasions by e-mail communications. He understands that there is no realistic prospect of recommendations being made about him pursuant to the Terms of Reference. He-----

COMMISSIONER: Well, no adverse recommendations. It may be that there are positive ones.

MR COUPER: Yes. He will give evidence because he perceives, one might say rightly, that some of the criticisms made of Queensland Health may be viewed as damaging to his reputation.

COMMISSIONER: Yes. Thank you, Mr Couper. Good morning, Ms Edmond.

WENDY MARJORIE EDMOND, SWORN AND EXAMINED:

COMMISSIONER: Please make yourself comfortable. May I ask whether you have any objection to your evidence being filmed or photographed?-- No, that's fine.

Thank you.

MR DOUGLAS: Yes, thank you, Mr Commissioner. Madam, is your full name Wendy Marjorie Edmond?-- It is.

You reside in Brisbane at an address known to the Commission?-- I do.

Thank you. You are a retired member of parliament?-- I am, indeed. I'm trying to be.

Thank you. And, Ms Edmond, at the request of counsel assisting this Commission, have you provided a signed statement?-- I have indeed.

And contrary to what I indicated earlier, the statement hasn't been tendered or placed with the Commission. Would you look at the document, please. I will give you the original and also a copy, Ms Edmond, to assist you?-- Mmm-hmm.

Is that the original of the statement that you provided to counsel assisting the Commission?-- It is.

And that document is a document which carries one annexure of two pages and the statement itself is dated the 24th of August 2005?-- That's right.

I tender that statement if it please the Commission.

COMMISSIONER: Yes, I will mark as Exhibit 302 the statement of the Wendy Edmond.

ADMITTED AND MARKED "EXHIBIT 302"

MR DOUGLAS: Ms Edmond, in respect of your statement, I want to ask you a number of questions?-- Yes

I will deal with that as economically as I can and after I finish, subject to the direction of the Commission, there will be a number of other questioners who may wish to elicit material from you?-- Sure.

Can I also indicate to you by way of precursor to my questions that my particular focus by way of touchstone is to avoid information to the Commission in relation to protocols and practices which would have historically been on foot with a

view to affording Commission information which will assist it in making recommendations in accordance with the Terms of Reference?-- Sure.

Thank you. Chronologically, Ms Edmond, I would like to deal first, if I could, please, with the issue of waiting lists?-- Mmm-hmm.

In the statement which has been tendered and which was circulated last night, Mr Commissioner, you deal with that particular issue in paragraph 10 on page 4 of your statement?-- Mmm-hmm.

You have that?-- Yes.

Thank you. And it is correct to say also that the annexure, one annexure to your statement pertains to that issue? Is that correct?-- Yes, it is.

You will have to answer for the record?-- Sorry.

That's okay. Madam, shortly after your appointment to the health portfolio in 1998, you were given information as Minister which suggested to you that, in fact, there was a or several unofficial lists of patients apart from the official waiting lists for elective surgery in the state?-- Sorry, was I given-----

Yes?-- Oh, the information I received was that waiting lists as collected - and that collection started under Mr Peter Beattie when he was Health Minister. Prior to that, Queensland had no centralised collection of waiting list data. The figures for the waiting list was collected in keeping with the protocols, the Commonwealth protocols, for comparison across the states. I was also informed that there was another list for people who were waiting for appointments. When I became Minister, that list wasn't centralised. It tended to be in people's back pockets, individual hospitals kept some - some kept paper lists, some kept only lists for different clinics, they didn't keep for others. It was very, very messy.

But-----?-- And I made that statement at, oh, I think probably the first press statement I released as Health Minister.

In fact, I'll take you to that. Could we just identify the list we're speaking of now. According to your understanding in 1998?-- Mmm-hmm.

The first list was a list promulgated which dictated patients who had been the subject of adjudication or a decision-making process such that they required surgery and that they were placed in what was described as the list of patients awaiting elective surgery?-- They were patients who had been assessed as needing surgery and were ready for surgery.

Thank you. The other list or lists of which you speak and which you identified in 1998 were those who hadn't yet made it

to that list, if they were ever to make it?-- Mmm-hmm.

But, rather, they were awaiting assessment by an appropriate specialist in order to determine the treatment regime appropriate to that patient, including the fact that may require and be assessed as requiring elective surgery?-- Sure. They were waiting lists for outpatient appointments, not for surgical appointments but for outpatient appointments. Something like 20-odd thousand patients are seen each year in Queensland in specialists outpatients unlike the other states.

You saw this as a matter which required immediate address by you and your department?-- I saw the - I saw there was some major issues in the collection of the data. One of the first things I was told was that about a third of the patients on the list never ever showed up for subsequent appointments. They just didn't attend. We needed to look at a more efficient way of determining which patients were going to turn up for appointments and which weren't. Having patients not turn up is very wasteful. The other thing was these patients - these lists were for across the board. More than 50 per cent of them were likely to be across the state medical appointments. They were never going to be looking at surgery; they were medical appointments. Of the others, there were a variety, and what we needed to do at that stage was implement ways to determine their priority so that somebody who had a more urgent condition, their GP would identify that in a referring letter rather than just saying, "I seek a second opinion."

Ms Edmond, you indicated earlier in your evidence today that one of the first steps you took as Minister was in this particular sphere?-- Mmm-hmm.

And you were appointed as Minister in or about July of 1998?-- Mmm-hmm.

Correct?-- Yes.

Thank you. Could I show you this document, please. I am going to put in your hands if I could, please, a media release issued by you on the 30th of July 1998, the heading of the media release being "Health Minister Lifts the Lid on Waiting Lists."

COMMISSIONER: I wonder if there is a spare copy that can go on the display.

MR DOUGLAS: Yes, could you make sure that's circulated now, please?-- Thank you.

I just pause for a moment. At the request of counsel assisting the Commission, you have provided copies of all of your media releases?-- Yes.

Which span the period of your six-year ministry?-- Mmm-hmm.

Thank you for that. This is one of those media releases?--

Mmm-hmm.

Could I ask a couple of things about it. You refer in this media release to lists which you describe as an official and unofficial list?-- Mmm-hmm.

You agree with that?-- Yes, it does refer to that.

And those are the two lists which you identified in your earlier evidence?-- Mmm-hmm.

Do you agree?-- Mmm-hmm.

Thank you. If you could answer yes, no or whatever-----?-- Yes, I'm sorry. Sorry, Commissioner.

-----you wish to say. Thank you. Remembering that it's being recorded?-- Yes.

Thank you.

COMMISSIONER: Mrs Edmond - sorry, Ms Edmond, evidence which we've received hints at the existence of a third separate waiting list and that's people waiting for diagnostic procedures which are a preliminary to surgery, for example endoscopies or colonoscopies. Did you become aware that there was that third waiting list?-- I was aware that they were handled differently because they're often not proceeded with by a surgeon.

Yes?-- So they don't go on surgical lists. Nor are they compared in the national - the collection of data for surgical waiting lists was largely so that Queensland could actually fulfil Commonwealth obligations. Prior to that, Queensland's recordings just said, "Not available", for all of this data. We thought that was inappropriate. We wanted to be on the same level as other states. So this data needed to be in the same line, the published data needed to be in the same line as that that was recorded for the Commonwealth comparisons for other states. So you didn't include things that weren't in their listings.

Right?-- You used the same categories. In terms of scopes and angiograms, et cetera, that was handled differently because they went through - they saw different clinicians and they were - went through different processes of assessment.

Yes.

MR DOUGLAS: Ms Edmond, dealing with the terminology raised by the Commissioner, the term "elective", perhaps by idiom or parlance, seems to conjure up something other than what we're speaking of here, perhaps some plastic surgery that a film star might require. But it is really not that at all, is it?-- The term "elective" is the term - the official term for it is that these are cases that can be delayed and doesn't mean to say that they're not wanted or warranted, and they are then categorised as those accordingly within that elective

phase. I think it's important, one of the issues that I was dealing with with waiting lists is it had been highly political because they had been secret. They went to cabinet and weren't going to be released for 30 years up until I became the Minister. One of the things I was trying to do was depoliticise and demysticise waiting lists so people knew what they were dealing with. More than anything, they were a management tool. You can get the best list if you don't provide that service, then you have no-one waiting for that service. So the aim was to look at how we distributed health services across the state fairly and addressed areas where there was a problem.

On the second page of your 30 July press release you utilise language to the effect that the list, that is the unpublished list, didn't present the whole picture?-- Mmm-hmm.

And you use the language that there was an untold story?-- Mmm-hmm.

Was it your view at that time that the matter required investigation within the department?-- Yes. I think it - what I was saying there was that at that stage we didn't know what the lists were. We didn't know, really, how many people. We had assessed a certain number but we also didn't know how many of those patients would be requiring surgery, how many would need to be seen, where those people were, et cetera. And, I mean, I think - I think I also was a bit flamboyant in my language as a new Minister coming in. I don't think I really appreciated just how complex and difficult this area is and how dependent on a whole range of variables such as the availability of clinicians.

There was a story to tell?-- There was a story to tell.

Thank you. You returned to that theme in the 16th October 1998 press release, which is annexed to your statement - if you could refer to that - by that time, Madam?-- Yes.

I take it some investigation had been undertaken and that had been reported to you?-- Yes. As I said, one of the first things we needed to do was to try and pull in centralised figures that had never been done before.

Did your investigations reveal that the unofficial list was, in fact, a bifurcated even trifurcated list. That is, it just didn't make - didn't compromise, as was discussed before, people who were awaiting appointments but in fact patients who hadn't yet received an appointment. That is - I'll put that another way. Was it divided such that there were patients who had been allocated an appointment yet the date for that appointment hadn't yet arrived but there were others who hadn't yet received appointments?-- I don't recall that it - I don't recall that it - that I had that amount of detail on it.

Did the investigation alarm you?-- The investigation made it clear that it was very complex and it was very dependent on the timing of the counter patients. For instance, lists in

February would be much higher because for most of December and January, there were no surgeons available to see people in outpatients or any other clinician.

The summer holidays?-- The summer holidays of course. So you found that there was a sort of double bounce in February. So if you compared the figures in February, they were usually much higher than at other times, I think. I can't recall the exact details but I do know that it was very complex, that it varied enormously. It also varied according to the clinical staffing of a particular hospital. For example, in Nambour, I remember some of the procedure - appointments blew out when you lost a particular surgeon. So if you have three surgeons who were doing surgery in outpatients and one of them leaves, suddenly that list becomes longer because all of those patients have to go on somebody else's list until you recruit another surgeon. So it changes rapidly and it can be very complex in getting a grip on it, and I don't think I really appreciated that until we had a lot more data.

COMMISSIONER: Ms Edmond, I don't know whether this helps but just going back to Mr Douglas's previous question, he asked you whether you're aware that the hidden list was divided into categories. I do see from your 16 October press release, which is in front of you at the moment, the last line on the first page, it mentions "36,000 people waiting, around 8,500 have not yet been given an appointment". So it seems that there was at least some information even if it wasn't-----?-- Sorry, presumably at that time - I'm sorry, I didn't recall that from now going back to there but presumably at that time, I had been informed that some of them were still waiting for an appointment.

MR DOUGLAS: The information you were given at that time as your press release of 16 October '98 reveals is that the number of persons on the list, that is the official list?-- Mmm-hmm.

And the number on the unofficial list, whether it was divided or not, were roughly equivalent?-- Mmm-hmm.

Is that correct?-- That was to the best of our knowledge, but all of the information I got on this for quite a number of years still indicated that there was a lot more work to be done refining it.

And, indeed, your press release went on to identify that an investigation team had been appointed within Queensland Health to address this very issue?-- Mmm-hmm.

And that is your recollection of the matter?-- As I mentioned earlier, these were largely to assist with management to see where there were problems. As a result of that, I think we provided extra funding for those areas of orthopaedics, ENT and ophthalmology as the areas that we identified had the longest list of patients waiting.

Waiting for what, Madam?-- Waiting for both. You can't

completely separate the waiting for surgery and the waiting for an appointment. If you have an orthopaedic surgeon, he will be seeing both outpatients and he will be operating. The two are interchangeable. What we were identifying is that some hospitals didn't have the number of specialists they needed, et cetera, to deal with both of those issues and what we were looking at was putting more money into providing those services.

The press release goes on to dictate that you expected recommendations to be made by that investigation team?-- Well, those recommendations would be where that funding needed to go and how we needed to address it.

Was it your expectation at that time, therefore, that you expected recommendations to be made?-- I have to say this was an ongoing issue for the full six years I was there. We were constantly looking - we used the waiting lists to identify areas of need or problems of lack of service, et cetera, and we tried to address those areas of need.

So, for the entirety of your six-year tenure of the portfolio, the problem of the official and unofficial list persisted?-- For the entire six years we had issues of a lack of specialists in different areas in different hospitals around the state. We tried to pick up where those were and to do everything we could to assist in recruitment and providing those services.

Did the problem persist?-- I think the problem persists, I think it is a problem that persists throughout Australia from my interaction with other health Ministers.

D COMMISSIONER VIDER: Ms Edmond, did the government at any stage attempt to set targets, as in, at the government level, did - was there any attempt to set parameters around what was acceptable waiting times for different categories?-- Of outpatient-----

Where I'm coming from for that is to say at the government level, were you able to say for certain specialities like, for example, those needing joint replacements, children needing ENT work, did the government set a timeline that was a maximum waiting time that would be acceptable politically? Having done that, you then have a better idea of the amount of resources you need to allocate to enable that to become reality?-- Yes, Ms Vider, the - what we found was that prior to my being a Minister, the referral letters from GPs to the clinics were often very vague. What we - and didn't delineate just exactly how severe a case would be. So one of the things we did was to put in guidelines for how to assess and how to indicate priorities within that. So, for instance, if you were referred to a cardiac specialist because the GP had identified a need, that would be treated at a higher priority than if you were referred because the GP felt there was nothing wrong with you but you were a bit anxious and you'd welcome a second opinion and, you know, that - we did set in place prioritisation, and as - and that is another reason that

it's very difficult to give appointments because the number of people with higher priority changes and they would have to take precedence, as you would agree I'm sure.

Mmm.

MR DOUGLAS: Did you subsequently receive from Queensland Health recommendations?-- Oh, I consequently received from Queensland Health continuing recommendations.

I'm speaking-----?-- All the time I was there we were looking at how to improve this and how to better address it.

Right. Do you recall the substance of those at all when you received them?-- No, I had - I had quarterly reports on waiting lists and the published data looked at the waiting list but, also, I received reports which indicated why there were problems at different times such as if a surgeon had resigned or had been on extended health leave, things like that could impact. So if reports I received actually drill down into what were the specific issues at each - at different hospitals, from that decisions could be made about giving extra support to those hospitals. Can I give you an example. Redcliffe Hospital, one of the issues we found was that there was a growing and increasing and disturbing list in cataract surgery for ophthalmology. When we drilled down into that we found that the VMO was seeing public outpatients. Those public outpatients he would separate into two categories: those with private health insurance, which he would then refer to his private listing, and those with public - without private health insurance, who would go on to the surgery list. But he did know and no-one else was doing any public cataract list. What we did from there was, you know, you had - so you had somebody doing outpatients, putting them on a list but no action being taken at the end of it. Because he refused to do public outpaitent lists, what we arranged was for the Mater Hospital, which had spare capacity in cataract surgery, to undertake a million dollars worth of extra surgery at the time we became aware of that. So the people who were waiting longest went to the Mater to have their cataract surgery rather than going on to a never ending list at Redcliffe Hospital. That was the aim of this - of the waiting list data, to identify problems and then try to deal with it as effectively and fairly as possible.

COMMISSIONER: Ms Edmond, if I can pick up from that: I guess I am alarmed to hear that when you took over as Minister, no-one could actually give you accurate figures of how many people were waiting to see specialists, and it appears that even after four months, all you could get from your department was rough approximations rather than specific figures. I rather have the impression from your media statement on October 16 that one of the things that you wanted the task force to recommend to you was ways in which this data could be better collected and made more reliable. The difficulty with that is that even today, it doesn't seem that there is a watertight system for collecting data in relation to people waiting to see specialists and waiting for non-surgical procedures. Do you recall whether the department came back to you at some time and said, "This is what we need to do to make sure you've got the data."?-- Well, a lot of things did happen. I mean, they put systems in place to actually collect the data, they put systems in place to actually prioritise the lists, but I think it's much more complicated than collecting the number of widgets produced by a factory.

Yes?-- I think the problem is that the lists constantly change, you constantly have different priorities coming in. Somebody who is a low priority may end up having other episodes which make them a much higher priority, so they might be seen the next day but they might have a week ago been on a much lower priority, so patients who were waiting longer than we preferred were usually asked to keep in touch with their GP and if their GP saw any change in their circumstances, that he should contact the hospital so that they could be given a higher priority.

The reason I ask you this, Ms Edmond, is reading both your July and October 1998 media releases, you make what in my view is a tremendously commendable commitment to openness and transparency in these issues, and I'm already on the record as saying how important I regard that as being. The difficulty I have is that after you've expressed your concerns to the department, we now find that of the 36,000 people in 1998 waiting for - to see a specialist, that number has blown out from 1998 to the latest figures we've been able to get, which is 2004, where it's over 100,000 people where the list has tripled?-- Mmm-hmm.

And I'd like to know whether that was a result of the department, the bureaucracy not providing you and your successor with information that this problem was happening and giving you the data, the details you needed to address that problem?-- Commissioner, that's a very complex thing. May I take my time in answering that?

Please do?-- There are a number of different issues there. I can see my learned counsel getting anxious, but the-----

He always looks like that?-- There are a number of difficult issues in there: firstly, Queensland was unique in providing an outpatient service, a specialist outpatient service. In other States, this service is not provided. If your GP refers

you to a specialist, you go privately, the cost of that is picked up by Medicare and what you pay out of your own pocket. Queensland is the only State that provides specialist outpatient services prior to people coming to the hospital for a particular function. Do you understand what I'm saying?

Yes, absolutely?-- That puts us in a bit of a dilemma because we're not funded through the Hacker agreement to provide that service. It has to come out of our other funding, so that's one of the issues we face here. Secondly, patients came to the hospital in the past, some of them would have seen their specialist in private practice but because they didn't have private insurance, would be referred to the hospital publicly. You had others who would come to the hospital outpatients to be seen, so you had a whole range of areas, and I think to be honest, I thought it would be easier than it was to get all of this information together and to then put it into a systemic or systematic way of dealing with it. I found that, as I said earlier, it was a moving feast. Priorities change, doctors come and go. One of the worst aspects was often a doctor would leave and then his lists would, both surgical and outpatient, would have to be divided up or wait until somebody to come and replace him, and this meant that the lists and the full numbers could go up and down on an almost daily basis. We did address the issue of non-attendance by sort of simply making phone calls or appointment reminders shortly before people were to come so if they weren't going to come you knew. We also do that in - that was one of the things we implemented in surgical lists because even people who are booked in for surgery often didn't show, and that's a waste of everyone's time. It also means that somebody else is waiting longer. So we did a range of things. Is it perfect? I can't comment on the latest lists, I don't know where that data has come from. If it came to me as a Minister, I would be drilling down to find out where were the lists? What was the data? What did they encompass? Was it because of shortage of clinicians or were there other parameters? Was it taken immediately after the January - December/January holidays when everybody suddenly gets put on the list? Or was it taken in a quiet time when the numbers from last year have been put there but no numbers are going off the other end.

Yes?-- For instance, the figures at December, the patients there may not be seen until February/March.

I have-----?-- Does that help?

Look, it helps a lot, and I have to say that I share your skepticism, I can't see why it's not possible to provide at least indicative figures? I mean, I accept entirely what you say about lists changing from day-to-day and so on, but health isn't the only industry in the world which has to cope with that, and most industries are able to and feel they need to come up with at least average statistics to provide them with the planning tools necessary to work to the future. To answer one of your points, I understand the figures that we have been able to obtain were as at 30 June 2004?-- Mmm.

So that would appear to be not at a seasonal high, that would appear to be a fairly indicative figure. But my worry for the moment, and I'll be candid with you, is whether during your time as Minister - and we'll hear from Mr Nuttall in his time - whether you were being told about this situation and about the fact that it was apparently getting worse?-- One of the other impacts on that, and I can't - as I said, I can't comment on the latest figures, but one of the impacts we saw happening was during my time there was with the drop-out of numbers in - of people who had private health insurance, more and more people were coming to the public sector for care and to public outpatient appointments and emergency departments. Now, that was the - there was an arrest to the declining figures in terms of private health insurance but it hasn't really gone up substantially high. Queensland historically has the lowest number of people who have private health insurance because people in Queensland have historically relied more on the public health system than in other States. But that means that there was an increase in the number of people seeking outpatient appointments or surgery or emergency departments care. There was also the fact that as there's been an increase in the gap between the Medicare rebate for both GPs and specialist services and those services provided, that people have increasingly sought care through the public health system. You will find that the private health system has had an increase, and I think the figure when I was there of about 16 and a half per cent in activity, but if you look at weighted separations, which takes into account complexity et cetera, you find that there's been a decline or there was when I left, a decline in the level of complexity in the private system and an increase in the level of complexity in the public system.

You see, it's been suggested to us in other evidence that transparency with these figures offers a number of benefits: obviously planners, including Ministers, need to have the figures so that they can decide on resource allocation, but it's also beneficial for the community, people can make informed judgments as to whether or not to have private health cover, whether to go to one hospital or another?-- Mmm-hmm.

In essence, it allows people to plan their own medical future and it also ultimately allows the public to make representations through the democratic system if the situation is not an acceptable one for all those reasons, it's suggested it's a good idea for these figures to be - to be made available to the public.

Again, my concern is that according to your media statement back in October 1998, you asked Queensland Health's investigation team to make recommendations including computerising data collection by the end of that calendar year, by end of 1998 because you then thought that it was important that at least as Minister you have access to reliable figures. What I understand from what you've said to Mr Douglas is that you can't remember the department ever coming back to you and saying this is what we recommend, this is how it can be done to give you reliable figures, all they

came back to you and said is it's very difficult because things change from day-to-day and we can't give you reliable statistics?-- I'm sorry if I gave that impression, that's not what I intended to give. The impression what I recall is that I did receive recommendations and I received advice that these things were steadily improving but that it was proved to be more complex than any of us had thought.

Right.

D COMMISSIONER EDWARDS: Could I just check or ask you to clarify the position that's when you said that Queensland was the only State providing specialist service within a public hospital which was not funded under Medicare or Medibank agreement?-- No, not specialist care, Sir Llew, I'm sorry, specialist outpatient appointments, the other States, most people see their specialist as an outpatient - sorry, as a private patient.

So it's only the outpatients because specialists-----?-- Yes.

-----can operate in hospitals?-- Oh, absolutely.

Sorry?-- No, no, I'm sorry if I gave that impression. Very definitely the specialists operate - private specialists actually provide services and in the other States as they do in Queensland and it's welcome, you know, but in the other States the process is for most clinics that they will see their surgeon out of the hospital in his private rooms as a private patient funded by Medicare and with a gap, and also their follow-up appointments which means that - you see many of the people who are having appointments are people who've had surgery but also need to be seen in follow-ups et cetera. That activity and in the other States to the best of my knowledge also takes place in the specialist private rooms.

Thank you.

MR DOUGLAS: Could I ask you to revert to the last answer you gave to Commissioner Morris' question? I understood you to tell the Commissioner that the department did revert to you with information in response to the proposal for recommendations. That would have been in documentary form, would it not?-- Oh yes, I would think so.

Would it be in the form of a submission to you as Minister?-- Over six years I saw many thousands of documents. It would either be in briefing form or it could be attached to a submission, but I think it would have been in briefing form.

Thank you. It would certainly be in documentary form?-- Yes.

And you can't say now when it was or approximately when it was you might have received this?-- No, I can't on the first one, but my understanding was that I got briefing on these issues. Every three months I had to provide to Cabinet a report on how we were going on waiting lists and other matters on a regular basis. Certainly there was quite a lot of information

involved - that was recorded and reported and went to Cabinet.

It was an ongoing problem?-- It was an ongoing problem.

It wasn't solved in calendar year 1998 or calendar year 1999?-- Definitely not.

Thank you. And you said that you took documents to Cabinet dealing with the issues so as to brief the other Members of the Ministry-----?-- Yes.

-----of the Executive of the issue?-- Yes.

Thank you. It certainly wasn't an issue to be dismissed?-- And it was never dismissed by me.

Thank you?-- For the full six years I was there, or almost six years I was there, this was something that we were trying to address in a fair way right across Queensland. May I say this is one part of the services provided by Queensland Health, elective surgery is about 15 to 20 per cent of what happens in hospitals alone, and there's much wider range of services provided. You also have to provide a whole range of care and responsibilities across the State. This was one of many that was competing for my attention and for funding.

You don't seek to diminish its importance by saying that?-- Not at all, but I'm saying it is one of many very important issues that we were trying to deal with.

Thank you. You will recall again that you - we were provided or the counsel assisting was provided by your solicitors with your press releases?-- I do.

May I put one of those in your hands, thank you? It's a press release for the 11th of October, Remembrance Day 1999. I've provided copies of that to the parties and to the Commissioners. That's press release headed "Health Minister Says Opposition Campaign to Discredit the Waiting List Data is Desperate and Dishonest."; that's correct, is it?-- Yes, that's what the press release says.

Do you want an opportunity to read that or have you read it before giving evidence?-- I know roughly what it says. What I don't have is what it was responding to by the - from the Opposition which would have been useful.

And what form would that take, Ms Edmond, because I may be able to procure it?-- Mmm?

What form would that take?-- Oh, I would presume there were press releases that they put out criticising the waiting lists.

COMMISSIONER: Or it might have been something in Parliament?-- Or it may have been something in Parliament.

MR DOUGLAS: Thank you. Can I indicate, Mr Commissioner, I

don't have any documents of that ilk in my possession or in the possession of the Commission as far as I know in so far as it might assist the witness.

D COMMISSIONER VIDER: Ms Edmond, once you had gone public with waiting lists when you became Minister in 1998, was there an increase in pressure on various politicians by their local constituents?-- Ms Vider, I think this is one of the areas where I accept I failed. What I tried to do by going public with the waiting list was to de-politicise them so that they were something that you, by being transparent and open you could educate the public, educate the media, educate GPs and educate the opposition. So that it was something that was just part of health management. Unfortunately, you're right, no matter how much some things improved, the Opposition would target the one area that had decreased and often in a very dishonest way. I remember a press release that claimed that category 1s in one place had increased by 50 per cent, and I was disturbed to read that in the local paper until I found out it was one patient.

Mmm?-- And the reason was that it was over Christmas and the surgeon had been on holidays and it was a hospital where their category 1s were a very very small number, as you'd understand in a small hospital, but that's the sort of alarmist reaction that I was dealing with at the time and I was trying to get to a stage where people actually talked about health services, not waiting lists and beds, but I admit I failed in that.

MR DOUGLAS: Ms Edmond - unless there's some question from the Commission?

COMMISSIONER: Well, I was going to follow it up because I feel very much the way that Ms Edmond has just expressed herself about this. Only it occurs to me that from most members of the public, the waiting list statistics as they're published are almost meaningless. What is important to most members of the public is how long it takes to get from their GP to receiving the appropriate treatment, and that's why I wonder whether this whole process of publishing waiting list figures hasn't miscarried by giving people only a part of the story and probably a misleading part. I accept entirely what you say that for Federal budgetary and comparison reasons you need to have waiting list figures that comply with the Federal protocols, but for the purposes of informing the public, it does seem to me much more important to be able to say to people if you're looking to have ophthalmological treatment for cataracts or whatever, you can expect to wait for 18 months, if you're looking for a hip replacement, you can expect to wait for three years, if you've got a heart condition or a cancer, then it will be treated within 30 days. That seems to me much more meaningful than the sort of waiting list figures we're talking about here?-- What you're saying is probably quite right, and in fact, I think that's what we were trying to give that information. One of the things we found that happened, and I guess it should have been expected, was as the public waiting lists for surgery went down, it attracted more people to the public system.

Yes?-- Obviously, the main reason people choose to go into the private system, with all due respect to Ms Vider, is because of waiting times or convenience.

Yes?-- Very few people know which specialists they want to go to. I don't know which one I would want to go to, I know some I would prefer to avoid after six years, but most people decide on because of convenience or because of waiting times. So as the waiting times for surgery decreased in the public system because of a lot of extra money being put in there, what we found was more people were wanting to go public rather than private.

I'm also very tempted to ask a question. This will probably be very stupid and you'll probably laugh at me, but I'm going to ask it all the same?-- Never Commissioner.

You were describing earlier the situation in New South Wales where - and other States where most patients referred by a GP to a specialist see the specialist as a private patient, the specialist is paid by Medicare and the patient pays the relevant gap?-- Mmm-hmm.

Do you know of any reason whether it would breach some Federal agreement or something like that why Queensland Health couldn't address these waiting lists by paying the gap for public patients to see private specialists?-- Well, I know the reason we can't change the system because that's something that's been discussed quite a lot.

Yes?-- The - you'd be aware, I'm sure, that half of the funding for hospitals comes from the Commonwealth.

Yes, indeed, I think Sir Llew was involved in that in the very early days, yes?-- Yes, and under the Medicare arrangements and the Hacker, as it's now called, arrangements. In that, it actually stipulates that the State cannot reduce its effort in anywhere from when the time they're implemented.

Yes?-- So because Queensland had specialist outpatient clinics freely available at that time, we are not allowed to charge or make any other - any changes to that.

Yes?-- Which really means that Queensland has been caught in a bind while the other States didn't have that in at the time of their agreements, we've been caught with that in. And it's made it much more difficult for us. It means that we need to attract more specialists per head of population in the public system in some areas and it means that it's harder to keep up with that demand.

You - it just occurs to me, I think, regardless of politics or everyone else, everyone in this room wants the best thing for Queensland?-- Absolutely.

That's the one thing that unites us all. If we are at a disadvantage compared with other States, rather than putting

on more specialists - because we've got no contractual obligation with the Federal Government to increase our efforts - it seems to me that it could well be more cheaper - well, be cheaper and more efficient to - for Queensland Health instead of employing specialists, to say well, we'll keep those we've got, but for patients who want to get to go to private specialists at the expense of Medicare, Queensland Health will pay the gap?-- I'm not sure when you last saw a specialist and saw what the gap was. It's probably more than the cost of running those clinics, but what we have done in Queensland is allocated to some specialists can apply for a right of private practice.

Yes?-- And that means that where a patient is referred to them by name, so instead of just medical outpatients.

Yes?-- It would have "Could Sir Llew see the patient?", for instance, get you out of retirement too, Sir Llew. That can be seen as a public patient.

Yes?-- As a private patient and bulk billed.

Yes?-- But that's a very limited amount. And that actually, that funding goes into a private practice trust et cetera which is divided up between the specialists, the hospital.

Yes?-- For the cost of facilities and all the rest of it.

Yes, I was really thinking more along the lines that if in a particular specialist area, let's say dermatology for the moment, there just aren't enough dermatologists in the Royal Brisbane and the PA and so on to deal with the workload, whether there is any capacity for saying well, those public patients will be referred to private dermatologists at their clinics in Wickham Terrace or at the private hospitals and we will make arrangements to bulk bill that and even pay a sum of money which wouldn't be the entire gap that they'd get for a standard private patient, but a sum of money to make up for the use of their facilities and resources rather than those at the hospital?-- Maybe it's something that should be looked at. I would be very reluctant in my experience to take on something from the Commonwealth.

Yes?-- Take some further costs over from the Commonwealth. That - the money would have to come from somewhere.

Yes?-- And it may well come out of then surgical services, I'm not sure.

D COMMISSIONER EDWARDS: Mmm?-- I'm just saying that if you take on an increasing burden of cost, then you have to pay for it.

COMMISSIONER: I was rather hoping-----?-- The other thing I would point out.

Yes?-- That seeing a specialist privately does not eliminate waiting times. The last time I tried to get a dermatologist

appointment, for instance, was something like nine months, privately.

MR DOUGLAS: Ms Edmond, I was taking you to the 11th November 1999 press release. Is it correct to say that that press release does address the official waiting lists which you described earlier?-- It does, it states quite clearly that the data is collected in exactly the same way. The only difference in the data on surgery waiting lists was that we published it. So for the - we thought it was rather rude of the Opposition to be suggesting that somehow it was manipulated when I think at that time it was not only collected in the same way, it was collected by exactly the same people.

You say in the press release that the level of transparency is unprecedented?-- It was.

Fifth paragraph - fourth paragraph, the two paragraphs on, you say this, and I'll read it into the record. "The pathetic attempts at the Opposition to claim that specialist outpatient appointment waiting times would provide the `real picture' of elective surgery waiting times shows a complete misunderstanding of the hospital system. People waiting for specialists outpatient appointments do not necessarily need surgery."?-- Is that a question?

Just a moment, I am just reading into the record. I want to ask you a question now?-- Mmm.

Might it be suggested that this is some epiphany on your part as to your concerns of the previous year in relation to the official/unofficial lists?-- I think what it reveals is that we're coming to understand the lists better, and I certainly knew - and if you said to me when did I know; did I know in '98 or did I know in '99, I can't recall - but I certainly was aware that about 50 or more than 50 per cent of people on outpatient waiting lists were waiting for medical rather than surgical appointments. The other thing was that of those waiting for surgical appointments, and by that I mean an orthopaedic surgeon or different things, were not necessarily waiting for surgery. People have cortisone injections from an orthopaedic surgeon, people have - they may be referred for physiotherapy. I have been to see an orthopaedic surgeon on probably five separate occasions and I have never had orthopaedic surgery. So the fact that they were waiting - and I think the figures - and I am trying to remember here-----

Certainly?-- -----I mean, this is quite a while ago, and I have switched off - I think the figures were, across the board, about one in 10 orthopaedic appointments would actually go on to require surgery. I think about one in three of the ophthalmology appointments - there was an indication that they may have better been seen by people such as an optometrist. They actually had conditions where they needed improved glasses rather than surgery or other problems, and only about - you know, about a third of them, I think they expected to go on to needing cataract surgery. Even there, in cataract surgery in the private sector surgeons would often delay until what they called - and Sir Llew may be able to explain this better than I can - the cataract was ripe. I think that was because they did not want to do surgery unless it was absolutely necessary in case something went wrong. You would wait until it was absolutely necessary, wouldn't you, Sir Llew?

It is correct to say that by this press release you were dismissing the claim - as it transpires, it came from the opposition - that specialist outpatient appointment waiting times would provide the real picture of elective surgery surgery waiting times?-- No.

You were dismissing that?-- No, I was dismissing the claim - if you will excuse me, I was dismissing the claim that the waiting lists that we were publishing were dishonest because they didn't include them, and I would say that here and now, that they were exactly the same, they were not dishonest, they never pretended to include the outpatient appointments.

Madam, you have recalled very well a number of matters which you have just related to the Commission. I am wanting to identify, if I can, even by way of category of document where the Commission might go looking for it, the sorts of documents that were - came into being and which you either read or could otherwise identify - a body of documents - between the time of

your press release of late 1998 and the time of this press release of November 1999 which enabled you to give this response?-- As I have indicated earlier, there were submissions to cabinet which - you know, which would go through issues such as shortages of specialists, et cetera, that impacted on the surgical waiting list.

Was that every three months?-- That was every three months.

Were those documents obtained from Queensland Health?-- They were prepared.

While you were on staff?-- They were prepared for cabinet. No, they weren't for my staff, they were prepared for cabinet by Queensland Health as any other cabinet submission is.

And that submission going to cabinet would be privileged?-- Absolutely. The - but other than that, I mean, there were briefings. I also used to meet on a regular basis with various parts of the department and they would brief me verbally on where they were going, how they were progressing issues.

Is it correct that after Remembrance Day 1999 you were no longer concerned about the issue of the official and unofficial waiting lists?-- No, I think I remained concerned about people waiting too long for anything, throughout my term as Minister, and did everything I could possibly do to address that.

Madam, after-----

COMMISSIONER: Mr Douglas, I am sorry to interrupt you, I apologise-----

MR DOUGLAS: Certainly.

COMMISSIONER: -----but I think, in fairness to Ms Edmond, I should point out, going back again to your 16 October '98 statement, which is attached to your Exhibit 302 - and please understand I fully appreciate, having been in this job for three months, how people in the public spotlight can say things in the heat of the moment that they sometimes come to regret - but in October '98 you were using the expression "hidden waiting lists" to describe the people waiting to see outpatients. By November '99, 13 months later, you were saying that all hospitals have processes in place to ensure that there are no hidden waiting lists. I think Mr Douglas's point was simply that over that 13 month period there had been a bit of a sea change in your attitude that initially you thought that these were hidden waiting lists, having been in the job for another 13 months you realise that, to use your pejorative term, was perhaps unfair?-- The hidden waiting lists before I became Minister included all waiting lists-----

Yes?-- -----for surgery. By the time of 1999 - in fact, well before that - the waiting lists for elective surgery were actually in the waiting rooms in emergency departments, some I

saw in lifts, as well as being sent to GPs and everybody else around the State. So when we're talking about the hidden waiting lists, I guess it was referring to the fact as much as anything that prior to my being Minister, these never saw the light of day.

Well, I am not sure about that because the first paragraph of the 1998 statement begins by commenting that your "investigation into hospital waiting lists has revealed a massive unofficial list of would-be patients who haven't even made the official list." So that's - the flavour of it seems to be very critical of these unofficial lists?-- Uh-huh.

But 13 months later you seem to have a much more charitable view as to whether they should be described as hidden waiting lists?-- And that was - you are probably right, that was a realisation of just how complex and difficult it was and how it was reliant on the clinical support in a particular facility. And if that varied, it could change dramatically overnight.

What I would really like to know, though, is whether that change of position was a result of your earlier lack of knowledge being replaced with a better knowledge of the system, or whether it was really a result of bureaucrats saying to you, "Minister, you can't keep going around talking about hidden waiting lists, because if we do that, it is going to bring Queensland Health into disrepute."?-- I think I'd already been bitten by that time. I think I first used the term "the waiting list to get on the waiting list", and these things have a habit of coming back to bite you. But certainly by making it publicly aware for the first time that there were waiting times for outpatients, yes, it became a bit of a punching bag from the opposition, I think throughout the time I was there. But I think it is fair to say throughout that time we were working on the issue, we were trying to address it as fairly as possible in terms of resourcing as much as we could, recruit people, and I think progress was being made.

MR DOUGLAS: Madam, I don't want to tax you with documents that postdate the cessation of your tenure as Minister, but as the Commissioner indicated earlier, there has been material placed before this Commission dictating what the respective waiting lists are, the official elective surgery waiting list and the anterior list or lists, and there is no material before that date that was mentioned, namely mid-2004?-- Uh-huh.

I'm chasing a hare down the hole here, but I am seeking to have you assist the Commission in enabling us to identify documents which you believe exist which will demonstrate the size of that unofficial list between 1999 or perhaps 1998, and that material that is before the Commission, which is dated mid-2004?-- I would expect there to be briefing papers. As I indicated, I was informally briefed as well as formally briefed, but I also think you need to look at the expansion of hospitals and the expansion of numbers generally over that time attending the public hospitals.

But, really, my point to you is, and it is a question, one could only properly do that, say in your position as Minister, by looking at the document and seeing the relevant comparison and perhaps the improvements which take place over time with the implementation of better policy?-- Yes.

And this Commission really can't judge that, in your view, perhaps without seeing those figures?-- I think there is a whole range of things that the Commission needs to be looking in that regard, is whether this is the appropriate service - way to deliver this service or whether there are more efficient ways, such as there are in other States, whether the growth in outpatient figures accurately reflects or is a measurement of the growth in the usage of public hospitals generally, because of increases in population, increases in expectation, and other parameters. I think it is also important to see whether the delivery of service is appropriately spread across the State, et cetera, and I am sure that you are able to get those figures. If I was Health Minister, I would be accessing those figures. I am not Health Minister and I haven't been for a long time, so I really can't comment on the direction those things were taking.

Put yourself in the position - back in the position of being Health Minister on, say, the 30th of July 2002, and you wanted to know at that time the figures on these respective waiting lists which you had identified earlier in 1998/99 in your press releases. What document or documents would you be asking to see?-- Question like that, I would be interested in, firstly, not numbers, but actually time waiting because that's what's important.

Yes?-- The - and we would go to the district - I would ask my office to ask the department to inquire of the district what the length of time in that particular place was.

Would the three-monthly reports made to cabinet, which you identified earlier, identify, in your view-----?-- No.

-----at that time that information?-- Probably not. They identified issues such as shortage of surgeons, shortage - you know, that ophthalmology waiting list at A hospital were long because of the fact that we hadn't been able to get an ophthalmologist in that place. They also identified things such as if you want your cataracts done, if you go to Weipa, the waiting time is zilch, or Roma, or Longreach, because we have fly-out teams who do them out there. It really varies from hospital to hospital and I don't think - I don't recall that those documents broke down the waiting lists - I don't even know that they gave an overall figure for the people waiting for appointments. I think it was more that they identified where there were problems and where there were - and what those problems were.

Your answer to my hypothetical question, I suggest, would mean that as at 30th of July 2002 your belief was that there was no central record across the State of those respective official

and unofficial lists?-- This is very complex. The total - the total means nothing, and I am not trying to make a disparaging remark about the total. But if you're waiting for a hip replacement, it is how long you are waiting to see the surgeon, waiting for that appointment, where you are. Different hospitals, the speed of seeing those would vary. What people wanted to know was how long it was going to take in Nambour to see a specialist, or how long it was going to take to see a particular specialist.

I am happy to rephrase the question: is it your belief, as Minister during that period, that, say, as at 30 July 2002 there was no central record within Queensland Health which recorded those respective waiting lists - let's call them official and unofficial - for the various hospitals across the State?-- I don't recall whether there was or wasn't at 2002, I am sorry.

D COMMISSIONER VIDER: During your time as Minister, was any consideration given to having other than elective surgery waiting lists after they had seen outpatients? I am thinking from the point of view of those non-surgical patients, were waiting lists published for them?-- Not that I know of, and I have to say I don't think - I don't recall that being discussed, whether we were going to give sums. What was intended - my understanding is hospitals would tend to indicate to the GP who referred a patient the waiting time for that particular service, and again it was determined by priorities.

I am coming from the point of view - I just think the emphasis on surgery today is the way that healthcare across Australia has gone, in a very economic sense, because it fits an economic rationalist model, you can measure it very precisely, and you can't do that with medical conditions to the same extent. So I just think it would be helpful also, and probably a good morale, for the people of Queensland to know what the appointment time is to see a cardiologist, or, you know, a non-surgical specialist would be helpful as well?-- I am not sure that we ever - well, while I was there I don't believe those figures were published either. What we - as part of the management of people who were waiting, what we were trying to determine is what we could do to care for them better perhaps while they were waiting. For instance, I was advised - and if you say who advised me and when and where, I am sorry I can't recall - I talked to a lot of people over my period - but I know I was advised that a lot of people on orthopaedic waiting lists would probably not need surgery (a) if they lost weight, because if you are carrying around less weight - if you are carrying around the weight you were designed - your knees and hips and feet were designed to carry about, it is less damaging on those joints, but also often by physiotherapy or other forms of treatment. Similarly, we were looking at bringing in optometrists. When I left we were looking at bringing optometrists in to care for a lot more eye conditions than was currently the case, in the belief that not everybody needed to see an ophthalmologist, and we would save their time for the more complex things that they needed to be

seen for.

COMMISSIONER: I don't want to protract this discussion any further than necessary, but the way I look at it, we've now got the figures for June 2004, they are broken down by hospital and specialisation within hospital, and they either are or purport to be precise figures down to the exact number of patients - not just round figures?-- Uh-huh.

What that demonstrates to me is that it was possible for Queensland Health to generate those figures in 2004, and presumably with some effort?-- Uh-huh.

They could therefore have been generated in 2003 or any year back to 1998 or 1997. Looking at your press releases from 1998, at that point in time you were announcing publicly a - an enthusiasm for getting those figures and making them public - not just the official waiting list, but all waiting figures. What I feel we need to get to the bottom of is whether the fact that that didn't occur was as a result of you - when I say changing your mind, I don't mean in a whimsical sense - but you being persuaded that it was undesirable to obtain and release those figures, or whether it was because Queensland Health told you they couldn't provide the figures, or whether something else changed to persuade you that you shouldn't follow up that course that you had announced in your earlier press statement?-- I think there are probably two factors there. I am just trying to recall my state of mind at the time. I think it is probably - I don't believe there was a conscious decision not to go ahead with it. I think it had dropped off the radar, in terms of things that were progressing because other issues come in and take effect. In Health, you are probably dealing with 10 issues a day, whereas in any other ministry you are probably dealing with one. So I think, you know, a priority of those issues changes. So I think it probably just dropped down the list of priorities, in terms of what I was doing and where I was going. I am pleased to hear you say that my initiative of setting up centralised recording in a similar way to the elective surgery has been finalised is up and working and it shows that it did happen. I do recall that it was far more complex than anyone ever imagined. As I said, I don't recall - I certainly don't recall Queensland Health telling me not to go ahead with it, I don't recall making a conscious decision not to do it. I do recall that I often regretted trying to - publishing the waiting lists because my intention in publishing the waiting lists was to depoliticise and demystify, and start the public thinking - forgetting about waiting lists and thinking about health, and that didn't work.

Mr Douglas, is that a convenient time for a morning break?

MR DOUGLAS: It is, but before we rise could I tender the press release of 11 November 1999.

COMMISSIONER: And I think you also referred to one in June or July of 1998?

MR DOUGLAS: Yes, I tender that as well.

COMMISSIONER: Yes. The press release of 30 July 1998 will be Exhibit 303.

ADMITTED AND MARKED "EXHIBIT 303"

COMMISSIONER: And the press release of 11/11/99 will be Exhibit 304.

ADMITTED AND MARKED "EXHIBIT 304"

COMMISSIONER: I have to warn you, Mr Douglas, that amongst admirers of Mr Whitlam, 11 November is remembered for other things apart from being Remembrance Day.

MR DOUGLAS: Yes.

COMMISSIONER: Well-----

WITNESS: Mr Commissioner, may I also remind everybody that these were a couple of press releases regarding elective surgery. I think we probably put out thousands. We tried not to put out press releases about elective surgery, but largely we were responding to claims made by the opposition at the time.

MR DOUGLAS: I will be dealing with other press releases relating to elective surgery after the break.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 10.52 A.M.

THE COMMISSION RESUMED AT 11.18 A.M.

WENDY MARJORIE EDMOND, CONTINUING EXAMINATION-IN-CHIEF:

MR DOUGLAS: Commissioners, before we proceed, could I deal with some housekeeping matters.

COMMISSIONER: Of course.

MR DOUGLAS: Thank you. You will recall at close yesterday Mr Andrews in fact informed the Commission that Dr Stitz had been arranged to give evidence this afternoon.

COMMISSIONER: Yes.

MR DOUGLAS: His statement, I'm instructed, has been obtained and circulated. It seems likely that Ms Edmond's evidence may well go after the luncheon adjournment. Really, the query which I make in open Court for those all here to hear and to perhaps respond to is whether or not Dr Stitz is in fact required for cross-examination.

COMMISSIONER: Look, I obviously don't know how long the cross-examination will go but given the array of talent at the Bar table, I think it would be safe to assume that we'll take up most of the afternoon anyway.

MR DOUGLAS: Certainly Dr Stitz, I'm told, can usefully put his time to his clinical endeavours.

COMMISSIONER: Well, as I've made clear from the outset, without any disrespect to former Ministers, I'm particularly anxious not to inconvenience practising clinicians whether they're specialists or general practitioners or nurses or anyone else. So I think at the risk of having Dr Stitz waiting outside, it would be better to call him off.

MR DOUGLAS: If that causes some lacuna this afternoon in the Commission's time, I'm sorry, it will have to be accommodated.

COMMISSIONER: We will have to live with that, thank you.

MR DOUGLAS: Thank you. Also, before proceeding with the examination of Ms Edmond, there was furnished to Ms Edmond's lawyers by counsel assisting the Commission a memorandum which the statement obtained from Ms Edmond accords. In other words, you will see, Mr Commissioner, that there is a numbering system within the statement.

COMMISSIONER: Yes.

MR DOUGLAS: It is thought now by those instructing me, and I think correctly, that it is appropriate for that document to be tendered. A copy has certainly been circulated shortly

before resuming to all those present and if that assists the examination process or otherwise assists the Commission to properly understand her statement, well, all the better.

COMMISSIONER: Look, that's sensible. It certainly makes it easier to read the statement if one knows the questions. I have to admit I haven't seen this before and I could make sense of the statement without seeing it but it makes more sense of the statement now I have seen it.

MR DOUGLAS: Thank you.

COMMISSIONER: So I will have that marked as Exhibit 302A so that it's associated with the statement to which it relates.

MR DOUGLAS: Thank you. It is a memorandum to Mr Michael Quinn and Mr Terry Martin of senior counsel from Mr Damien Atkinson dated 19th of August 2005.

COMMISSIONER: Yes. That is Exhibit 302A.

MR DOUGLAS: Thank you. Ms Edmond, I'm almost finished with waiting lists?-- I thought I had, so.

Thank you. Could I put in your hands a bundle of press releases which have been taken either from the source documents provided by your solicitors to the counsel assisting the Commission or from the Premier's central site. Copies of those have been provided to your solicitors as a discrete bundle as well. I don't want to take up too much time with it, Ms Edmonds, other than to - Ms Edmond I should say, other than to identify this, that over the period from 1999 up to the cessation of your tenure of the portfolio in February 2004, you issued a number of press releases which dealt with the issue of the waiting list for elective surgery which has already been canvassed in evidence thus far today?-- Mmm-hmm.

You agree?-- An incredible number of them were released.

Thank you. Certainly the bundle we have given you-----?-- That would be a fraction of them.

A fraction of them. Well, I can assure you that so far as counsel assisting is concerned, I'm happy for them to be augmented if you think it would assist the Commission?-- I don't think that's required.

Thank you. You've looked through your press releases before giving evidence?-- Not all of them, I have to admit. As I said, there are thousands of them probably.

If I misquote them - if I misquote them at all I have no doubt that those who are representing you here today will correct it, but can I just give a flavour of it. For instance, a press release of yours the 20th of November 2000, 20th of November 2000?-- Mmm-hmm. I have got that.

The press release seems to be a response to what's described

as an AMAQ report card. No doubt there was a press release by the AMAQ which was critical of the government in some particular way?-- Mmm.

And in your press release you say this, among other things, "Queensland already has one of the most comprehensive reports on elective surgery waiting lists that is published quarterly hospital to hospital, category by category and speciality by speciality"?-- That's right.

COMMISSIONER: And that was undoubtedly correct?-- Sorry, I was waiting for another part of the question. Yes, from my discussions with other Health Ministers in other states, no other state did such a comprehensive list. Some states didn't publish any lists. Others published total figures but didn't break it down to a hospital by hospital or category by category.

And as that - the highlighted passage identifies, those were lists relating to elective surgery. They didn't pretend to be anything more than that?-- That's absolutely right. We always made it clear that it was elective surgery. Obviously urgent surgery took precedence over everything else as did urgent medical admissions. They had to take precedence over everything else. And also, it didn't - we made it very clear from the very first time I published them that it didn't include outpatient waiting times.

MR DOUGLAS: Are you speaking in your last response of the press releases that were issued in 1998 and to which we went before the break?-- Yes.

Suffice it to say the average Queenslander reading The Courier-Mail wouldn't have access to those press releases that you might have issued a year or four years beforehand. The answer is obviously yes, Minister?-- Yes, that's probably right.

Can I take you to another press release and that is for the 3rd of June 2003, 3 June 2003?-- Sorry.

3rd of June 2003?-- Yes.

And, Minister, you no doubt recall this being said many times in a press release or words to this effect: "The recent Australian Productivity Commission report found Queensland had the shortest waiting list times for elective surgery and the Beattie government is determined to maintain the effort." Have I read it correctly?-- Yes.

And that was proclaimed as a virtue of the public hospital system in Queensland on a number of occasions, particularly over the period from 2002 to 2003, to your recollection?-- Probably. I think prior to 1998, the Productivity Commission didn't have access to the waiting list data. There were large chunks of that data - I'm just trying to remember because there were a number of different reports that came through and I was in the opposition at the time, but the health - and Sir

Llew might be able to help me here. There were productions of data from Canberra in which Queensland featured mostly for its long lists of not available. This was - so it was very satisfying to see that not only were we making the lists available in the same format as other states but that they compared favourably.

And, in fact, the virtue sought to be identified by those press releases was that Queensland in comparison with other states had a short waiting list for elective surgery?-- I think it was meant to say that Queensland was performing pretty well compared to the other states, yes.

In fact, better than the other states, the shortest waiting list-----?-- Mmm-hmm.

-----times for elective surgery, is what the press release identified?-- And that's - at that time that would have been the information we had.

Thank you. Do you agree that to wax lyrical in press releases about short waiting times for elective surgery without referring in the same breath to the particulars of the unofficial list is, to put it at its lowest, misleading?-- Can I take time to answer that question?

Certainly?-- One of the things I tried to do as a Minister was to take the focus off just surgical waiting lists by saying in every press release that I issued that surgical waiting lists were a small fraction, not unimportant but a small part, of what happens in a hospital and health services generally and we tried to reiterate that on every occasion. That they went up and down according to what else was happening in the hospital at the time. For example, in winter, operating lists tend to get shorter because there are more medical admissions. We were trying to get across that waiting lists were there but they weren't the sole measure of what was happening in a hospital or what Queensland Health was doing.

If you look at the bundle of press releases, on one day, for instance on the 26th of April 1999, you issued a series of press releases about different hospitals?-- Yes.

And that's not uncommon-----?-- Particularly when the public that - that would have been the day we published the waiting lists.

Certainly. And-----?-- So on that day you would get queries from media around the state about how their particular hospital had performed. So only some of these press releases would have been in reaction to queries. Some would have been in reaction to statements by opposition members but they would have related to the fact that that was the day the quarterly figures were being released.

But if the subject matter of the press release is a waiting list, that's the issue that's being addressed by you in the press release, you don't consider it at all, again at its

lowest, misleading not to avert to the very issue which you considered to be of such vital importance, namely, the unofficial lists which you referred to in your press releases of 1998?-- I'd have to say at that time the focus was on getting the published data for the elective surgery waiting lists. That was where media attention had been focused. That was where public interest was focused. Certainly, as you have suggested, there were other areas where hospitals were performing. That was going on but that was not what was being released that day.

But-----?-- The reason-----

I'm sorry to interrupt you?-- I'm sorry, I'm sorry.

I apologise?-- But the reason they were focused on the waiting lists is that the waiting list data had just been released and that was what people were inquiring about.

Given your extent of your knowledge of your investigations from 1998, to which you took us this morning, did you think it wise to inquire as to the particulars in the various hospitals across the state pertaining to the unofficial list prior to releasing a press release, as I've put it, waxing lyrical about the short waiting lists present in Queensland?-- I think we were focused - as I indicated earlier, the focus at that time was on reducing the surgical waiting list to acceptable levels. So what we looked at was what the issues were in each particular place. Where we perceived there were problems, we looked at ways to address them I think you'll find that most of these press releases actually alert people to a problem such as saying in Mackay, we have a shortage of orthopaedic surgeons and we are doing our best to recruit a new orthopaedic surgeon. So that was the tenor of these press releases.

The press release-----

COMMISSIONER: I'm sorry, Mr Douglas, I wonder if I might just approach that a slightly different way. Ms Edmond, let me make it clear, and I'm sure at least Sir Llew would join me in saying this, we understand perfectly that in a robust and healthy and vigorous democracy it is part of the job of government to tell the public what they're doing well and it is principally the role of the opposition to snipe and to criticise things that they perceive aren't going well?-- Yes.

And I don't think anyone could seriously blame you or your government for promoting the fact that you got the best results in Australia for elective surgery waiting lists. I think, however, that Mr Douglas's question is really focused at a different point. In a perfect world where these issues were depoliticised, which we know won't happen, but in a perfect world, would you agree that to give an accurate view of the situation in the state's hospitals, it would be desirable to go beyond just the data for elective surgery and provide the other sort of data that you'd earlier described as the hidden waiting lists?-- I think that would be desirable

but can I say that in the context of these press releases, that wasn't what I was dealing with.

No, I understand?-- And they focused very much on the issue that I was dealing with at that time.

One of the problems it seems to me with continuing to publicise details about elective surgery is that, as the evidence we've heard tends to suggest, it may ultimately have skewed priorities so that, as we've heard, there was extra funding to address delays in the elective surgery waiting list, no funding for diagnostic and prophylactic procedures such as scoping and mammograms and so on, and a number of very eminent medical people have given evidence saying that that's totally upside down, that the priority should be on early detection and cure rather than surgery?-- Commissioner, you have touched on something that is very dear to my heart that I annunciated very, very clearly before I became Minister and I followed through throughout the six years. It's - it was referred to frequently by my staff as my health sustainability speech which got produced in various formats continually. I first made it prior to becoming Minister and what it does is identify that there's undue emphasis on elective surgery as the only measure of a hospital or a health system's performance. I also made the points, and I'm delighted that The Courier-Mail has recently picked them up, because often when I made these points, I came under an amount of ridicule from - from the media for raising them, is that I don't believe and I still don't believe that any western health system can deal with the increasing demand because of a whole range of issues: increasing expectation, increasing ageing population, increasing technology. I don't believe any health system can deal with those and afford them unless it starts getting really serious about prevention.

Exactly?-- So my aim was that if you wanted a sustainable health system, you had to focus on early detection - or prevention first of all, early detection, early intervention, et cetera, and try and keep people out of hospitals. I used to say, and I'll probably get banged for this, that hospitals have sick people in them, often with things that you don't currently have. So one of the best ways to stay healthy is to keep out of hospitals. I don't know how you want to interpret that but, I mean, what I was meaning there is if you have prolonged bed rest, you can end up with pulmonary infarcts or DTs.

Yes?-- If you - and that used to be the way people were treated.

May I ask by the way, and I apologise, I should know this and I do apologise sincerely that I don't, but you had a medical or allied background before you went into politics?-- Yes, I trained in radiation therapy and I graduated in radiation therapy in 1966.

Yes?-- I worked overseas in that capacity in Denmark, the US, in New York at the major cancer hospital there-----

MR DOUGLAS: You worked in nuclear medicine as well?-- And, also, I trained in nuclear medicine when I was working in Montreal. So I have both qualifications, yes. I had-----

COMMISSIONER: I merely ask you-----?-- I was still working I think with Ms Vider at the time I was elected in 1989.

It does strike me that you and Sir Llew are probably the only two Health Ministers at least in living memory who did have a medical background. Perhaps Dr Delamonthe at one stage.

D COMMISSIONER EDWARDS: No, he was never Health Minister. Dr Noble.

COMMISSIONER: Dr Noble.

MR DOUGLAS: He was the Justice Minister, I think, Commissioner.

COMMISSIONER: And I might say the same things's happened in Justice and Attorney-Generals, that until Mr Foley came along, there hadn't been a lawyer in that position for generations. Do you think you have brought particular advantages to the portfolio because of your professional background?-- I think I probably brought a different understanding of health issues and by having worked in three different states in Australia and a number of countries overseas in health systems in both the public and the private, I think I brought to it an understanding that these problems are not only in Queensland. They're problems that we face, you know, are being faced by governments around the world. I also probably brought more passion because I - having worked in the US, I have to say I'm a passionate supporter of the public health system. The system I encountered there was - could be excellent if you had the money and it could be dreadful if you didn't. In - I still recall, and I mean this, I guess, impacted on me a lot, being asked when I was working at Memorial Sloan-Kettering, in one of the best cancer hospitals in New York, by the parents of a small child was it worth having the treatment, could I guarantee that he would be cured because they were selling their house to pay for that. I don't want to see Australia end up in that situation. If that means that I get a bit cross and cranky and defensive and passionate, then so be it. But I don't ever want Australians to be put in that position.

Yes, thank you?-- Sorry.

No, no, I - I'm glad someone has said that. If I can just move on from there. Our interest in waiting lists really stems from the indications we've received over the last few months that there has been this distortion in priorities based on wait lists - waiting lists and based on the public push to deal with waiting lists. It occurs to me and I have the great benefit of hindsight, which I know you didn't at the time you were Minister, but it occurs to me that, for example, it might have been a better strategy to say, "Well, these were the surgical waiting lists at the time we came into government but

these are also the waiting lists for diagnostic and prophylactic procedures when we came into government and we have done some good with the surgical waiting lists but we've done even better with the waiting lists for scoping and other procedures", and instead of then having money earmarked to deal with the waiting lists, it would have been politically sustainable to have money earmarked to deal with the demand for those sort of procedures that are ultimately much more beneficial?-- Probably I wish I'd had the benefit of hindsight too, but when I became Minister, the focus was - the political focus and public focus, media focus, was on surgical waiting lists. So that's what I set out - one of the things that I set out to address. In addressing that, you really have - the outpatient waiting list is often hand in glove with the surgical waiting list because it's often the same provider that's doing both, particularly in regional centres. It will be the same surgeon who is seeing them in outpatients as in - as is doing the operation for instance. So, if you have a shortage of specialists in that area, that's going to impact across the board. So in addressing the surgical waiting lists, you were in effect also looking at how you addressed or addressing the outpatient waiting lists.

Now that we both have the benefit of hindsight, bearing in mind that our, probably, most important role is to make recommendations as to systemic changes in the health care system in Queensland, one of my fairly passionate views is that, as you said earlier, this whole waiting list issue should cease to be a political football?-- Mmm-hmm.

And it seems to me that one way to achieve that is to ensure that statistics are published across all waiting areas based on the fundamental premise that people want to know how long it takes to get from their GP to treatment. That, I think, will not only, as I said earlier, make the public more informed in making choices as to whether they go to a particular hospital or whether they get private health insurance and so on but it will also take away the political pressure which has been apparently misdirected towards surgery so as to ensure that there is a sensible recognition that surgery isn't the be all and end all of proper funding of the health care system. How do you feel about all of that?-- I thought I'd retired from being Health Minister, Commissioner, with all due respect. I think there are a number of things. I think the other area that impacts on this is emergency departments.

Yes?-- And one of the things we did - and GPs of course and their interaction. One of the things we also published were times - for the first time ever were waiting times in emergency departments for categories 1 through to 5 or 6 I think was the lowest in there. The - I think it's one of those - I'm sorry, I'm just trying to think on the go here. One of the things you find is that if waiting lists go down, it actually attracts more patients to the public system.

Yes?-- Obviously if you ring up your dermatologist and he says the next non-urgent appointment is six months privately, but

you ring up the Royal Brisbane and they say, "Oh, we can see you in six months", that means that people are going to go to the Royal Brisbane because the waiting time is the same but there's a significant cost barrier there for a lot of people. The same is true for, you know - I'm not - I'm sorry, I'm not - I hadn't really addressed that - that issue in gathering my thoughts together but - if you see what I'm saying, the better you do in the public system, the longer your waiting lists are going to be because you're going to have more people attracted to it.

And that's something you have to consider very seriously. What was happening in Queensland in particular was we were seeing a significant drop-out in private health insurance as the waiting lists went down, we saw more and more people deciding that they didn't need to have private health insurance and that became - meant that we were attracting a bigger pool of people.

I'm actually seeing it though, if I may say so, from the opposite viewpoint. If it is the case that at the moment 2 or 3 per cent of Queenslanders are on a waiting list somewhere to see a specialist, over 100,000 people, then it's equally important that they be informed of that fact so that they can make their choices, and if they choose to, spend the gap fee on going to the dermatologist at Wickham Terrace rather than the Royal Brisbane Hospital, people can only make informed choices if they're given that information?-- Most of them can make that choice when they know when their appointment's going to be.

Well-----?-- So if they get informed from their GP or get informed that their appointment is in a year's time, most of them then make a decision or they go back to their GF and say, "Well, can you refer me to somebody else?"

What we keep hearing though is, and this may not have been the case when you were Minister, but what we keep hearing is that at a number of public hospitals, and the Royal Brisbane has been identified as one of them, you don't even get an appointment time, that there are in a sense, waiting lists for the waiting lists for the waiting lists, you don't even get on the waiting list to see a specialist, you're just told that you will be given an appointment when your number comes up?-- I think - well, from my memory, that occurred if you didn't have a specialist in that category whereby they couldn't give you an appointment because they didn't know when it would be.

Yes?-- But there was usually an indication, and certainly I know that because I got letters from people saying their GP had advised them that it was going to be too long to get in, and, you know, complaining to me as the Minister. We would write back and make other suggestions where we could or write back to them and suggest that their GP check that they were in the category that he had originally suggested.

Ms Edmond, I'd like you to understand, I frankly don't care what anyone else thinks for the moment, people have raised their eyebrows at the passion that I've displayed during this Inquiry, and that's because I strongly share the views that you've articulated. I for one cannot understand why the most wealthy and powerful country on the face of the earth and in the history of the earth has people dying in the gutter because there's no public health system, I just find that absolutely bizarre?-- Mmm-hmm.

And I am passionate about doing what little we can through the Inquiry to protect and improve the Queensland Health system, and that's why I really do seek your guidance as to whether

those sort of approaches, if they've been tried and failed, then we need to know that?-- May I comment on that?

Yes?-- I had discussions with the Danish Health Minister which has the socialised system, and it's one of the countries I worked in when I was travelling around as a wild young thing - back I think-----

So this is quite recent, is it?-- You're too kind - in 2001. He raised with me the issue of waiting lists and waiting times, and one of the issues he raised was that in Denmark they - their waiting times accorded to when you went on the list.

Yes?-- They didn't prioritise, so the big problem they faced was that people who had brain tumors were waiting according to when they went on the list rather than to whether this was a serious issue or not. He was very intrigued with the fact that we categorised those patients according to their need, not to their money, not to when they went on the list, but to their need, and for the most part, people who have an urgent need are either seen immediately, if it's non-elective, or if it is, if it can be deferred, they're seen - category 1 patients were seen quickly and they were operated on within a month and he wanted advice on how we did that, how we did the prioritisation and the categorisation of patients both in the outpatients system and also which we were working on, but more importantly, on the elective surgery list. I think you would agree that somebody waiting to have a fairly minor surgical repair operation of a ligament or something wouldn't - shouldn't take precedence on somebody waiting for the treatment of an osteocystoma simply because they came on the list first.

Yes?-- But that's how it worked in Denmark, and that's a system that's, you know, a totally public system.

Yes. And I think one of the things we fail to mention at this Inquiry often enough is that there are so many good aspects of the Queensland Health system that are not being focussed on here because they don't need fixing, we tend to lose sight of the fact that there are great benefits to our system as well as some possible shortcomings?-- I think may I say that both in my experience in working in the health system and in being Minister and before that - I don't think I've ever ceased being involved in health in one capacity or another - I think what has struck me are the vast numbers of the really excellent people working in the system, whether they're in bureaucracy or in hospitals. If I sat in my office and went through the media, I would be very depressed if that was all I saw, because it was always the critical aspects. It was the complaints and the critical aspects. You got a far better picture by getting out, outside the office, getting out into the hospitals, getting out into the community health centres, getting out into the parenting programs et cetera to see all the wonderful good work that was being done by people who were very hardworking. I know there's been some suggestion that clinicians in the public are not as efficient or effective as

in the private system. I would dispute that. The most passionate caring people I have ever met are those people who are out there doing work, doing excellent work day in day out without getting a mention, a line in the media.

When you talk about those numbers, I'm not sure whether Mr Douglas was going to come to this, but again, I'd appreciate your input, but the best sort of figures we've been able to get are along the lines that there are 63 or 64,000 staff within the Queensland Health; of those, something, a little a over 1,000, 1,100 or maybe 1,300 are doctors and those include doctors who are clinicians as well as doctors who are in administrative roles. Another 13,000 odd are nurses, and again, many of those would be directors of nursing or in other positions that are essentially administrative?-- Sorry, can I just jot those figures down?

Yes?-- Sorry, what did you say?

A total of 63 or 64,000 staff all up?-- Yep.

Let's say 1,300 doctors and 13,000 nurses?-- Mmm-hmm.

Now, I'm afraid I can't give you more precise figures than that, and I appreciate that there will be other clinicians involved, there will be physiotherapists and so on?-- Yes.

I'm sorry?-- Sorry, go on.

And also there are people who do essential jobs that are patient-related, like making beds and cooking meals and so on. But it does seem surprising that four out of every five employees of Queensland Health on average are not clinicians?-- Okay. If we go back to 63,000, I think that's probably right. When I was there, the figure was just over 60,000 employees, but that came down to 40,000 full time equivalents.

Right?-- Okay, I think that's the first thing you need to do, is a lot of those people are working part-time, so it was just over 40,000 full time equivalents in the public system.

MR DOUGLAS: So there might be part time wardsmen or part-time cleaners or something like that?-- Or part-time nurses. You have a lot of nurses in the public system who may only work one day a week, particularly on weekends or after hours. Nursing is one of the areas where you probably have more part-time than anywhere. A doctor, an awful lot of the doctors are part-time VMOs. For example, there's a lot of VMOs, so a lot of those, the hotel services, of course, are those services that provide for patients, the eating, the cleaning, the sleeping arrangements et cetera, and that would - I would be surprised if that wasn't the bulk of the numbers that are non-clinical staff, I'd be surprised if it's administrative. The biggest increase in administrative staff I was probably responsible for. I thought it was totally irresponsible in terms of cost-effectiveness to have clinicians two-finger typing reports and things, so I actually

agreed to administrative support for clinicians across the board, people like ward clerks et cetera being made available so that nurses, doctors, physiotherapists and it's inefficiently doing their own paperwork and it was one of the commonest complaints I got from clinicians when I became Minister, was that they were expected to do that work and they just really felt that they weren't the best typists in the world or the most effective or it was the most effective use of their time.

COMMISSIONER: Exactly?-- Much better to put on a - and I'm not playing down the important role of clerks et cetera - but much more important to put on a clerk and who's efficient and can manage these things, then expect a clinician or a nurse or somebody who's not trained to do it.

And much more efficient to have somebody who's paid 30 or $40,000 a year doing that job rather than somebody whose salary package is $200,000?-- You've been getting your specialist cheaply, Commissioner.

D COMMISSIONER EDWARDS: With the greatest respect, I don't think that's the full story. We're hearing that the reports are coming back much quicker, but really, there's no more and rather than a report from a doctor being typed in seven weeks or six weeks, they're now being typed within a week?-- Mmm.

So I don't think the, from what I have heard, that we can really argue that the clinical servicing has improved in those number of - in those numbers?-- I'm sorry, you're saying that the reporting has become more efficient?

What I'm saying is because we've built up all these support staff?-- Yes.

It's just reduced the time in which the responses have come in from correspondence from seven weeks to two weeks and things like that, but the actual service to the patient has not improved one iota in times, appointments, when they have to see a specialist and so forth?-- Well, Sir Llew, I think the aim of it is to not only mean that the report gets out faster, but it's not an extra load on the clinicians, so it frees the clinician to be able to see more patients or do more things.

But he's not, I'm sorry to say this to you, it's not. All it has done, we think from what some of the information provided and if the information is incorrect, I stand to be corrected, but what we are hearing is that all it has done is reduce the correspondence time, it's reduced reporting time and some of the medical practitioners, particularly in the recent areas have made it clear to us that their waiting lists are getting longer, but the time which the reports are going out are getting a bit shorter and that's not much consolation to somebody who's on the waiting list?-- No, but I don't think that was the big issue we were addressing here, we were addressing bringing them up as much as possible.

I'm addressing the outcome, and I don't think that's the point

that's being listened to enough?-- Sure. Well, I guess that means you have to ask what they're doing with the free time that they've got when - if their request for administrative staff was to free them up to do more clinical work and you're saying that they're not to doing it.

No-----

COMMISSIONER: I think that what's happened in practice is that a specialist who had use of .2 of a full-time equivalent of a clerical assistant may have had that increased to .5, so that their typing and filing gets done quicker?-- Mmm.

But it doesn't give the doctor more time because the doctor still dictates the report and it's still typed by someone and it might be typed quicker but there's no extra time for the doctor to see patients?-- Mmm-hmm. Can I say, Commissioner, they welcomed it at the time, it was seen as a priority and they welcomed it.

Yes. Again the picture we hear - and in case anyone thinks otherwise, it's not that we've got concluded views, we're just putting things to you that we've heard from various witnesses and we've read in various submissions - a picture has been painted to us of a bureaucracy in Charlotte Street which is totally unresponsive to the needs of clinicians, and administrators in, particularly in regional areas, we've had directors of medical services and district managers saying how particularly in areas classed as policy, the inquiries go up to Charlotte Street, they don't hear anything about it, there's got to be a committee and the report and memoranda written and so on. If they get any response at all, it's usually too late to be of any use and it's usually negative, but there's just a sense, rightly or wrongly, that there's a look of transparency, and when you get down below the level of the Director of Medical Services or the District Manager, when you get down to clinician level, people tell us they're tearing their hair out because they are convinced that they can come up with a proposal which will save money and which will do good for the patients and increase the services, they're told they have to put in a business plan, even though they've got no training or experience in writing business plans, but they do it and it goes off up the line and goes to the Deputy or Assistant District Manager, the District Manager, to the Assistant Zonal Manager, to the Zonal Manager, to the various tiers within Charlotte Street, and again, they don't hear anything for months and they're got no way of finding out what is going on, how the matter's being considered, how it's being dealt with, no feedback, no transparency, no opportunity to address any shortcomings in their proposal that might be - a bit of tweaking might make it easier, and there is that sense, rightly or wrongly, that clinicians are being hampered by red tape?-- How do I respond to that?

Yes?-- Is that the question?

Yes?-- I had submissions put to me on a regular basis in a

variety of ways, sometimes it would be in a letter or a copy of a letter that was put through to the department and I have to say that they were acted on, at least responded to. It depended on the quality of the submission. I'll just give you an - a couple of examples?

Yes?-- As well as formal advice from the department, I also had a sort of ad hoc advisory group of senior clinicians, mostly, I have to say, from Brisbane because I didn't want it to be an expensive exercise bringing people down to talk to me, certainly was one from Toowoomba, but where we met on an informal basis every six months or so and bounced ideas about exactly that, how do you improve the system? Are their things out there that you could do to improve it? And this actually grew out of my concerns about the complaints you're hearing, and what I did at that time was request - a Ministerial request I understand - but a request nonetheless for a number of people that were identified as very experienced, at the leading edge of their work et cetera to come and tell me about how things worked in their hospital, how it happened in their particular specialty, what the problems faced. And out of that we came up with some very practical problems. I mean, one clinician at the Royal Brisbane Hospital explained to me the problem he was having with elective surgery lists was that his elective surgery list or his lists - surgery lists was on a Monday. That that had two problems: one is Monday you get an unfair share of public holidays; secondly, quite often patients would be - get a cold or et cetera over the weekend and not be suitable for having an anaesthetic, but he wouldn't find that out until the operating theatre manager came in at 9 o'clock on - or 8 o'clock or whatever on Monday morning, so there was no time to actually review and find another patient that could slot into that position, and that meant that his surgical time was wasted, another patient was not operated on when they could have been or another patient slotted into that space. Simple practical issue that could be resolved by having somebody review the lists and review the patients coming in either early on Monday morning or Sunday night, and one of the things came out of that was the proposal that for elective surgery, we have a bit like stand-by lists, a bit like flying, so you have people who are fairly able to make short-term arrangements to come in and have surgery so that if they got a call at 7 o'clock on Monday morning saying, "We have a space today, you're on the list, can you come in?", we could do it. You know, that's the sort of thing. Another proposal that came out of that group was how we managed orthopaedic services on the south side, which was a vast improvement, whereby Princess Alexandra - and when I say the south side, I mean the south side of Brisbane, PA Hospital clinicians explained that their elective lists were often disrupted by major trauma, and so one of the decisions we made was to have elective surgery largely done at Queen Elizabeth Hospital where they didn't get much trauma so that it wasn't interrupted as much so you sort of separated the - those coming in off the street, as it were, from those who were booked in for elective surgery. And also as part of that, they were looking at - and I think it has been established now - but it was over the time I left, to focus PA and have a

trauma centre at PA which better focussed it. That what we found was that by moving the lists to QEII, that virtually reduced the number of patients that were being bumped because of more urgent things coming in, and some of these patients had been bumped two or three times because every time they got to the operating theatre, there was a car crash down the road and they had to whip them out and whip in other people, which is very distressing if you're prepared, you've prepared yourself psychologically and physically for surgery and then suddenly you're told, "Oh, we can't do you today because there's been a four car prang on the Ipswich Highway".

What I find fascinating about those examples is obviously in your ministerial experience you were able to cut through the red tape and action proposals, sensible proposals, some might even say in one sense no brainer proposals, they're so obviously sensible that there's little alternative, but we can contrast that with the examples we've heard from people throughout the State that they've come up with proposals which are equally attractive and they're just lost in the mists of bureaucracy. I'll give you one example, and it comes from a submission we've received from a doctor in a fairly remote rural town which is a one-doctor hospital. Before you came to office when I think Mr Horan was the Minister?-- Mmm-hmm.

He came up with this proposal, that instead of medical superintendents at one-doctor hospitals having three days off a fortnight, which created problems, because if you're in Cunnamulla and Thargomindah or whatever, it's very hard to go anywhere in three days, that it should be changed to six days a month?-- Mmm-hmm.

What he's told us is that Mr Horan agreed to that, but as soon as he tried to implement it, as soon as the doctor tried to implement it, he was told by Charlotte Street that it wasn't yet official Queensland Health policy and the Government changed it about that time and I should tell you, the doctor pays tribute to you for-----?-- I was going to say I implemented it.

Yes, for implementing the previous Minister's commitment?-- Mmm-hmm.

But the concern he raises is that unless it was for your ministerial intervention, he was getting nowhere with the bureaucracy, the bureaucracy - although it was such an obvious and sensible and simple improvement, it took the Minister's intervention, initially Mr Horan and then yourself to get it through?-- I can't comment on what happened before I took the place, but I did implement the policy. Can I say not everybody likes it.

Yes?-- And that's one of the issues you have, what one person thinks is a good idea, and I have to say most of them do.

Yes?-- I had regular meetings with the Rural Doctors Association both before and after I became Minister and these were the type of issues we discussed. But while most of them

would agree with it, I also got letters from people complaining about that very policy and saying, you know, that we were postponing their time off et cetera.

Yes?-- But it certainly made it - it was more practicable to provide a relieving officer for a bank of six days.

Yes?-- Than two, you know, at regular intervals, yes.

We've also heard, to give you another example from the medical superintendent at Townsville, Dr Andrew Johnson, who - and these are my words rather than his - he told us that it had virtually reached the point where he didn't bother asking Charlotte Street for permission to do things because it was - it was in the long run quicker to get forgiveness or absolution than to get permission, and some of the reforms that he talked about implementing, patient safety initiatives and putting on diverting staff away from office jobs to patient-related jobs and so on, he just gave up waiting for Charlotte Street to give the approval and went ahead and did it because he just kept running into this mystical word "policy", that that was a policy issue and therefore it had to go to a committee and had to be dealt with and he couldn't expect a decision this side of Dooms Day?-- I can't comment on that. I mean, I know Dr Johnson well, I knew him when he was head of - what's the private Catholic hospital? Calvary in Cairns, as well as when he moved to Townsville.

Yes?-- I haven't seen any examples of that. I do know that I had a lot of interaction, probably more interaction than most Ministers, with clinical staff and in the regional hospitals because I would get out there.

Yes?-- I would go there and I would tour with them and I know most of them pretty well and I was there a long time, you have to - I think, Commissioner, one of the things you need to realise is that before I became Minister, or when I became Minister, everyone I met who'd been in health a long time said to me, "You're the 10th Minister we've had in 10 years." There had been enormous upheavals, you had - you've mentioned I think the system of boards that had gone.

Yes?-- Then you had regional health and then Mr Horan got rid of regionalised health with autonomy in the regions, and I think some of them were saying we really want the autonomy we had when we had regions and the district system implemented. So there had been enormous upheaval. When I became Minister, there was an urgent need, people were change exhausted; do you know what I mean?

Yes?-- They didn't know whether they were coming or going or what to do or what was the thing. I felt there was an urgent need for stability, which probably reflected my decision to stay there for two terms, which I think was about four times as long as-----

Less than Sir Llew?-- Less than Sir Llew?

D COMMISSIONER EDWARDS: No, slightly more?-- I think there were three health Ministers in every other State.

COMMISSIONER: Yes?-- That's when I decided it was certainly time to go. But people were - the system was change exhausted. There had been so many changes without time to settle them down and see through those changes, make sure things were working properly. So I made a decision that I would minimise the impact of my becoming Minister in terms of change. What I did see, and I know this was criticised and has been criticised as an extra layer, what I did see that if you had 39 districts, which I think is about four times as many as there should be.

Yes?-- And is one of the issues that creates a lot of the problems that Queensland Health is working under, with 39 districts, there was a lack of coordination between those districts. You often had districts sparring with each other for resources and competing about managing their budgets, et cetera, in a way that was not helpful to anyone. I therefore implemented the system of the zones, the three zones which had minimal infrastructure on them to coordinate those districts so that you didn't get this conflict, that you did get coordination across districts with them cooperating, working together and not sort of competing with each other.

If it assists, I don't think you need to persuade any of us here that the zonal system was a very positive initiative. I am not sure whether you feel in a position to defend your predecessor's decision about reducing the regional autonomy. That is something which I think we would be much more critical?-- May I - do you want me to comment on that?

Yes?-- When in opposition, I went around - I did a lot of travelling around the State talking to people on the ground, and probably I was able to pick up on these things because of my background, whereas, you know, maybe somebody else wasn't. One of the - the problem of having 39 districts is we simply do not have that many top level administrators around. Certainly outside of Brisbane there was an overwhelming call for regionalisation to be brought back in.

Yes?-- Most of them liked regionalisation, they thought it brought a level of autonomy. Yes, it needed extra work, but they really wanted it to stay, and I seriously thought about taking that as a submission, that we go back to regionalisation, et cetera. In defence of Mr Horan - and I think he was under enormous pressure from the major centres - they actually liked not being part of a region but being part of - having their own districts. And that's fine because they're not the areas that have difficulty recruiting, they are not the areas that have difficulty getting resources. They have a wide range of services available. It is out in the regions where people have difficulty recruiting, even places like Townsville have enormous difficulty recruiting. All the time I was Minister there were a number of holes in the service delivery at Townsville that we couldn't recruit for. Sorry.

No, no, no, this is tremendously valuable. Can I-----?-- Health Economics 101.

Can I let you into at least my present state of mind - and I won't suggest this reflects the views of all of us - I really am inclined to think that we should be able to seize the best of both worlds by retaining the zonal system that you implemented so that control of the referral hospitals and control of retrievals and that sort of thing within the three zones remains under a central control?-- Uh-huh.

But on the other hand, for rural and regional hospitals outside the referral centres, the community, and particularly the local medical community and other allied healthcare professionals, be given more autonomy to make their own decisions, whether it is budgetary, or employment, or clinical, under, of course, a strict regime of regulation, but the local community having input into what goes on at their hospital?-- Sure. I think it is important for districts or areas or regions, whatever they are, to have an ownership, to feel an ownership of their health facility. Some people have talked about going back to the boards - and, certainly, when I went around I talked to a number of people who had been on the boards, particularly chair, some of them were on the health

councils which were set up under my predecessor but were there. So often they had on those councils former board members. The boards had a certain degree of autonomy but there were also problems associated with that. The boards accumulated debts of about - between 6 and 700 million.

Yes?-- Which was picked up - I think Keith de Lacy - I am trying to think here, so, please, if there is an error in something I say, please understand I am trying to think back to about 10 years ago.

Look, I will cut you off because we are familiar with that history?-- Uh-huh.

If we were going to restore some system of local autonomy, it would have to be, we think, very closely controlled so those sort of problems don't develop, and so you don't have the problem - and I can afford to be frank about this - the problem that existed, say, in the 1980s when the local health board often reflected the local membership of the National Party, because there was a tendency to have-----?-- You could say that, Commissioner. I couldn't possibly.

No, of course you wouldn't. But there was at least the-----?-- Perception.

-----perception that there was a political interference?-- Yes. Many of the board members had little or no medical background. Some did, some were retired matrons and medical superintendents, et cetera, who played a valuable role. When I talked to board members, they also told me that they had a disciplinary role in the running of the hospital. One told me that on one certain night a week they would have disciplinary matters heard, where they would fine staff for not conforming to the code of conduct in their appearance, so nurses who had holes in their stockings would be fined, doctors who were late for surgery or other things, without a note, presumably, were fined - fined or reprimanded.

D COMMISSIONER EDWARDS: But that's playing stupid, isn't it?-- Well, I thought - I didn't know how they would get away with it today, Sir Llew.

But it is stupid, isn't it, focussing on those kind of things rather than on the care for the patients?-- Yes. I think the other thing that came out of that was a lack of coordination. When I asked them about planning issues, it tended to be - the planning seemed to solely relate to what the next door town had.

COMMISSIONER: Yes?-- If they had it, we want it, rather than - are you familiar with the term "clinical ability" - you know, I am trying to think of it - clinically viable. It is not clinically viable to have heart surgery delivered in my home town of Gin Gin.

Yes?-- ICU services - I am told that if you are having long-term ventilated patients in ICU, you need to be seeing

100 of those a year. You don't sort of try and provide them in every small hospital because you don't have the expertise, you can't maintain the number of staff with that expertise, et cetera, to provide those services properly. So you have to look at clinical viability as well, but my understanding, in talking to the chairs - and probably it was different with the chairs in the city, in the major hospitals - but certainly in the rural hospitals, the planning seemed to be largely on the basis of doctor so and so said he wanted his own beds, So we built extra beds. He didn't want his patients somewhere else, and, secondly, the town next door got this service so we wanted it, rather than thinking the town next door has that service, this service is missing altogether-----

Yes?-- -----put up your hand for that service, so that between the two towns you had complementary services.

Minister, I apologise to Mr Douglas, I have interrupted him at considerable length, but I guess also one of my concerns is that any system has to be proofed to the individual holding the position at the time. For example, it has to be minister proof. We can have a minister who is, like yourself, a person with a clinical background, we can have a minister who is, like me, a lawyer, or a minister who has been a boiler maker. You know, there are ministers and ministers. There are, I think - and I am not giving any secrets away in saying some ministers who are more diligent and enthusiastic in their duties than others, there are some like yourself who make the point of going out and meeting the people at the coalface talking to the people in the hospitals, and some ministers who don't do so - and I am not reflecting on any particular minister?-- I understand.

I am just saying there are different standards. And the same, what I have said about ministers, can apply at every level of administration. It can apply to a Director-General, Deputy Director-General, it can apply to a Chief Health Officer, it can apply to a district manager, it can apply to Directors of Medical Services, and the system has to be capable of utilising the best possible person in that role, but also capable of withstanding the weakest possible person in that role, and it strikes me that one of the biggest problems at the moment is that the structure depends so much on positions like district managers, often people without a clinical background or training, and if you have got, to use him again as an example, Andrew Johnson, you can expect innovation, progress and reform but you can't expect to get that in 39 districts throughout the State. You might possibly get it if you have a structure that at least has the benefit of an autonomous local council making those decisions rather than one district manager?-- I think it needs to be put into the context that in the management of any district - well, in the management, you don't just have the district manager. District manager is across the entire district. That's not just the hospital. That's all of the other services out there as well as the hospital.

Yes?-- Within the hospital you have the hospital manager but

you also have the medical superintendent and the director of nursing who play very key and important roles in the provision of advice to the district manager and to the health department, and certainly I talked to and listened to medical superintendents every bit as much and directors of nursing every bit as much when I went around districts as I did to the district manager. So the district manager, I guess, is the conduit but is not the sole provider of advice to the department or to the minister.

Yeah, I accept, of course, entirely what you say. I guess my concern is that if that conduit is blocked or leaking, then the whole system breaks down. The district manager is really central to the present structure?-- I am not sure. It is usually - I am sorry, we're going way off my expertise into suppositions and, you know, are sort of - I am thinking on my feet. I am not sure if having autonomy in the districts is going to make that better or worse, and I say that with the experience of talking to my colleagues in New South Wales. They have had a system where they have areas, they are called - everyone tries to think of a new term - regions, areas, districts. We are a running out of synonyms.

I had my thesaurus out. We might make them provinces, or locales or something?-- They had run into other problems where they have autonomy in the areas to the extent that, from memory, they are separate legal entities and, therefore, it makes it difficult for the minister to actually get information and intervene when things go wrong, and I think a classic example of that was Camberwell-----

Yes?-- -----hospital where there were reports about things going wrong regularly and numerously, but the minister's ability to intervene was limited by the very fact that these were separate legal entities.

I was going to ask you one other thing, because that will sort of exhaust the store of issues that I wanted to get your input on. We have also heard a great deal about what's described, perhaps inaccurately, as the culture within Queensland Health and so-called cultural problems. Normally I am not someone who believes that changing the name changes anything, but it does seem to me that there has been this trend over the last decade or so to use the language of business or the language of commerce to describe the provision of medical services. So we have medical superintendents referred to instead as directors or even sometimes executive directors. We have clinical staff required to put up business cases, we have the department, despite the fact that it is a department of government, referred to as corporate office. We have all - we even have patients referred to as clients, which I find mind-boggling?-- I am still old fashioned. I call them patients.

And I noticed you refer to medical superintendents as well. I just wonder whether that sort of - the sort of culture people talk about has, in a sense, been either created or exacerbated by this pretence that it is a corporate business rather than a

taxpayer funded service to the community?-- We are getting philosophical, Commissioner. Do you mind?

Not at all?-- You're being philosophical; am I allowed to be, too?

Of course?-- I probably agree with you. I think it has probably gone too far, but I think the changes came back - you have to - I am probably showing my age here. Ms Vider will sort of remember these things, and probably Sir Llew, but in the good old days, as people keep referring to them, patients weren't allowed to see their files, they often weren't even told what was actually wrong with them. It was a case of "you trust us, we're the doctor, and don't ask questions." I think the move back in the early 90s, I think it happened, to start saying clients rather than patients was a way of reinforcing that these people had rights, too, they had rights to access their knowledge. I mean, in my day, patients were not - an absolute no-no was that patients were not - simply not allowed to see their case notes, and yet you would say, "Well, who is more important as seeing their case notes of the patients than themselves?" So it was a change of attitudes to try and get away from what was a patronising treatment of patients, and other staff would be probably fair to say and to show that the patients, as clients, had rights, they had a right to know what was wrong with them, they had a right to have a say in what their treatment was going to be, which was a novel concept at the time, they had a right to know what the doctor was vague about them in his clinical notes, they had a right to know what other options there were and how they could best be addressed. So there was - there was an attempt to change a patronising attitude to one that reflected the patient as somebody more in control, and I think that was where the client word came in. Probably it has gone too far, and, as I said, I am still old enough and old fashioned enough to talk about patients as patients, but I hope not in a patronising way.

Thank you. Mr Douglas, I will try and give you a free run now. Sorry, Sir Llew.

MR DOUGLAS: I understand Mr Carmody, the Commissioner of Taxation, refers to us all as clients as well, Mr Commissioner.

Ms Edmond, if I can deal with a different topic now, and it is - the topic is your contact with the Director-General and those other within the department during your time as minister. During your time as minister, your ministerial office was located at Charlotte Street, is that so?-- Yes, it is.

Were you on the same floor as the Director-General?-- Yes, the 19th floor was divided into two parts with the foyer and lifts basically in the middle and the reception area.

And the Director-General, during your time, was Dr Stable?-- For the most part it was Dr Stable. It was only towards the

very end that the general manager of health services, Steve Buckland, became Acting Director-General.

He was Acting Director-General from about late October 2003 until the conclusion of your term?-- Yes. I made a conscious decision that I thought it was inappropriate, given that I had indicated I would not be contesting the election, that I would be retiring, I spoke about this with the Premier and said that I didn't think it was appropriate for me to appoint the incoming Director-General on the basis that I wouldn't be the one who would be working with him. I thought it was only fair to leave that until such time as a new Health Minister had been appointed, of whichever party.

Thank you. And Dr Buckland was appointed after your term had concluded?-- Yes.

If I could ask you to speak for the moment, when I ask these next series of questions, about Dr Stable only? Throughout your term as minister in the successive governments, how often would you speak to Dr Stable?-- It would be a rare day when I didn't speak to him.

You might speak to him by telephone?-- Yes.

Or in person?-- Absolutely.

Apart from speaking with him, would you have regular meetings with him, say once a week, once a month?-- Yes. We had - if there was nothing else that we were meeting about, we generally had a cabinet debrief after cabinet on the Monday, which usually involved issues that related to health. So I would report from cabinet decisions that impacted on health that he would be following up. It may be a submission that health had taken to cabinet or it may be a submission from another department where health was asked to do - participate in. So we would have a cabinet debrief on Mondays. On Thursdays it was my practice Thursday afternoon to have a regular meeting with the DG for two reasons: the first was to go through what was in the cabinet bag or what submissions, et cetera, from Queensland Health or other matters in the cabinet bag for the following Monday morning, and also at that time we would raise any issues that I was concerned about, if there were matters I picked up through correspondence or others that I wanted clarification on.

Whether it be in the almost daily discussions or in those series of meetings that you identify, you would raise with the Director-General or members of his staff present any issue that you might have come across in the papers that you were given, or perhaps even in the newspapers?-- Absolutely. We had media monitors and - sorry, I was trying to remember the name for monitoring TV and audio. So those would come into my office. Any matters - I usually rang the DG on my way into the office in the early morning to say was there anything that I should know about? We also had made an agreement when I interviewed him when I first became minister to what we called a no-surprises policy, which means that if there was anything

happening, any bad news happening or any problems, he would call me at home or tell me in the morning. But - and out of that came things such as - I mean, when we had an armed intruder in the dialysis ward at the PA Hospital, I mean, I think he rang me at 5 in the morning.

Yes?-- To say that that was occurring, et cetera, and how it was being managed and what was being done. I know not everybody operates like that but I felt it was better to do that.

In fact on that occasion he might even have rung you from the scene, is that so?-- I don't think so. I think he had had calls.

Thank you. No need to pursue it?-- Oh.

Would the Director-General receive your press releases?-- Yes, he would usually see a copy of them, yeah.

COMMISSIONER: Usually before or after they went?-- We would usually seek - I mean, when a request for a press release came in, my staff would seek that information from the department.

Yes?-- Or determine whether it was a departmental response that was being required. If it was a straight departmental response, that response may come completely from the department and just be reheaded, more or less, with my comments on it, or if it was a political response, we would get the information to make sure that the information we were giving in that response was accurate.

MR DOUGLAS: Press releases weren't always reactive; they were sometimes proactive?-- Absolutely.

When meeting with the Director-General would you attend with your ministerial advisors?-- Usually there would be my senior ministerial advisor - or I divided my office, the staff in my office, into different policy divisions, so that, for instance, I had a nursing advisor who also covered aged care, mental health, a number of issues. You know, I had divided it up. I had somebody else who looked after food, safety and quality issues, dental and things. So I had different policy advisors. Because it is such an enormous department, enormous spread of areas of expertise, I thought it was unrealistic to expect all of my staff to be across all of the issues. So what I did was have them focus on particular parts of the portfolio and that particular person may be with me, not always, my senior policy advisor, depending on the issues being discussed.

Apart from your senior policy advisor, how many advisors did you have during your term?-- It varied.

I don't mean over time, but at any one time?-- I had very loyal staff, so a lot of them were with me a lot of time. Look I would have to count that up. It is a handful. It is not dozens, it is a handful. It is probably about - you know,

because in my office there were admin staff who dealt just admin.

I am really not seeking to identify them?-- If you don't mind me using the fingers, I will sort of see what I can do.

Certainly?-- I had two media advisors for most of the time. Policy - probably four policy people, plus my senior policy person.

Thank you. It was among those four that there was this division of responsibility-----?-- Yes.

-----with the senior policy advisor overarching?-- Yes.

From a human resources perspective, did you appoint the advisors?-- They're appointed in combination with Premier's Department. They are employed by ministerial services.

And during your term as minister, were you able to identify any prerequisite for the appointment of a person as a minister?-- As an advisor?

As an advisor, I should say?-- I tried as much as was available to pick people who either had health experience or had ministerial office experience. By ministerial office experience, it is quite a complex way cabinet papers, et cetera, are handled, the machinery of government is handled. So you needed a combination of both. A number of people in my office had backgrounds in health. I had a nursing advisor who was a nurse, an experienced nurse, who looked after a range of those things. I had - in latter days I had somebody who was an environmental health background.

What I am seeking to identify for the Commission, Ms Edmond, is this: if there was a particular issue that arose as a matter of through the focus of the media or some other way, through the Director-General, that particular advisor, if it fell within his or her bailiwick, that person would be expected to follow that matter through and then come back to you?-- Yes. There was a liaison officer appointed in the Director-General's office, whose role was to liaise between my office and the department. So mostly it related, I have to admit, to media inquiries, but they would - the media would talk to that liaison officer and that liaison officer would go to the department to get that information.

So, for instance, in the matter we canvassed before the break this morning, in relation to the lists, the official lists and unofficial lists, one of your media advisors - I should say, I beg your pardon, one of your advisors would have been allocated the task of following that through and coming back to you. Is that so?-- In terms of the media query, are you saying?

Well, no, in terms of that being an issue to identify what those recommendations eventually were for your consideration?-- I actually don't know that waiting lists

were allocated to someone. It tended to be more we had somebody who dealt with oral health, someone who dealt with the food safety issues, which were completely different to other aspects that we were dealing with in health. That's about regulation, food control, genetically modified foods, novel foods, that sort of thing, so I don't know.

So would it fall to the chief advisor to assist you in that regard?-- I don't know that anyone was specifically allocated waiting lists as a part of their particular area of concern, area of expertise.

Can you assist us now as to which of your advisors would have assisted you on that particular topic?-- I would think that would mostly be the media, in terms of generating press releases, et cetera, through the department, through getting the information from the department, and probably my senior policy advisors, of which there were changes over the period.

Can I just pursue that a little further? That is an issue, this is the 1998 waiting list issue-----?-- Uh-huh.

-----as far as you can recall, would have been handled in part by your media advisors, is that correct?-- In July 1998 I think I had two departmental officers helping me in my office because I had no staff. The staff largely hadn't been appointed. Most of the people I had working in my office were acting. I had somebody who had worked for me as a media advisor when I was minister for employment and training, who came in to lend a hand a couple of days a week because I didn't have a media advisor, and the first one who was appointed was not particularly capable, with all due respect, and didn't stay there very long.

If you can move to October, did you have an entrenched staff then?-- By then I would have had most of my staff on board, yes.

All right. Well, who would have been handling that?-- In October 1998?

Correct?-- Would have been handling the media?

Who would have been handling the waiting lists issue? Is it your media advisor and your chief advisor?-- I think at that stage it was still largely being handled as a media issue and it would have been my media advisor and me.

But the media advisor, to your expectation, would be accessing the health department for information in relation to that issue?-- Yes.

Could I take you to another topic dealt with in your statement, but I want to ask you questions in the same vein. In paragraphs 3 and 4 on pages 1 to 3 of your statement you recount your recollection of the so-called Lennox Report issue. Do you recall that?-- Uh-huh.

And the issue surfaced, can I suggest to you, in The Courier-Mail in October and November 2003. Do you recall that?-- Uh-huh.

You have to respond, I am sorry?-- Yes, sorry.

Thank you. As a result of that matter being ventilated in the press, you were informed by someone that there was a report but it was in draft?-- Yes.

Who informed you of that?-- I am not sure. It may have been that my media advisor asked the department and he - I think it was probably the case that my media advisor told me that Hedley Thomas was asking for this report and he had been informed from the department that it was a draft. We didn't have it in my office.

Right. Did you make any inquiry of anyone in order to ascertain who was happening with the progress of this report?-- I inquired of what the report was about, and I was told that it was largely putting in in writing, I guess, a lot of concerns that had already been raised in the press, we were aware of, and that was the growing shortfall in the number of medical graduates and the difficulties that was creating in terms of recruitment in Queensland in particular.

Described to you in that fashion, you would see it as a valuable document in adding to the body of knowledge pertaining to that issue?-- Well, the work - the report as such in my understanding was putting together the work that was being done in that area already in the department but was part of, as I was later informed, a discussion paper for a committee that Dr Lennox was on that involved a lot of other players. But this work was already - there was already work being done on these issues. I was well aware of them. I had been speaking about them for probably three years. The shortage of medical graduates, I started lobbying for an increase in medical graduates on the basis that Queensland couldn't keep on relying on overseas trained or interstate trained graduates in 1997 before - well, before I became Minister. As a result of that, intense lobbying and some stand-up arguments with my federal counterparts, we got approval for James Cook University to have a medical course.

Wouldn't you see some value at that time in having in one place a report dealing with this issue of overseas doctors?-- We had a group of people in Queensland Health who were working on these issues. The report on my understanding was putting together the issues we had already identified in a format to give to another committee.

Did you see value in having in one place the body of knowledge that had been accumulated by whatever working committees existed with respect to this issue of overseas doctors?-- I think that was useful. That would be useful, yes.

Talk is cheap in a way, isn't it, because for you as a Minister wishing to progress a matter, you need to have a body of information which-----?-- Absolutely.

-----accurately informs you of the situation on a particular topic?-- Absolutely.

And albeit identified in the press, you would have seen this as an opportunity to have that information in one place?-- From what I saw in - well, from the inquiries I made, having seen the articles in the press, the first queries I made were that the report contained the information we had already - we were already aware of in terms of overseas trained doctors and the issues relating to them. Dr Lennox was not the person I usually - I had regular briefings from that part of the department from Dr Michael Catchpole, who was the - was the person that I had most interaction with.

Where was the corpus of information that you're identifying by your last answer, where was this body of information that one could look at and say, "There it is. If I need to refer back to it, even though I know about it and have been told about, it is there and I can see what it is"?-- Probably a lot of it was in my brain. I accumulated data from a wide variety of sources and I remembered it maybe - I don't now but at the time I was remembered for having an excellent memory when I was working on these things on a regular basis.

You would agree that having them in your brain isn't an efficient way to marshal an issue at a governmental level. I'm not criticising you saying that. Are you suggesting that it's somewhere else in the department this body of information is located, in writing, for someone to access if it was required?-- There was - the issues of particular rural workforce, we had a rural workforce unit who had all of that information. What they provided to me on a regular basis were briefs, et cetera, outlining that information. I - I added that information about workforce shortages, et cetera, together with the information about the shortage of medical school places and the fact that they hadn't increased and it was from there we developed submissions and arguments and I debated at ministerial council level on a regular basis the need for Australia to start paying enough for the education of enough medical graduates to have an impact. This was an ongoing debate at the ministerial council level. It was an important part of ministerial council meetings. It has only been in recent years it's been recognised but it is still nothing in Australia and the shortage of doctors is going to change until we have enough Australian graduates coming through our medical schools. As a Minister, as a result of my lobbying, there were three new medical schools approved in Queensland. Now, the impact of that is going to take 10 years from when they start. James Cook University is coming near to fruition but the others are relatively recent. I think I'm the only person in Australia's living history, only Health Minister in Australia's living history who's actually argued the case with the Commonwealth and got three new medical schools approved. Prior to my becoming Minister Queensland was by far the worst off - worse off than any other state in terms of medical graduates per head - or medical training places per head of population. The situation was dire. But we reversed that. In fact, I sat all of the players in a room and locked the door, basically, until we got agreement about James Cook University.

COMMISSIONER: I-----

MR DOUGLAS: And I'll be more precise, Mr Commissioner. I really need you to focus on my question. At the outset I asked you to - or reminded you I was seeking to provide information to the Commission to enable them to make their recommendations. There is evidence before the Commission that there was a report I can tell you, it's articulated in your memorandum that's given to your lawyers. There is evidence before the Commission that a report was prepared by Dr Lennox?-- Mmm-hmm.

That it was apparently finalised, in so far as Dr Lennox was concerned, in August of 2003. There are some exchanges with the AMAQ in relation to it. Ultimately it seems that the report is leaked to The Courier-Mail and there are conversations had through your staff with you and with the Director-General. Ultimately even Mr Beattie, as you know from the memorandum, responds to the report in early November 2003, or the report of the report, to the effect that it hasn't yet been adopted, if it's - if and when it's complete,

it will be looked at and perhaps changes will be made. What I'm seeking to have you address is this process or protocol whereby the existence of such a report can be raised and what exists to identify whether or not that might well be a valuable addition to the body of knowledge in a documentary form for decisions to be made rather than what you might have done in response to that particular issue generally?-- Okay. The way a report - I mean, a submission - a report such as that was for - developed for discussing with other players. In the final submission, the final report, you would expect the comments from those other players in response to it. It would be - you know, a consultation document, you expect to see the outcomes of that consultation as part of it. I don't think I've still seen that. A report wouldn't be considered complete until it had that documentation in it, costings included and a range of recommendations and then it would go to the head of his department for sign-off and then through the chain. To my knowledge, I am unaware of that ever happening and as the document that I have seen through the auspices of the Commission doesn't include the outcomes of consultation, et cetera, I am unsure or a sign-off by the unit - head of the unit, I'm unsure whether it is a - is a finalised document. Maybe it was final from Dr Lennox's point of view but maybe not from an expectation of the department point of view.

That's the very issue I want to seek to address with you?-- Mmm-hmm

What was your knowledge at that time, say, the second half of 2003, which is the final portion of your tenure?-- Mmm-hmm.

What was the protocol or practice to your knowledge that existed within the department that would bring that matter to fruition, either to ultimate adoption or not adoption within the department?-- It would go through considerations and other comments, et cetera, made and it would come to me in the form of a submission with a recommendation from along the chain, from the head of that unit and the Director-General - the Director-General would say - would put a comment on it. I think I've - I think you've seen copies of briefing papers. It would have a briefing paper attached to it giving a summary and whether or not issues had been raised and how those - what those recommendations were, and that would come to me when it was a complete document for me to then consider and make recommendations on.

Was the final decision yours?-- The final decision would be-----

I'm sorry, I'll rephrase it-----?-- Yes.

-----because it was unfair. Would the final decision in respect of adoption of such a report be yours?-- It would depend whether it had other implications. It would depend whether it had budgetary implications that I had to take to cabinet or changes in policy. If it was largely operational, it would be a decision made in - obviously on the advice or

with the - not on the advice - with the advice of the department but it would be my decision. If it had budgetary implications, policy implications or changes in policy implications, then it would have to become part of a cabinet submission.

Putting to one side a need to go to Treasury or perhaps a need to go to the Premier's office, in so far as the health department is concerned-----?-- Mmm-hmm.

-----would the ultimate decision be yours?-- I would be guided by my senior officers in the department but the ultimate-----

I'm not suggesting otherwise?-- The ultimate decision - the ultimate decision would be mine.

And obviously the matter in the first instance would have to be brought to your attention by the senior members of the department in order for you to be placed in the position of making that decision?-- Yes, but it is important also that documents coming to me for decision have all the information and that would include the results of consultation and advice. It is not just, "We think this is a good idea." You have to have an analysis of it and any other views put to you too.

Well, what protocol was in place to your knowledge in the latter half of 2003 to ensure that such a report did come to you ultimately, at all?-- I'm not sure. I'm just trying to think through this. And I'm not saying this about the Lennox report but in general, some people in the department would put up policy suggestions that never got off the ground. They'd float a balloon that would be pricked very, very prickly because of just being totally impractical. The - when I had queries about the Lennox report, I was advised that it largely - it reiterated as part of the discussion issues that we knew and were understood and were addressing. It also said that some of the things - you know, a lot of things we were doing was the right thing and the right way to go. I think in general, having read it, it seems to implying that what we were doing in Queensland Health should be extended across the board to other areas which were not under our control but under the Commonwealth's control. What I mean there is I instigated a program called Doctors for the Bush and my reading of it is Dr Lennox is saying, "This works well because this is how we do it, and that should be extended to cover GPs", et cetera. GPs did not come under our management. GPs were funded by the Commonwealth and largely came under their management. So there was some - there would be a major change in policy and in decision to take on what was - would be seen normally as a Commonwealth issue by Queensland Health. It would mean us taking over the issues of a shortage of GPs, the use of short-term overseas locums, which was one of the areas we did get complaints about by agencies and there were a whole range of agencies, I think the AMAQ had one, there were a number of private organisations that had agencies that imported GPs on a short-term basis for either after-hours or relief work. From what I can see, and I mean, I haven't had the opportunity to really go through it and analyse it and

compare it with what was happening at the time and how I recollect it, this would have been a major shift. This would have been saying Queensland Health should be taking over the role of supervision, registration, organisation, et cetera, of all those other areas that we weren't currently responsible for.

The first time you were shown that report was in the last week?-- Mmm-hmm.

Do you agree?-- Mmm-hmm.

I think the answer is yes, isn't it?-- Yes.

Is that a convenient time?

COMMISSIONER: I just wanted to clarify a little of that if I may. Ms Edmond, what's of concern to us about the Lennox report, apart from the fact that it does have a particular relationship to overseas trained doctors and, after all, that's the starting point of this inquiry, but again and again we've been given evidence, largely anecdotal but we have been given evidence about what is said to be a practice or a culture within Queensland Health of doing two things: firstly, barring any report that contains bad news and, secondly, shooting the Messenger who is providing the bad news. That's the substance of the allegations that are being made. The Lennox report is really suggested to be an example of that because it was, on the evidence we have heard, officially authorised or requested by Queensland Health through Dr Buckland, it was prepared, the author had finished it, he had done his job, he'd prepared his report and then two things start from there. One is that - the suggestion is the sort of plausible deniability of saying, "Well, we haven't got a finished report. It's never been finished", and then at a later stage it wasn't even an authorised report, that was the next sort of step in the process, and that Dr Lennox had sort of gone off on a frolic of his own to report this report. That was after your time, was it?-- No, no, I'll comment on that if I may.

So really, again, what I want to know is I take it that your evidence would be that you and the Premier in good faith passed on the information that you were given that this report hadn't been finalised, didn't have official status and that it would be dealt with on its merits if and when it was finalised. That was what you believed to be the position from what you were told?-- That's right. But may I clarify something, Commissioner?

Yes?-- Can I just step aside from the Lennox report and say any report that is developed - you know, any policy report that's developed in Queensland Health, it wouldn't be regarded as an official policy until such time as it had come up, been approved, been costed and accepted as a change of policy. So when you say it wasn't policy, it's not saying it's not a good idea.

Yes?-- When you say it's not - I'm not sure about the authorised. I think what they were saying there was it hadn't been signed off by his unit and his - his superior officer. So when you - you may have a lot of good ideas but they don't become policy until they've been costed and it's gone through - you know, if it is a change of where we're going through cabinet, et cetera. Then it becomes policy. Then it becomes an official policy and it is recorded as such and there will be a decision made from cabinet to Queensland Health that you will implement this policy. Until such time, it is not official policy.

Well, I think you and I might be at cross-purposes. I'm-----?-- I'm sorry.

-----certainly not asking you about the point in time at which it acquires the status of being official policy and, in fact, what the Premier said was, "When the report is finalised, we will look at it and consider it", and so on. So obviously, the Premier wasn't saying, "When this report becomes government policy, we'll look at it and so on", because if it had become government policy, it wouldn't have to be looked at. The Premier was obviously talking about a two-stage process: The person who has been commissioned to make a report finishes his report?-- Mmm-hmm.

Then the government looks at it and says, "This is what we'll do." The concern that arises here is that a person is commissioned to do a report, a person does a report, a person finalises a report. No-one is saying for a moment that it's official policy yet but as a report, it's reached the end of the road. The person writing it has written it. And it is not just Lennox. We see it - there are numerous instances, the most recent being the North Report in relation to Hervey Bay. We have had a report in relation to the emergency centre at Rockhampton, a report about the cardiac centre that we heard evidence about just yesterday at the Prince Charles. Again and again these reports, that are not in any sense policy documents, they're just reports-----?-- They're operational.

Report that is there is a problem, operational reports, and again and again they don't - they never see the light of day, no-one is ever told what the outcome is, including the complainants, including the stakeholders in it, and if someone has the temerity to say something bad about Corporate Office in the report, that person finds himself or herself, like Dr Lennox, shunted off to a remote location such as Toowoomba because you don't want people around you who are going to say bad things?-- With all due respect, Commissioner, Dr Lennox was in Toowoomba before he came into Queensland Health.

Yes. I don't think so. He's been 25 years in Queensland Health?-- Well, he was a Medical Superintendent at Toowoomba Hospital-----

MR DOUGLAS: Ms Edmond is correct about that.

COMMISSIONER: Yes, yes. Anyway, that's the proposition that's made. So it is not a question of whether or when it becomes official policy. The difficulty with the Lennox report is that it was suggested initially to The Courier-Mail's journalist that it wasn't finished, it wasn't finalised as a report and then later it was suggested that it never - never had any status. It was - it wasn't commissioned by the-----

MR DOUGLAS: Mr Commissioner, I'll read it into the record.

COMMISSIONER: Yes.

MR DOUGLAS: Mr Beattie is quoted as saying on the 4th of November 2003 in respect of the Lennox report, "When this final report is completed as opposed to a draft, then obviously cabinet will want to have a very close look at it." It went on, "If the reports in The Courier-Mail and the draft report are sustained in the final report, then we will need to change our systems and we will"?-- Would you like me to comment on that?

COMMISSIONER: Yes, please do?-- I think most people, when they saw The Courier-Mail article, because attached to comments about the report were comments about some surgeons in Hervey Bay.

Yes?-- I certainly believed, and I think a lot of other people and probably the Premier believed, that the report included lists of doctors that they thought were inappropriate and I think that's what the Premier was referring to as part of that. I certainly thought the report must detail particular doctors and concerns around the state and I think it was in that context I asked, "Well, what's in this report?", and I was told, "It's all about the shortage of doctors. It largely reiterates the issues that we have been talking about and know about, and it's - it was developed for a working party group that Dr Lennox was on and that it hadn't been finalised." That was the advice, roughly, that I received at the time.

My difficulty is, and I'm only seeking to explore the truth here and if it's all innocent, I'll be quite happy to hear that, but the words used by the Premier as read out a moment ago by Mr Douglas suggests that he had been told that this was a draft report, that if what it contained was there, would need to review policy and so on. That doesn't sound like the Premier was ever told the truth about this report, that it was a report which brought together information which had already been gathered by the department. And my difficulty, it's one thing for the public to be snowed, if that's what happened, but it is even worse if the Minister and the Premier were snowed by their public service advisers as to what this report was all about?-- The Premier's advice probably came from my office. It would be normal for his media officer to say, "The Premier has had such and such a question. Can you give us advice."

Yes?-- So the advice was probably along the same lines as I

had been given. I think this all goes round as what is a draft report and what is a finished report. To me, a report is a draft until it has been finished and signed off by the appropriate officers, and that would include a whole range of things, not just an idea and developed it no matter how well. It would also include, if that was developed in conjunction with a working party, comments from the other working party, whether they supported it. There is no point putting up a proposal if the other proponents don't agree with it. The - so it would - I would expect such a report to include statements from the other players on the committee, a summary - even if it was just a summary of their - their - their ideas or their thoughts on it. It would also include costings, it would also include whether or not it interacted with Commonwealth legislation, whether it needed amendments to any legislation, et cetera. To my knowledge, even in the copy of the report I got, none of those things are there. You might be able to enlighten me as to whether those things have been provided in a complete report since I left office.

Not to our knowledge?-- To my knowledge they have never been - they were never part of a substantive report to which - so, to my thinking, it is still unfinished then if you're saying they haven't been provided and, in that case, it would be a draft. It is a draft until such time it is finalised.

MR DOUGLAS: It can't-----?-- With all of the information required.

COMMISSIONER: Just let me try this one point, Mr Douglas.

MR DOUGLAS: Yes, Mr Commissioner.

COMMISSIONER: My concern is not so much about the use of the word "draft". I mean, people may have different interpretations but it seems from what the Premier was saying publicly, that he had been told if what's in the draft is in the final report, then it's something we're going to have to look at very closely and explore and re-examine our policies and so on. That was the sense of what the Premier was saying. If that was the Premier's understanding, no-one can have told him the truth about the report, that it merely said things that the department already knew and already had well documented?-- I think the Premier had been asked a question about the Fijian doctors in Hervey Bay and the implication was that that was in the report.

I see.

MR DOUGLAS: Do you agree that the finalisation of such a report can't be a matter of whim for a senior public servant?-- I would agree. I would think a senior public servant would know that that was part of the finalisation process and would - would put that together. I mean, I think every - I would have hoped that senior public servants know that those things are expected as part of such a report.

Is that a convenient time?

COMMISSIONER: Yes, thank you, Mr Douglas. We will resume at shall we say 2.30.

THE COMMISSION ADJOURNED AT 1.11 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.36 P.M.

WENDY MARJORIE EDMOND, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Douglas.

MR DOUGLAS: If it please the Commission, there's one housekeeping matter: I'm informed by Mr Andrews that Mr Kerslake's statement will not be tendered today. Apparently there are several parties who require Mr Kerslake for cross-examination, so it's proposed to call him at a later time.

COMMISSIONER: Thank you.

MR DOUGLAS: Thank you. Mr Commissioner, I tender the bundle of press releases from 2000 to 2003 about which I asked Ms Edmond this morning.

COMMISSIONER: Thank you. That bundle of press releases 2000 to 2003 will form Exhibit 305.

ADMITTED AND MARKED "EXHIBIT 305"

MR DOUGLAS: Mr Commissioner, that's my examination. Thank you Ms Edmond.

COMMISSIONER: Mr Martin?

MR MARTIN: I have nothing at this stage.

COMMISSIONER: Thank you. You will, of course, have the opportunity to re-examine if you choose to avail yourself of it.

MR MARTIN: Thank you.

COMMISSIONER: I don't know if there's been any discussion at the Bar table generally, but in a fairly approximate way I've tried to arrange things so that people who have a community of interest with the witness cross-examine first and those who have a contrary interest cross-examine last, but on this occasion I wouldn't even hazard a guess as to what order that leaves, so unless anyone has a better suggestion, I thought we'd just do it in the order in which people are seated at the Bar table.

MR GOTTERSON: If I may indicate, I have no cross-examination, thank you.

COMMISSIONER: Thank you. Mr Boddice?

MR BODDICE: Thank you. Just a couple of matters.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR BODDICE: Ms Edmond, you were asked some questions about the elective surgery. Do you understand that the term "elective surgery" is a defined term?-- Yes, it's a defined term nationally and within the categories that Queensland Health established that, and there are guidelines into how that determination is made which is set forward in consultation, I understand, with the colleges.

Yes. And so it's a term that Queensland alone doesn't use, it's used throughout Australia-----?-- That's right.

-----the term "elective surgery" and how it's defined?-- And the categories are much the same across Australia.

And Ms Edmond, you were asked some questions in relation to the various advisors, and in that context, I think it was that you said well, there was a whole range of things that Queensland Health dealt with, obviously, not just public hospitals?-- Sure.

And you mentioned, for example, the food side of things and oral health was another one?-- Mmm-hmm.

So does that include the school dental?-- Yes, it does.

And those sorts of matters?-- Mmm-hmm.

What other areas?-- Well, there's all the public health areas in prevention programs, there's also - I instigated Queensland Health Promotions, which was about putting funding into research about improving health outcomes et cetera and campaigns such as quit smoking campaigns and some that have been in the media recently, I guess.

Yes?-- The - there's also HACC, which is the Health and Community Care Program which is a joint Commonwealth and State responsibility where we provide support for people outside nursing homes to try and prevent their having to go into nursing homes, that's visiting nursing et cetera, community health programs. One of the other areas that I introduced was the child - was the expanded child health clinics including parenting programs as a way of preventing hopefully in the future child abuse, or I guess that's a generational thing, but it was something that I felt was important, but also support to new mothers et cetera when they came home, particularly those at risk. There's a huge gamut of things.

School nurses was another part of the program that I introduced as a Minister to try and anticipate problems of adolescents, these were adolescent trained nurses working in the schools but reporting to Queensland Health trying to address issues that young people face in their maturation and try to prevent the dreadful rise in youth suicides that we were seeing at that time or prior to that time.

And the numbers that you were talking about in terms of employees, that covers that whole breadth all of those programs, not just the public hospitals?-- Absolutely.

Yes, thank you.

COMMISSIONER: Thank you Mr Boddice. Mr Allen?

MR ALLEN: I'm quite content for any of the learned silks to precede me. It may be consistent with the earlier indication as to the usual process.

COMMISSIONER: Well, that makes sense. Can I ask for volunteers to go next?

MR APPLEGARTH: Well, you were going around the table so I'm happy to do that.

COMMISSIONER: Thank you Mr Applegarth.

CROSS-EXAMINATION:

MR APPLEGARTH: Mrs Edmond, I appear for Mr - or I should say Dr Buckland. Could I first deal with this: you mentioned earlier that it was only a brief time when you were Minister and he was acting Director-General, it was about three months; wasn't it?-- That's right.

Dr Buckland, as you said, was Acting Director-General came into that post in early November 2003?-- That would be about right.

Now, the election was in February 2004?-- Yes.

And you decided some way out from that election not to contest?-- I made it public in August 2003 that I would not be contesting the next election and therefore would be standing down as Health Minister at that time too.

And at least in the last month of your time as Minister, there would have been some time of caretaker mode if the election campaign went for three or four weeks?-- That's absolutely right.

So the overlap was November 2003, December 2003 and January 2004?-- Mmm-hmm.

Now, Dr Buckland wasn't a complete stranger to you as at November 2003 when he became Acting Director-General?-- Not at all, he had been General Manager of Health Services for a couple of years.

Could I suggest it was for about 15 months from-----?-- Oh okay, sorry.

I'm perfectly content to accept that that's your recollection. Now, can I deal with the matter of briefings? During the time that he was General Manager, Health Service, he might be called in to attend briefings of the kind that you spoke about earlier?-- Yes. The departmental officer responsible usually came in for briefings, but if they were briefings with organisations like the AMAQ, it was normal for somebody more senior to come in, there - if it was dealings with the RDAQ, the Rural Doctors Association, it would have been somebody in charge of the rural doctors area or maybe also the General Manager Health Services, if it was dental, it would be somebody from the dental unit.

Just in terms of the regular briefings that you spoke about in your evidence this morning, the regular Monday briefing?-- Mmm-hmm.

Typically, that would be conducted by you and your staff?-- Mmm-hmm.

And the Director-General and his staff?-- Yes.

Could I turn broadly to the briefing process, and one of the key responsibilities of the Director-General is to advise the Minister?-- Yes.

And that advice takes the form of formal submissions and briefing papers?-- Yes.

And personal briefings of the kind that you've mentioned?-- And often they would be very informal.

Because is there practically a door between your two offices?-- There is a door, but I mean, we always ran on the policy that it was always open so there was free interchange between them.

And so the suggestion this morning that you might phone up the Director-General, you might, but you - it would be a short walk to go and have a talk?-- Oh yes. When I said I phoned the Director-General, that was usually on my way to work in the morning.

Yes?-- Once I was there, it tended to be more popping in, you know, or sending a message over that you wanted to discuss something.

And there would also be those exchanges between your staff and the Director-General's staff?-- Yes, there was a liaison

officer on the Director-General's staff who worked with my office to facilitate exchange of material or information or getting reports back et cetera.

COMMISSIONER: Mr Applegarth, if you don't mind my interrupting: one of the witnesses at a much earlier stage of proceedings either said or implied that there was something regrettable about the fact that the Director-General's office and the Minister's office were located side-by-side. In your experience in Government, I take it there's nothing at all unusual or extraordinary about that situation?-- No, I was quite comfortable with that. I worked - I'd been a Minister prior to that as a Minister for Employment and Training and there - I have to say the Director-General had even closer access.

Yes?-- I don't think you had to go through the foyer to get access to my office. Yeah, I don't think that there's an impediment. I think you have to have - I think you have to be able to access the senior staff quickly at times, you know, there are times in health when you really need to talk to someone very quickly and act very quickly, and I think it was important to have a fairly close relationship. I guess it becomes a personal matter of personal choice how you manage things. So, sorry, I haven't really thought about this before but-----

It's quite all right. I'll tell you outright, I don't see the slightest problem with that, and unlike other Commissions of Inquiry in the past, we're not going to go into a theoretical discussion about the doctrine of the separation of powers?-- I was going to say we each knew our - where our responsibilities lay. I guess some people said I was a very proper Minister in that I often was very meticulous about who I met. For instance, if somebody - this is a bit away from Mr Applegarth's - but just to explain, if I got a request for a meeting, one of the things I would do would be to check with the department to make sure that whoever that person was, if it was someone unknown to me, weren't in either conflict with the department or, you know, in a contract or something like that-----

Yes?-- -----before I met with them, and I think some people saw me as a bit proper - prim and proper over those issues, but I thought it was important that that separation in concerns be there, the Minister was looking after one side of things and the DG was looking after another avenue of things, they provided advice but in the end I had to be responsible for my actions.

I emphasise I only raise the point because a witness had criticised it and I thought it might be useful to hear your response?-- I honestly don't think that there's an issue. I think they have to work very very closely together, otherwise it would just take too long and it would be so much paperwork, it was so much easier to be able to pick up the phone and speak to somebody who was highly informed than if I had to write a letter and wait for one to come back or send a memo

and wait for one.

Thank you. Yes, Mr Applegarth.

MR APPLEGARTH: Thank you, Commissioner. I was going to ask you about paperwork, Mrs Edmond, and this might bring back bad memories, just the shear volume of that paperwork that goes into the Minister's office, can I ask you this, obviously some of the paperwork consists of quite formal submissions?-- Mmm-hmm.

About major initiatives?-- Mmm-hmm, yes.

The report on the provision of services, there would be submissions that-----?-- There would be submissions that - there'd be a variety of submissions. There would be briefings. Some of those briefings required actions, some of those briefings were for my information only, they were statistics et cetera that came through from various sources. You also had media, you had documents relating to relations with the Commonwealth and the negotiations with the Commonwealth. You also have a large volume, I think it was about 300 a week of letters, correspondence to be signed by the Minister which used to take up most of my evenings.

And in terms of briefings, as you said, some briefings might be on minor matters, not minor personally involved but they may involve one individual or one particular complaint?-- Mmm-hmm.

And other matters of great substance about submissions on the Cabinet Budget Review Committee and things like that?-- Mmm.

And there'd be briefings about emerging issues?-- Yes.

Issues of the day that might result in possible questions in the Parliament?-- Yes.

Or media inquiries or questions at Estimates? Sorry, you have to say yes?-- The Estimates brief alone consists of about three volumes so thick.

COMMISSIONER: And you're indicating what, about two or three inches thick?-- About three or four inches, I think.

MR APPLEGARTH: That's why you need a staff to help you with that paperwork?-- I'm sorry?

You obviously need a staff around you, a dedicated staff just to keep the paperwork flowing?-- Yes.

And bring it to your attention?-- Absolutely.

You can't read everything that comes into your office but you obviously made the best attempt that you could to read everything that you could?-- I would. Can I say this: there's another issue there. Sometimes the material you received in your office could be submissions about the same

thing but at different intervals in time. So, for instance, I'm just using something completely that isn't touched on here, meningococcal infections, you know, was a really really high on the agenda while I was there, the increasing number of meningococcal infections, so I may have received a regular briefing paper on that which a lot of the substantive material would have been the same but the actual figures in it would be different, you know, they would be updates et cetera.

And apart from briefings that came through and in formal channels, that it would be registered as incoming briefings or correspondence?-- Yes, Mmm-hmm.

There would be meetings as well where someone would walk in with paperwork and, in effect, give you an oral briefing?-- Yes.

And be talking off a piece of paper?-- I regularly met with a number of different areas in the department. Rural Health was one, Legislative Review Committee was another, et cetera, so they would come up and brief me on a regular basis and that would be sort of half-a-dozen people coming up who were working on different projects to give me - to say where they were at on those different projects, where it was going, any problems, say if they saw any reactions from other people as a result of consultation et cetera.

Now, can I emphasise there's no competition hear between individuals?-- No, no.

No, I'm just prefacing my next question on both the Health Minister and the Director-General are extraordinarily busy people?-- Yes.

Going from one meeting to the next?-- Yes.

Having to go to meetings with staff who notate what they do?-- Mmm-hmm.

And keep the paperwork flowing. Now, apart from providing advice to the Minister, another role of the Director-General is to set strategic direction for Queensland Health, isn't it?-- Mmm-hmm, yes.

The Director-General, some people might think, has to attend to individual cases or complaints about particular matters, the Director-General may well have to do that, but given what you've just said, the idea is that matters should get resolved at a lower level and closer to the complainant than going to the Director-General?-- Going to the Director-General or the Minister should be pretty much a last resort. But I mean, complaints came into my office either by phone call or letters et cetera, they were generally referred to the district for dealing with because the, you know, it was usually seen to be better to deal with things as locally as possible. Often those complaints, of course, were of a - complaints about somebody's manner or matters or et cetera or the cost or a whole range of different things, but they, as much as

possible, we tried to get them resolved locally.

And leaving aside complaints, moving on to reports, and we won't debate whether they're draft or final and the like?-- Mmm.

Ideally, reports should be generated through the system in the manner that you explained before lunch?-- Mmm-hmm.

That a report should be in the type of final form that you indicated before it reaches the Minister?-- Yes.

And you'd expect that there would be some lapse in management if an incomplete uncosted draft report found its way to the Minister's office?-- When it came to my office, a report would usually come, if it was coming from the department, it would come with a briefing paper associated with it outlining what it was about and also outlining on the, you know, whether it had been - was supported by the Director-General or not or by other areas of the department that were involved with it. It would also include quite - if it had gone out to consultation or been used on a working party, comments about how it had been accepted by that working party if there was opposition to it et cetera, because what you're trying to look at is this something that can be implemented or is it going to be opposed by the very people who were part of the project or looking at it.

Can I then just return to the responsibilities of a Director-General? One of the responsibilities of a Director-General is to liaise with other public and private health providers, they have to liaise with Commonwealth and State agencies?-- Yes.

AMA Queensland?-- Mmm-hmm.

Unions and the like, colleges?-- Yes. Meetings that I had with the AMA usually the Director-General or General Manager Health Services came into those meetings too.

And there'd be advisory bodies that the Director-General would serve on-----?-- Yes.

-----at a national level and those wouldn't be the meetings that you had to go to, the Director-General had responsibilities to attend those sorts of bodies as well?-- I think, yes, there were a number of bodies, including national bodies, for instance, Dr Stable for most of the time I was the Chair of AHMAC which was one of the major Commonwealth bodies.

And the next key responsibility of the Director-General is to effectively oversee the governance of the organisation both in its clinical and organisational side?-- Yes.

Now, can I turn to, very briefly, the next position down, as it were, I don't want to sound too hierarchical but it is?-- Sorry, can I just a moment?

COMMISSIONER: Yes?-- There's a thing in the floor here which is making an awful noise. I don't know if it's possible to get a bit of cardboard to stick in it? Every time I move, it goes debang debang.

We hadn't heard it from up here?-- Now do you hear it?

Yes?-- Old health workers know how to fix everything with chewing gum or cardboard.

MR APPLEGARTH: Mrs Edmond, can I turn to the position of General Manager Health Service?-- Mmm.

Because I'm not representing anyone except Dr Buckland here, and you mentioned that he was General Manager Health Service for 15 months before he became Acting Director-General?-- Mmm-hmm.

Can I suggest to you that the General Manager Health Service has a lot of responsibilities not dissimilar to the General - I'll withdraw that question - has a lot of responsibilities?-- Yes, he does, he's effectively, while I was there, he was effectively the Deputy Director-General. It was divided up, there were two Deputy Director-Generals, one was, I guess, the number crunching side, corporate office side accounting, you know, area and the other was all of the health services that were being delivered, so the General Manager Health Services was basically the person in charge of all of the health side rather than the money side.

Yes, now I won't take everyone's time to go through this in too much detail, but just to give a flavour of, for example, the type of responsibilities that Dr Buckland had during his 15 months as General Manager Health Service, he would have had the conduct or did have the conduct of the negotiations leading to the signing of the Visiting Medical Officers Agreement?-- Yes, he did.

That expired early this year?-- Mmm-hmm.

Just dealing with that matter, that's an area of obviously complex negotiations to say the least?-- Mmm. Well, it is, and very difficult negotiations.

Because the Health Minister, the Director-General aren't at complete liberty to sign off on whatever agreement they like, it has to be in conformity with government policy?-- No, it's government, it has to be within the guidelines set down by government policy at the time and also with enterprise bargaining negotiations of any form, we were advised by Treasury on what we could and couldn't do.

And so it's also input from the Minister for Industrial Relations?-- Yes.

Because the Minister for Industrial Relations can say what the Health Department is putting up, the General Manager Health Service is putting up doesn't please me and the Government's

industrial relations policy?-- In reality, while I was there, it was put to the Minister for Industrial Relations to have carriage of the generally being the negotiations.

But there would be representatives of the Queensland Health there too?-- Oh, absolutely, but he had - he was actually the Minister responsible for those negotiations.

Next during Dr Buckland's time there, he was negotiating arrangements to try and resolve what was described as a indemnity crisis that was facing Queensland Health?-- Yes. I think when I gave an answer to Mr Douglas before, I don't think he - I guess that was what I was saying, there were a number of major issues that came up, not necessarily just in Queensland which sort of took precedence in our, you know, in what we were thinking about and what we were looking at and what we were doing and one of those, of course, was what was called the indemnity crisis right across Australia where the increasing cost of litigation - I'm not going to make any comment here on how you could reduce that, Commissioner - but the, you know, the cost of litigation, the cost of indemnity was going through the roof and causing major concerns, so that was a major issue throughout - oh, a whole year, you probably got the dates there, but for at least a year that was what occupied us more than anything else.

COMMISSIONER: I think, actually, Shakespeare beat you to it. He said, "First kill the lawyers"?-- I think at that time, too, the VMOs walked out, or threatened to walk out. So recent happenings is not dissimilar to what happened then.

MR APPLEGARTH: So in terms of a couple of big ticket items, we've dealt with Dr Buckland looking after negotiations of a VMO, next trying to reach a successful negotiation of the indemnity crisis. And on that latter matter, didn't he succeed in having Queensland Health avoid the type of significant service disruption that was experienced in other States?-- Yes, I think we all - there was a huge effort there and I think we did avoid - my discussions with my colleagues in other States were the effects down there were far worse than happening in Queensland.

And apart from those big ticket items, if I can call them that, Dr Buckland, as General Manager Health Services, would have regularly been meeting with universities, colleges, and unions to try and coordinate, as best one could, the alignment of these different bodies to try and get them pushing in the same direction as Queensland Health wanted to go, in terms of forward strategy?-- Yes, he was. Can I just say, part of the where we were going at that time was the launch - I am not sure of the exact date, but we launched a major document about the future of health services called Health 2020, which set out - there were a number of documents, actually, set out where we were in health, what we expected the future to be like, and how we should be trying to address it.

And I expect Dr Buckland, or someone else, will put that document into evidence, thank you, Ms Edmond. So we will move on?-- I mean, I don't-----

We have got it. I have seen it. So I don't want to take more of your time?-- Uh-huh.

Apart from dealing with those sorts of matters, there would be dealings with specific organisations and trying to negotiate arrangements on projects the General Manager Health Services would do?-- Yes.

And just as an example, during Dr Buckland's time he came up and implemented a new strategy to recruit radiation therapists within the public health system?-- Radiation therapists was another issue, because of the shortage of them, and, yes, we came up with a strategy, which, from my understanding, has almost resulted in a surplus of radiation therapists, but even that's a good move. That's a very good move.

But Dr Buckland is not claiming ownership of these-----?-- No, no.

-----I emphasise?-- I think they were team efforts.

Yes. And that adverted industrial disputes involving radiation therapists, didn't it?-- Yes, it did, but can I -

can I comment on that?

I am not being critical of them?-- No, no, no. I want to say, even more importantly, Dr Buckland made - did negotiations with other private hospitals to facilitate the treatment of patients who might be adversely affected by the disruptions, and that, to me, was more critical, that patients were getting treatment when they needed it.

Can I move on to the topic of overseas-trained doctors, and you have outlined your position on this at page 7 of your written statement?-- Page 7? Dot point 7?

Page 7, when you said, "The major issues relating to overseas-trained doctors are briefly as follows", and I won't read them into the record. I am not sure if you have got your statement there?-- Oh, okay.

I am sorry, Mrs Edmond?-- Oh, page 7. Okay, sorry.

Just - I won't deal with them all, but the second one you particularly made your views known about the obvious moral question associated with luring doctors from underdeveloped countries to Australia when their own countries were in great need?-- There is absolutely no shortage of very talented bright young people in Australia who want to study medicine. The only impediment are the number of training places provided by the universities, and that is restricted by the Commonwealth Government, and was even more so up until recently. I thought it was absolutely outrageous, and I still feel it is absolutely outrageous, that a relatively rich country and educated country like Australia is not funding the training of enough doctors for its purposes, but rather relying on the likes of Botswana, New Guinea, Fiji and other places to provide, you know, the services of doctors. Some of those - can I say, some of those would have been trained in Australia but under scholarships, et cetera, sometimes paid for by their particular country. So we have Australia, as it were, poaching skilled professionals to the detriment of countries that desperately needed them. If somebody can tell me New Guinea doesn't need every trained doctor they can get more than Australia does, you know, I would be very surprised. I have talked to people in New Guinea, I have seen some of the services they have. They desperately need these people. We should not be trying to lure them here with significant increases of pay than they would get at home when they are so needed at home.

COMMISSIONER: And, Ms Edmond, I would suggest to you what makes it even more scandalous is that the result is some of the poorest countries of the world are actually subsidising the training of doctors to work in Australia?-- Yes.

Whilst our young people are missing out on the opportunity of pursuing that career?-- I agree, and it is for that reason that I spent a lot of time really lobbying the Federal Government to increase the numbers of training places. I am pleased that they did, as I said earlier. Three - they

approved three new medical schools while I was Health Minister, but the Commonwealth also then went on to increase a number of - they did a number of things. One was to say that people who are over here training from other countries would be able to stay here longer to fill the places of junior doctors in hospitals. Well, that just goes back to the same issue I'm raising. These are people from other countries who have trained here and got experience here, which is great, but then the Commonwealth is relying on them to fill the places in our public hospitals rather than give the opportunity to young Australians.

Are you able to tell us, because I haven't been able to get to the bottom of it, how this myopic and frankly dumb idea of freezing the number of medical graduates ever came into place?-- You are going to get me into trouble here, Commissioner. I do know the reasons. It was basically an issue of rationale. There was a belief that the more doctors you have, the more it puts up the costs. It was seen that with Medicare - for example, once Medicare came in, it was seen that there was no economic competition for doctors - for people to become doctors because they were being heavily subsidised, and if you had more doctors, instead of that meaning that the costs would go down and people would be able to see more doctors and the fees would be less, it was experience that - or this was given as the reason - it was experience that doctors basically created their own income to their own requirements. That is, if you had insufficient patients to provide you with the income you wished, you saw your patients more often. And that - there were tales at that time of doctors visiting nursing homes and everybody in the ward would be ticked off as a patient that they had visited and checked on that day. So the theory was that the more doctors you have, the more costly it is going to be, rather than the other way around. The argument falls down, though, if you have a shortage of doctors and you are then importing doctors to fill those positions.

Yes?-- It is a crazy situation.

And my impression is that the situation with a significant numbers of overseas-trained doctors in Australian hospitals - not just Queensland, but throughout the country - isn't something that's arisen over the past half dozen years; this goes back the best part of 20 years, anyway?-- Yes.

40, Sir Llew says?-- When do you want it to start?

D COMMISSIONER EDWARDS: I suggested 40 years ago?-- It has been fairly traditional for young doctors from the UK, Ireland, et cetera, to come to Australia for experience and training, et cetera. It has also been part and parcel for Australian young doctors to go over there and to other countries for experience. I travelled - not as a doctor, I hasten to assure you - but I travelled and got experience in a range of other countries and that's seen - there is a flow to and fro and it evens out, as it were. But what's happened in recent times is because of the restrictions on undergraduate

places, and also the restriction on GP provider - GP training places and provider numbers, it has actually pushed it down in Australia, the numbers coming through down in Australia, and so it has been increasingly one way. We have had more - we have been relying on more coming in than we have been sending over. And that's been exacerbated by a number of things that have happened worldwide. In the UK, they have recognised the national health system is undersupplied with doctors. I had meetings with senior officials in the Prime Minister's department over there - the UK Prime Minister's department - about this and one of the things they said they had recognised that and they were going to increase by a figure of something like 10,000 GPs over five years. Well, that's not going to leave many UK graduates out there in the pool for other countries to soak up.

COMMISSIONER: And that's how we ended up taking them from the sorts of places you mentioned; Botswana and Cuba?-- Yes. Those numbers were shrinking, meant you were casting your net wider and wider. South Africa became a major supplier during the troubles of South Africa when many wished - made a conscious decision they wanted to leave South Africa, and a lot of the doctors we have in the Doctors for the Bush program are very experienced South African GPs who basically wanted to leave South Africa and have chosen Australia.

Ms Edmond, if Mr Applegarth will forgive me, that leads on to something that I meant to ask you earlier. We've had suggestions - and one often hears this said in the community - that the various medical colleges have for years run this sort of cartel where they restrict the number of people coming in to various specialisations. I am not frankly concerned whether that may have been true at one time in history, but what we've been told from a number of sources is that certainly in recent years, at least the last decade or so, the colleges have worked with the government to provide training for every training position in every public hospital, and there is no monopolisation or cartel sort of system as may once have existed. Do you have a view about that?-- I know that is - that suggestion is out there, and I probably saw more of it when I was working in the system than in recent years. While I was minister, I met with the colleges, and I think on a number of occasions browbeat them, bullied them, you might say, Commissioner, into accepting that Queensland graduates had to have a fair go. And I say that because a number of the colleges are based in southern States and they tend to allocate training positions from those southern states, and that also applies to the college of GPs. And, in fact, I think the strongest stoush I had was with the college of GPs who were based in Melbourne because they were filling Queensland - Queensland only had 80 GP training positions per year, and they were filling them - I think two thirds of them were from South Australia and Victoria. Now, those people, when they finish, tend to go back to South Australia and Victoria, and what I said was that Queensland training positions should get - should be a priority for Queensland graduates who are applying for them so that with any - any hope they will stay here, because the evidence is if they

train here, they establish a practice here, they marry somebody locally, they are likely to stay, and this was really quite a significant argument because they allocated the places not on where the applications came from, but on some list that they had somewhere and they determined where people would go.

I think that's a slightly different point, though. The criticism which has historically been levelled at the colleges is that they kept the numbers low for their own benefit, and what people in the community will say is the reason it takes six months to get an appointment with a dermatologist is that the dermatologists have kept a closed shop?-- They-----

However, what we have been told is whatever may have happened in the past, these days every training position is filled?-- Every - while I was minister, I wanted to see every training position filled, and every training position that they provided we made sure was funded. The difficulty arises when they put up parameters that were sort of in defining a position that you couldn't fulfil other than in major hospitals. And then I had discussions with some of the colleges about how we could work around that. Some of the colleges were great. Some of them worked really closely with me in an innovative way. So, for instance, the College of Physicians, we worked on where you wanted to get physicians and paediatricians, et cetera, out into regional centres, but each regional centre on its own would not have enough different cases, et cetera, to give the experience that was required. What we did was set up a system whereby they could do their year's training, particularly their last year's training or senior year's training, in a number of different facilities maybe around the State, maybe three months in Mackay, three months in Rockhampton, three months in Townsville, or three months in Cairns, so they got the depth of experience they needed, but not necessarily in one position. We also brought in systems - and I think it has been referred to already - about the paediatric referral system where support and advice, et cetera, was provided, not by a surgeon, or not by a physician or a paediatrician standing next to them, but by somebody at the other end of the health service, et cetera, so that even though they might be working in an area - by that I mean a geographic area that didn't have access to some of the things that the colleges wanted them to have access to - we could provide it by other means. As I said, some of the colleges were really good and really worked with us to try and find innovative ways to get people out there and getting the proper experience and supervision they needed, but perhaps not in the traditional way.

Sorry, Mr Applegarth.

MR APPLEGARTH: Not at all, Mr Commissioner, if I could just put on the record one matter that Mrs Edmond referred to, the position in the UK - I will give the Commission the reference - but the moral issue that Mrs Edmond raised has been raised there, because a recent report on the BBC indicated the number of doctors that were going into England from Africa depriving

Africa of doctors. But I will move on to another topic because we don't have all afternoon?-- Yes.

In terms of the position that you outlined about overseas-trained doctors and the shortage of Australian-trained doctors, particularly Australian-trained doctors to work in regional areas, it was your priority, and when you said "we" before, I take it you meant not only you personally, but the department as a whole?-- Yes.

To advance the types of goals you were talking about?-- That was the royal "we", where the department and I were of one mind on that.

So the suggestion there was some deliberate policy to bring in overseas-trained doctors because there was some preference for overseas-trained doctors over Australian-trained doctors didn't enter your thinking; quite the opposite?-- Oh, quite the opposite. We did everything we could to get Australian-trained doctors; advertising, trying to lure them here, and I guess with tourism brochures, et cetera, but there was - there has been a long-term acceptance that Australian-trained doctors, in Queensland, anyway, are very reluctant to go - we used to say North of Noosa and west of Ipswich - right, Sir Llew? That's not new. It is quite amazing because I had - I remember discussing this issue with an overseas-trained specialist in Mackay and he couldn't believe that we had difficulty getting people to Mackay. He was from the US and he said, "This place is glorious. You know", he said, "there is no crime, the weather is fantastic, the pay is fantastic. Why don't people want to come and live here?"

Well-----?-- I couldn't answer that.

Well, try as you may, you couldn't find those doctors?-- No.

So there was a high reliance on overseas-trained doctors?-- Sure.

If we just go to February 2004, which is when you left politics, at that time the degree of reliance on overseas-trained doctors, I suggest to you, was about 30 per cent of the Queensland Health's medical workforce being overseas-trained?-- Yes. My understanding was that it bounced around between 25 and 30 per cent all the time I was there.

Now, if you had to, in a few sentences, state what the position was with overseas-trained doctors in February 2004, it would be that due to the increasing competition in the international medical labour market, many overseas doctors were recruited under various arrangements of difficulty with English language and cultural assimilation?-- I think the first problem we saw arising was that the universities we were dealing with were less known, you know, so it made it harder to assess qualifications. But, yes, it was recognised that this was becoming increasingly a problem. Can I say, there

was another category of overseas-trained doctors and those were people who were living in Australia who had come here under other auspices. I mean, we're talking here about once that Queensland Health imported, as it were, you know, we went out, advertised people, applied for positions. There were also a volume of overseas-trained doctors who were here because they had come here as refugees, et cetera, and there was also a lobby group to get these people - these doctors assessed, et cetera, and, again, some of that was very difficult. My understanding is the Federal government had - was going to implement a fast tracking of assessment of their backgrounds and histories, et cetera, and try to get them into the public system, too. But that was after I left.

But one of the key things that you did before leaving office was to facilitate Queensland Health taking on the responsibility to fund and manage the centre for overseas-trained doctors from July 2004?-- Yes. Prior to that - this was based at the University of Queensland and it was a joint-funded facility funded by the Commonwealth and the State. I think it was - it was probably at that time that the Commonwealth indicated that even though we had all of these issues, that they were withdrawing funding from it. They thought it should be, I think, fee for service or self funding. And there was a concern about it, sort of just rolling in a heap at that time.

And, Mrs Edmond, the purpose of that centre, which was going to be funded by Queensland Health from July 2004, was to facilitate the processes of screening, recruiting and preparing overseas-trained doctors for employment in Queensland public health hospitals?-- Yes.

Because, clearly, apart from problems with English language and cultural assimilation, there were concerns about the competence of some - I emphasise some - international graduates?-- Yes, some of the top specialists we have in the State trained overseas. But, yes, there was concern about some. It was also about cultural differences and language, et cetera, but - and I think also the health system we had here. So it was all of those things came into it, yes.

Now, when you left politics, you had this store of knowledge?-- I am sorry, I am smiling because I thought I had left politics.

Well, there might be a few people voting for you for Federal Education Minister, if you will take on the role, but I think you have declared your non-availability. Dealing with the transition, you mention in your statement that your knowledge about overseas-trained doctors was, amongst many other things, available to the incoming minister if the incoming minister sought it?-- Yes.

And if I can go on with that, because it is not dealt with specifically in your statement, obviously you and your staff built up a large number of papers in relation to these sorts of issues?-- Yes. I left - I don't know that we actually

wrote any particular papers on it, but certainly there were quite a number of filing cabinets full of material from my time as minister, and also the time I did do a lot more research of my own was when I was in opposition when I looked at varying health systems and how things worked. So all of that was left for the incoming minister.

Could I-----?-- And - sorry.

Thank you, I just need to move on because there is a couple of other people who may want to ask you questions before the afternoon is out. If you still have your statement in front of you, Mrs Edmond, this is responding to a question about performance bonuses. You say, "To my knowledge only the Director-General was on contract, which included a performance bonus."?-- That's right.

That's the Director-General during your time?-- Yes.

You are not talking about Dr Buckland? He wasn't Director-----?-- Well, he was, -no, he wasn't appointed as Director-General, he was acting, yes. You are right - quite right.

COMMISSIONER: And as Acting Director-General, he would not have been entitled to performance bonus?-- I have absolutely no idea. The Director-General's conference-----

MR APPLEGARTH: I am sorry to interrupt. I am sure Dr Buckland will inform the Commission.

WITNESS: Can I say the Director-General contract is with the Premier, not with the Health Minister.

MR APPLEGARTH: I want to move on, as briefly as I can, Mrs Edmond, to a specific matter which has been referred to in some places as the "Berg matter", and just dealing with your knowledge of that, which you have outlined in your statement. Your involvement in it starts in about December 2002?-- Yes.

And by that time, when certain revelations come to the attention of the department, or at least senior levels of the department, Dr Berg - I am sorry, misnomer - the alleged Dr Berg - call him Berg - had gone for some two years?-- Yes.

He hadn't been employed by Queensland Health for about two years?-- Yes.

And patients he had seen would have been in a new therapeutic relationship if they still needed that type of care?-- One would have expected that.

Now, in the folder of documents that we were given this morning that is attached to your statement - and please go to this if you need to?-- May I see which one you are referring to, please?

I am sorry, it is not attached to the statement but if someone

can kindly give Mrs Edmond the tab, just in case she needs to look at it. Tab 11?-- Sorry, can you tell me which one?

It is tab 11. I can probably read it out to save you time, because I only want to ask you about the start of it. One of your earlier responses, Mrs Edmond, recorded under tab 11 was to write on the 4th of December 2002 to the executive officer of the Medical Board, and in that letter you refer to your briefings to date on these matters?-- Yes.

Those briefings would have come about because someone in the department would have arranged for the attendance of the executive officer of Medical Board and others to attend upon you?-- I actually think the Medical Board Registrar, Mr O'Dempsey, rang my office and said he needed to see me on an urgent matter.

In any event, the Berg matter comes to your attention?-- Uh-huh.

In early December 2002?-- That's right.

And you receive briefings - they may be oral briefings by your staff and perhaps others about the emerging issues there?-- By Mr O'Dempsey.

Yes?-- Yes.

But in addition to Mr O'Dempsey?-- Uh-huh.

There were other people involved at that stage, weren't there?-- There were a number of things happened fairly quickly. I had briefings from Mr O'Dempsey, and I think then - I can't remember - sorry, I can't remember if it was altogether or fairly rapid sequence.

It doesn't matter. In the event, you promptly issue a direction to the Medical Board that we have seen there?-- Yes.

And there is another direction given at about the same time to the Director - to the then Director-General to take certain action?-- Yes.

Now, when this Berg issue arose, I suggest to you the responses were on two levels, the ministerial level that we've dealt with, your immediate responses, and there were required operational responses, if I can call them that?-- Yes.

Further within the system. You would have expected someone in the system like Dr Buckland to request the District Manager to involve the audit and operational review branch to facilitate investigations?-- Yes.

To do things like put the matter in the hands of the police, if the audit branch thought it was a case for a police investigation?-- I think the first things we were concerned about were twofold. One was how did this happen and making sure that it didn't happen again but even more - more priority was given to checking out the patients, making sure that they were receiving appropriate care and making sure that, you know, there were no untoward outcomes from this.

I'll come back to that in just a second but in terms of, as it were, taking enforcement action, part of the thing that you would have expected to happen was for the audit and operational branch to initiate action, for example, put the matter in the hands of the police or - and/or the CMC?-- Yes. Yes, if there's any suggestion of official misconduct it is a requirement of the senior officer to refer that matter to the CMC or to get advice from Queensland - Queensland Health had a police liaison officer, to get advice from that person as to whether it was - constituted a criminal offence or, you know, something that should be investigated through the police.

And, Mrs Edmond, you may not have had a chance to look at all of the documents but I suggest to you that both of those things happened?-- Yes.

It was put in the hands of the police and was referred to the CMC?-- Yes, I am aware that that happened, yes.

Can I return to the important matter that you mentioned, that's what's to be done in the interests of patients. Now, Dr Berg had gone two years ago so a first step would be to review the files to see who he had contact with?-- Yes. We were also told that he had been closely supervised, which we assumed meant that the senior psychiatrist had been - he was - he was a conditional registrant. By that I mean-----

Yes?-- Yes, there were always questions about his qualifications because of where he came from, et cetera. So he was a conditional registrant and - oh, a training - and for training purposes and, therefore, his work should have been supervised, and that was - we were advised that he was supervised.

So a first step was to review the files just to find out how many patients he may have had-----?-- How many patients he had seen.

-----dealings with?-- Whether they were in hospital, therefore under the care of other people seeing he had been gone for two years. Whether he had seen people outside of the people who were in the hospital and in care, because there's a range of different areas to provide mental health care, you know, through community health centres, through inpatient

facilities.

And-----?-- Et cetera.

And in these early days, the first task was identification. Then the next emerging issue would be what do we do to communicate with these patients?-- Yes.

COMMISSIONER: And as a result of that identification process, was it brought to your attention that it had not been possible to identify all patients?-- I think the assurance was that they thought that most - the vast majority of patients, it's never possible to say that 100 per cent but I think there was a fairly comfortable feeling that they were pretty much all accounted for.

We have been told that the estimate was there may be 10 or a dozen that couldn't be identified?-- Less than 10 I think was the word used to me.

Right.

MR APPLEGARTH: In any event, these sorts of actions were the subject of discussion between the respective staff of the Director-General's office and the staff within your office?-- Yes, they were.

And the issue of contacting former patients was one that had to be approached with particular care?-- Absolutely. I think - I think we were all feeling a little sensitive about mental health because in - not that long before, we'd had - that many years before, we had had a lot of fairly sensationalist and lurid publicity regarding mental health patients and for many months after that I know I received reports from people who said their loved ones refused to go to doctors, refused to take their medication, et cetera, because of that publicity. So I think we were all very cautious about how patients were handled, given that they have varying insight into their illness, and I think we were all very cautious about how they were to be approached and dealt with.

And, Dr Buckland was then general manager health services?-- Yes, he was.

And you would have expected him to seek advice not only from the people in Townsville but to speak to psychiatrists in a Mental Health Unit about the best approach to the situation?-- I would - yes, we had a chief psychiatrist in Queensland Health. I would have thought there would be interaction between them.

Because what to say and how to say it or how to communicate it to patients pose some very difficult ethical and clinical judgments, didn't it?-- Oh, yes. I think probably one of the most difficult things I ever had to deal with were, as a Minister, mental health issues because it was very hard to predict how people would behave. Often patients, when they're in hospital and on medication, come to think that they're

cured and that when they go home, they don't need to take their medication, et cetera, and with really quite sad consequences to either themselves or others and that's very, very difficult to predict and I think we all understood that.

Now, I wouldn't want it to be suggested from your evidence about this Berg matter that it fell to you to make this difficult decision. What happened was that this situation arose and fell to someone to make some decisions in the December/January period?-- Mmm-hmm.

And that person, as it happened, was Dr Buckland?-- Yes.

Steps were put in place to identify patients but the communication plan was still to be worked out?-- Yes.

It's distinctly possible, isn't it, that in December either you or your staff or I should say you and/or your staff were informed that decisions had to be made about communicating with patients?-- Mmm-hmm. Yes, sorry.

COMMISSIONER: You don't recall receiving any such communication?-- Oh, there were discussions about talking to the patients, et cetera, but I was largely leaving that as an operational matter.

Right?-- Once, you know, we had decided that the patients had to be treated and changes of treatment offered or whatever was necessary, but that would be largely something that would be done operationally.

Sorry, I was just going from paragraph 16 of your statement where it says, "To the best of my recollection I did not participate in a decision not to disclose information concerning Berg to the public nor so far as I can recall was I made aware of any specific decision not to disclose the information to the public"?-- And when I said - yes, sorry, - sorry, which page are you on, page 6?

Page 5 paragraph 16?-- Yes.

About four lines from the bottom of the page, "To the best of my recollection"?-- I don't remember anyone saying to me, "Should we or should we not go public on this matter."

Yes?-- I've searched my thoughts and I can't remember it, but I say that in that I'm quite of the view that we should not have gone public by putting ads in the paper or anything such as that for a whole range of reasons and I'm happy to go through those with you if you wish. So if it was put to me and I just instantly agreed, saying, "I agree with that", I would be less likely to remember it than if I disagreed. I'm not sure if I was making that clear.

Yes?-- It would be when I was in disagreement with the advice being offered that it would stick in my mind.

No, it is just that Mr Applegarth said it was a distinct

possibility that it was raised with you or with your staff?-- Yes.

Your evidence is that you can't recall it now-----?-- I can't recall it but I'm not saying it wasn't raised and that I instantly said, "Oh, yes, I agree with that and just moved on to the next issue about how we did it.

Yes.

MR APPLEGARTH: Because any communication, whether in the media or in some limited circumstance, presented certain risks and you've identified some of them and offered to identify some more?-- I've sat with parents of a young boy who thought he was cured and then went home and hung himself. It's not a pleasant experience. If anyone else in the room has done that, I'd ask them to decide whether or not these are easy decisions. You know, they think they're okay when they're on their medication and the hardest thing to do with mental health patients is to keep them on their medication when they feel well and if they don't, the consequences can be dire, and tragic.

If even a proposal to put the matter in the media as it was put out this information by some press release being vetoed, had the matter been disclosed to some people, then there is a real risk that it would find its way into the media. Do you appreciate that point?-- Yes, I do. I have to say I don't think that risk was to Queensland Health. I think that risk was to patients. I mean, I think it's been suggested that somehow Queensland Health was trying to cover up but I don't see that that was the risk. Can I just use an example. When we've had problems where things like hip - faulty hip prosthesis that have been implanted in dozens of patients, when we had vaccines that have been used and later been found to be defective, we have put ads in the paper calling for the patients who had those treatments to come in and be identified so it could be rectified. But in this case, you're dealing with people who are often unstable, often have poor insight into their own problems, they are a very difficult group to manage and very close to the edge and very unpredictable. It is very difficult to predict how they will react to certain circumstances.

And so, you're dealing here with a significant number of people and so you're not making the prediction about one person, you're attempting to assess risk over a large group?-- Exactly, yes. Some of whom who may have had a lot of contact with Dr Berg, some have only met him once.

But one obvious fear is that if the patients were told, they may well stop their medication?-- That's right.

Or withdraw from a therapeutic relationship, with their existing psychiatrist?-- I thought - I thought about this at the time and I thought if I was a mentally ill patient and I was just told that the guy who put me on my medication which I resented because it has side-effects, et cetera, I just found

out he wasn't a psychiatrist I'd say, "Well, obviously I don't need this medication and I'm going to stop." I think that would be a very expected outcome of publication like that.

Or, "How can I be sure that this next person who is treating me is a psychiatrist"?-- That is another possibility.

And that's why you took the decisive action that you did in writing to the Medical Board and taking the other action in your memo to the Director-General in early December?-- Absolutely. Particularly in Townsville, which had a long history of contentious mental health issues over many, many years as you'd probably remember.

Now, another factor that would enter into any consideration in assessing risk one way or the other was that a significant period of time had elapsed since the patients had seen Berg and one would hope that those at greatest risk had been followed up or were in the course of being followed up by Queensland Health?-- Well, people who were quite ill you would expect to be seen quite regularly. So while Dr Berg or Mr Berg - I'm not sure what we call him these days - had been gone for nearly two years, I think it is a reasonable assumption that those who were quite ill and under intensive care would have been seen by somebody else.

Now, you've perhaps in recent days seen a note that Dr Buckland made at the time, and it's dated the 31st of January 2003, where he recorded ethically and clinical the course that was being pursued of not communicating certain matters to patients was ethically and clinically sound given that the clients have a mental illness and he said, or he quotes, "Any at risk patients have been identified and managed." You have seen that in recent times?-- I have seen it in recent times.

You appreciate the difficult ethical and clinical judgment that Dr Buckland had to make at the time?-- Oh, very much.

You wouldn't describe the decision that Dr Buckland made as errant stupidity?-- No, not at all. In fact, I would have thought it was the appropriate decision and I still believe it's still the appropriate decision.

Can I move on to another topic, which is the budget process which you've dealt with towards the end of this statement and you'll be pleased to know I'm getting towards the end of my questions, Mrs Edmond. Being Minister for Health doesn't mean that can you decide where all the money goes?-- No. I wish.

Probably a lot of people out in the community would think that. You're the Minister for Health and you call the shots. You just say a million over here, money there. That might have been a perception amongst members of the general public?-- It's certainly the case that health takes up a large swag of the state budget. I think it's about 25 per cent. Education takes up about 25 per cent so that's half the budget gone before you get to any of the other

departments. And that's - that's fine, that's a priority of the government. The budget is a finite cake and it needs to be divided up amongst all the varying areas that need to be dealt with but it's also important to understand that hospital - hospital funding, half of that comes from the Commonwealth, so you're not only lobbying the state government, you're also lobbying the federal government and those two are interlinked.

In terms of the state budget, there may be a budget allocation but the budget allocation and the decisions of the cabinet tie funds to certain projects or services. There is discretionary funding but the decision-----?-- For the state.

In the state?-- Well, in the state, I have to say that is largely - you know, the Health Minister has - mmm, this is quite complex. The - you have the historical budget. The budget - you know, the starting point. From there, the government would expect that the first priority is to commitments that they have made before you go into anything else. So any commitments they have made, EB increases, et cetera, have to be funded before you go to any discretionary funding. It is the allocation of the discretionary funding that you have some say over.

Given the time, I don't want to take too long with the budget review process and I don't want to bring back any bad memories but if we can just deal very quickly with it so that we can have an understanding of it as a public sittings and maybe someone can explain it later in some more detail. There is a budget round, isn't there?-- Yes.

And I suppose it depends in what year you're talking about when the budget is going to be, but in recent years it starts in about October with Treasury advising departments then moving into the budget cycle and Treasury puts forward a timetable for budget proposals?-- Yes.

Then finance staff in Queensland Health put together a submission of all of the known issues that arise for the following financial year. For example, there might be new enterprise bargaining agreement and the like?-- That's right.

So QH puts forward its submission?-- And they tend to be locked in things that you have to fund because they're - you know, they're locked in, they're decisions that have already been made, yes.

And there's communication between Queensland Health and the Cabinet Budget Review Committee?-- Yes.

At an early stage?-- Yes.

Where there might even be a draft of the department's submission that goes up for preliminary consideration. Is that your understanding?-- Yes.

And at that point the CBRC may say, "Forget about that

one" - you're laughing about that one. Some people on television may see you?-- Yes, I guess it's termed - you know, Queensland Health would put up its wish list and Santa would decide what was going - you know, how much would fill the stocking, a bit like that. But, yes, they would give us parameters within which we had to work.

And they may say, "We'll be interested in a bid in this area", because that area conforms with some government - whole of government priority or a-----?-- Absolutely, yes, yes.

Or a particular election commitment or the like?-- Yes.

So from that initial exchange then, a further reduced list of packages goes forward to the Treasury and the CBRC; is that right?-- Yes.

And that would form a substantial cabinet submission that would be signed off by the Minister prior to being formally sent to the CBRC?-- Yes.

My client didn't have the pleasure of going along with you to the CBRC but I imagine his predecessor did. There is a day comes when you the Minister, the Director-General and some finance staff attend upon the CBRC where you have a meeting?-- And we are examined on our budget proposals, yes.

And you have to my client uses the term "pitch" why Queensland Health needs certain additional funding?-- Yes, you do. You have to explain the various submissions you have put forward and what priority you place on them. You have to explain why you are putting that particular proposal forward; is it because of rapid growth, is it because of lack of services, is it because of an emerging need or a new technology, et cetera.

Now, you are always listened to politely, no doubt, but sometimes do you get the impression that some decisions have been made before you came to the meting?-- Yes, I think I was recognised as being one of the more robust and forceful Ministers and well informed at CBRC. Certainly the feedback I got was I was more able to argue the various elements of our budget submission than most.

And after that meeting, CBRC would then provide some formal notification of its decisions?-- Yes, they would indicate basically what we were going to get and if there was any room to move on issues or they would invite further exchange of ideas.

So, apart from recurrent matters, there would be particular advice about additional funding-----?-- Sure.

-----in particular areas and any new projects that have been approved?-- If you had a new initiative for example, one of the proposals that you could put forward was - okay. I'm just thinking. A new - an ICU unit at Caboolture Hospital. Caboolture Hospital had been up and running for a few years. There was a decision and a commitment made to put an ICU unit

in. There with so many extra beds. There would be various parts to that proposal. There would be the capital element, which is one of funding. There would be equipment, which while sort of one-off, would be expect to be repeated, say, several years down the line. And you had your recurrent operational budget for maintenance, et cetera, and your wages in a staffing component and consumable component. So you would have several different areas and you had to have all of those in your budget submission. Capital funding was usually easier to require because it's one-off and it creates other jobs, et cetera, than recurrent. Treasury was very concerned always about what the recurrent was going to be for a facility.

And apart from saying yes or no to new proposals or additional funding, on occasions the CBRC would come back with its spreadsheet-----?-- Mmm-hmm.

-----and tell you that you actually had to make savings in some areas, that there would be less money for next year for some projects or some services?-- Yes, it could be as tight as that. Though I have to admit, in Queensland I didn't experience having any budget ever cut in all the time I was there. I had an increase, a significant increase in each budget-----

I'm not suggesting otherwise. I'm just talking about in some specific-----?-- Oh, specific areas.

Some specific areas there may have to be savings the CBRC would tell you?-- Yes, we did a round of ERs, et cetera, as a way of creating savings at one stage.

The communication back from the CBRC, in what form would it take? Would there be a form or a spreadsheet or would there be some explanation for why decisions had been made? If you can't remember, just say so. It is a long time ago?-- Look, it was complex. We would get a range of documentations but I believe there were spreadsheets and I think there were explanatory notes, et cetera, but sometimes it was a bit more brutal than that.

D COMMISSIONER EDWARDS: Just plain no?-- Hmm?

Just plain no?-- Mmm.

MR APPLEGARTH: Finally, much has been said about the funding of health services funding comes from both the Commonwealth and the state?-- That's right.

So if there is a, whether one uses the term chronic under-funding, under-funding, whatever one is concerned with, one can - is concerned with funding coming from two governmental services, we haven't got the time in the next seven minutes to solve the problems of Commonwealth/State fiscal arrangements but the point that you made earlier today about the fact that specialists in public hospitals for a feature of the Queensland Health system but not others, does

that suggest that the Queensland Health system-----?-- Oh, sorry, I'm sorry if I gave that impression. It's not specialists in public hospitals. It was specialists in public outpatients.

Thank you. My fault?-- Yes.

That's a cost that Queensland carries that other states don't?-- For public outpatients, yes.

Yes?-- There are a number of areas where Queensland does more than other states. We often hear about, you know, comparisons but it's very difficult to compare across the states in a range of areas because things are done differently. But, for example, when the Commonwealth stopped funding oral health care, Queensland - for public patients, Queensland was the only state to continue.

But all - all things being equal, one would expect in Queensland the funding for health to be higher than the national average because of our decentralised population and the spread of services that are needed across a decentralised state?-- Yes. The provision of services in rural areas is certainly not cost-effective. I'm not saying it's not worthy, it is, and I would be the last person to see it removed. In Victoria they - back in middle, early to middle 1990s, they basically solved that problem by closing their rural hospitals. Queensland, the distances are just too far apart. So we must maintain services in remote and rural areas, and small regional areas. So it does - in one - it does cost us more. On the other hand, Queensland is recognised as being more efficient. If you look at our - I have to say, I haven't seen the last figures, Commissioner, but the last figures I saw, Queensland was still the lowest or second-lowest in most case weighted costs of separations. I think South Australia was the only one on about a par. That comes from a range of operational issues, including the fact that, I understand, we pay our public servants a lot less as well as other payers. We have different arrangements for our public specialists, we - in how we employ them and other arrangements by covering them for - for example, for covering them for indemnity by the Crown, that saves a small fortune from other states where they subsidise their private indemnity costs, you know, paid through a - to a private fund.

Ms Edmond, I could talk all afternoon about broad issues-----?-- Yes.

-----which I'm not sure are within the Terms of Reference but I'll contain myself. Thank you for answering my questions?-- Thank you.

COMMISSIONER: Ms Edmond, I didn't want to interrupt Mr Applegarth but I would like to follow up on a couple of points that he raised. Just going back to the third matter previously, he referred you to a statement that the decision is ethically and clinical sound. Leaving aside the clinical judgment, I'd appreciate your explanation as to why if I have

been treated by a person who is unqualified, a charlatan, a fraud, if that's the appearance, I don't have an ethical entitlement in your view to be told that that's the case?-- I don't think I've suggested you don't have an ethical entitlement. I think I suggested it would be very difficult to make that decision and I think it should be done on a case by case basis.

So you don't endorse as a general proposition that it's ethically sound to withhold that information?-- I think - from my understanding, that was dealing with an issue of putting advertisements in the paper and the broad scale non-directed notification.

And that's the context in which I asked the question. If I was one of those up to 10 patients who hadn't been identified, don't I have an ethical right to find out?-- I would think that there are other ways of contacting you and I think - I'm just trying to remember and, I'm sorry, I don't recall, but as I indicated earlier, we were advised that Dr Berg was - or Mr Berg was largely - was well supervised. The - I think it should be able to - should - there should be an ability to identify all the patients.

You also told us that had you received a submission that you disagreed with. It is more likely it would have stuck in your mind than a submission that you did agree with?-- That's right.

Should I take it from that that it was never brought to your attention that there was a very detailed submission from the Townsville Hospital general manager supported by the psychiatric unit in Townsville, that with a proposed action plan including a very carefully prepared media release relating to this issue?-- I've seen that document in recent times. I don't recall seeing it at the time. I should point out, Commissioner, I went on holidays from the 14th to the 28th of January.

Yes?-- So some things may have happened while I was not there and I think I was filled in on matters when I came back but - so, whether there were other discussions that took place when I wasn't there, I can't comment on.

All right. I'd also like your explanation about this concern you had, and I agree it's a desperately important concern that of patients going off medication. If we consider the situation that Berg had left two years earlier?-- Mmm-hmm.

Any patients who were then on ongoing medication presumably would have had another clinician dealing with them in the meantime, another psychiatrist or-----?-- Yes, that's one of the things and that's why I think we thought that most matters would be, you know, there would be a continuing treatment program.

Yes?-- Because it wasn't a case of Mr Berg suddenly disappearing. It, you know, it had happened two years before and those patients would have presumably been put on other people's lists for care and attention and required repeat prescriptions and all the rest of it. Now, the reason I was concerned about people going off their medication is a lot of patients don't like the medication that they're on for mental illness, particularly schizophrenics, the - some of the most common medications increased weight, it makes them dopey, you know, sort of things and they don't like it, and if they felt that there was any good excuse for dropping it, they would, and I think that was one of the things we were concerned about and often, either a sudden withdrawal or even a, you know, stopping over time can lead to dreadful consequences. I've had to deal already as Minister with people who've killed people when they've stopped taking their medication.

I understand entirely what you're saying. The point that I'd like your comment on is this: that patients who are under ongoing treatment?-- Mmm-hmm.

Could be contacted and reviewed by the hospital. As it seems to me, the big concern that the clinical staff at Townsville were highlighting was people who had come to Berg and been told, "You don't have a problem" so they weren't on the list, they weren't under continuing treatment, they'd been two years without psychiatric attention. How do you get the message through to those people that they should come back and be re-assessed and by someone who's actually qualified and competent to do it? And it seems to me that one of the issues here is leaving that group of patients out of the loop?-- I don't think that actual aspect was raised with me. I actually think that one of the concerns at the time was that some people might have left the area.

Yes?-- Therefore, not been contacted, which would mean you would have - the only way of contacting them would be through media advertisements et cetera, which was of a scatter gun effect which could have quite serious consequences, I thought.

Of course, it wouldn't have needed media advertisements and I don't think that was proposed, I think the proposal was just a press release. I suspect the media would have advertised the matter for free without placing advertisements?-- Oh well, yes, it would have, it again, I don't think it would have been helpful to any of the patients involved to see that on the

front page of the paper. I think it would have brought them into a lot of stress. A lot of people - I mean, I know when mental health issues have been in the paper before for whatever reason, you know, even nothing to do with them, people who - with a mental illness feel stressed. I've had them come to me at different consultation committees, I've had their patients ring me up about it, they feel stressed, they won't go to their doctor, they don't want to be identified, they sort of almost go into a shell when any of these issues are played out in the public.

And finally on that subject, whilst you and I and other people may have different views about what was clinically best for the patients, would you disagree with the proposition that the people best able to make that decision were the clinicians at Townsville in the psychiatric section who were looking after these patients?-- There were a couple of issues there: some of the people who gave Berg the best references were in there.

Yes?-- I'm not sure that we would feel - it's very difficult to go back several years afterwards and decide how you were feeling. There were a few worries about how things had been handled before that and judgment in terms of accepting Mr Berg into the training program and the glowing references that various people, various psychiatrists-----

Yes?-- -----gave them. Given that, you sort of have this little nagging feeling that perhaps there's some protection of their own interest.

Yes, I'm wonder-----?-- I'm sorry, I'm trying not to malign anyone here.

Yes?-- But there was a little bit of doubt that these people had been acting in the patient's best interests before that.

I'm just wondering, and I realise that you're going entirely from memory, but I'm wondering if you're confusing the situation at the Gold Coast where Berg had previously practiced and where he received quite glowing references which allowed him to get the position at Townsville?-- I thought to get on to the - to be accepted he had to be assessed by Dr Allan and others? I thought there were references from doctors in Townsville for him?

You spoke of glowing references?-- Yes.

And the only ones that I'm aware of that could be described as that were from the Gold Coast?-- Well, the ones from the Gold Coast were regards to the his joining the training program in Townsville.

Yes?-- But there was another from - I'm just trying to remember his name - from I recall asking somebody and I can't remember who, how on earth did he get, if he had no documentation, how did he get into the program? How did he get accepted? And I recall being told that I think he'd been interviewed or whatever or submitted something that made it,

you know, made him seem very acceptable-----

Yes?-- -----et cetera.

Moving on to - and the final topic dealt with by Mr Applegarth, the budgetary-----

MR APPLEGARTH: Before you do, may I ask some questions arising out of your questions?

COMMISSIONER: Yes, you may when I finish.

MR APPLEGARTH: Thank you.

COMMISSIONER: Just going on about the question of the budget, I just want to link that with the issue concerning waiting lists that we spoke about earlier this morning. You've told how you went to the Cabinet Committee and pushed the barrow for Queensland Health?-- It went to Cabinet.

Yes, and to Cabinet. In those circumstances, would it not have been a useful weapon to be able to tell your Cabinet colleagues there are X tens of thousands of people waiting to see specialists in Queensland?-- I think that was dealt with in terms of un - what an area we called unmet need where we identified where there was rapid growth.

Yes?-- And where we didn't have the facilities or the specialists et cetera to deal with it. So I'm fairly sure that we covered issues such as that, maybe not the exact figures but that there was a significant un - we may not have had the actual number, Commissioner.

Yes?-- But we would have had dealt with issues such as there is a - we need extra resources at, for instance, Caboolture Hospital because of the growing numbers of people who are living out there and demanding those resources. I think one of the - I'm just trying to think of other examples, you know, that was how that was managed rather than - or in a more general sense that we need X number of extra orthopaedic surgeons across the State to deal with, you know, the issues of elective surgery and others, rather than in specific there are so many people waiting. Maybe it was a useful tool but it would have been one of many parameters that would have been looked at.

Just that from your evidence this morning, my impression was in broad terms that very early on in your tenure you'd asked for these statistics to be gathered and made available and for whatever reason that didn't happen?-- Mmm-hmm.

We now know that it has in fact been possible to gather the figures and we don't know how things went from 36,000 when you became Minister to over 100,000 now, but if your fellow members of Cabinet had been told that that was an escalating problem, is it conceivable that you ought to have received a more generous response from Cabinet?-- They were aware that the numbers of people attending Queensland hospitals had

significantly risen over that period of time and that was taken into account.

But it's not the number of attendances we're concerned about here, it's the number who weren't able to attend because they couldn't get an appointment?-- But I think the two are related. If you've got X plus so many times number of people attending, you know, a huge increase in number of people attending, obviously that's placing pressure on the situation and you need to deal with that to be able to look after the people who are waiting.

Yes, Mr Applegarth.

MR APPLEGARTH: I'm terribly sorry to have interrupted, Mr Commissioner.

COMMISSIONER: No, not at all.

MR APPLEGARTH: My apologies, I had hoped just to ask some questions about the Berg matter at the same time that you had and I apologise.

COMMISSIONER: Yes.

MR APPLEGARTH: Just dealing with a point that the Commissioner made about the possibility that some people who had seen Berg who were unable to be contacted as against the vast numbers which-----?-- Were contacted.

-----which the document that you had in your statement under that, that he saw 259 patients; do you appreciate that the difficult dilemma was dealing with a group of this size, one wasn't simply making a clinical and ethical judgment about one individual?-- Mmm.

You'll have to say yes?-- Yes, yes, sorry.

And that is, that there could be the identifiable harm that the Commissioner has identified, the risk of harm?-- I'm sorry?

There was the distinct risk that people who had left and couldn't be contacted just simply wouldn't find out about the matter if it was to be communicated as against the identified risk that you discussed earlier of telling all and sundry of this problem?-- I think it was a very difficult decision for anyone to have to make and it's a decision that I was happy that - to accept guidance on from people I think who had more clinical experience than I did. I-----

Thank you Mrs Edmond - sorry, I didn't mean to cut you off?-- No, I think it was probably one of the toughest decisions anyone would have to make, and the possible consequences that could flow from it-----

Yes. Thank you?-- -----either way.

COMMISSIONER: Mr Applegarth, we might take a - and everyone else, we might take a 10 minute comfort stop and if that - if anyone wants to urge for a longer period, I'll listen generously, but otherwise we'll try and be back at 20 past 4.

THE COMMISSION ADJOURNED AT 4.12 P.M.

THE COMMISSION RESUMED AT 4.29 P.M.

WENDY MARJORIE EDMOND, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Ms Edmond, you would prefer if at all possible to conclude your evidence this evening? I just want to make sure that it's - I know you've had a long day in the witness box and that you won't mind if we go on until 5.30 or 6 o'clock if necessary?-- Look, I would prefer that. I've put my life on hold, my retirement on hold, I haven't done a lot of things that I would like to do over the last few weeks.

Yes?-- And I'd really like to get back to normal life.

We'll certainly do our best. Does that inconvenience anyone at the Bar table if we go on any longer than usual? Thank you.

D COMMISSIONER VIDER: Ms Edmond, I've got a question that I'd like to ask you that actually comes back to the workforce issue and I'll relate particularly to Bundaberg?-- Yes.

When the Commission was set up, of course, Bundaberg was one of the focal points that we dealt with originally, and at that stage, the overseas-trained doctor numbers I found quite staggering, I think it was 1,700 or something in the State totally, that's outside Queensland Health as well as within it?-- Mmm.

I presumed before we started receiving any evidence, that that meant that there were no alternatives in terms of a medical workforce in places such as Bundaberg. But I was really amazed to find the number of specialists that are living and working in that district but are not being utilised by the public sector at the moment. Were you aware of that?-- Certainly all the time that I was a Minister, there were shortages of specialists at Bundaberg Hospital in a number of categories. Those positions were regularly advertised. I don't recall that anyone applied for those positions and was knocked back.

COMMISSIONER: But those were advertised as full-time positions, I think Deputy Commissioner Vider's point is that

there were a lot of specialists in the town who may have liked to make their services available as VMOs but simply were not offered?-- The - certainly I'm not aware of anyone's services being turned down. The normal thing is if somebody approached us about VMO positions at a hospital, regardless of whether it was Bundaberg or anywhere, if those services were required, we would go to any length, and when I say "we", I mean the Government and the department would go to any length to facilitate that. For example, I'm aware of times when private hospitals in, say, Mackay or Rockhampton said we have the opportunity of getting a cardiology - I'm not sure, I can't recall if - which particular specialist, but we have the chance of getting a particular specialist but we don't have enough times for him available, would the public sector be able to use him? And in those cases we'd almost create a position if there was a vacancy or if there was a need for that person, we would almost create extra sessions to fill that. Often, you understand specialists going into regional centres often need some public sessions to support them while they become established and build up their reputation, and so it was quite frequent that appointments to VMO positions at the regional hospitals was done in conjunction with or at least in consultation with - I don't mean there was formal documentation - but discussions with private providers and private hospitals in those areas.

See, we've had evidence, for example, directly from one that comes to mind, a man who's been described as a brilliant young surgeon, formally Director of Surgery at QEII, chose to move to Bundaberg as a private surgeon, indicated to the hospital management that he would be not only willing but keen to make himself available to perform VMO sessions there and was told that that was not a priority. Do I take it that that sort of incident is inconsistent with the policy that you've promoted as Minister?-- You would really need to look at the particulars. I would find that very strange, though I am aware of some instances where particular specialists, and this isn't in Bundaberg, but one particular specialist only wanted to operate and do very complex surgery on a Friday which meant that it, you know, was significant difficulty that that could be accommodated, because he said the private hospitals wouldn't let him do this complicated surgery on a Friday in the private hospital because of the extra costs et cetera involved, so he wanted - he would only do it in the public. They're difficult decisions to make and I think they have to be looked at in each particular case there, but there was certainly not a policy to discourage it. In fact, I would say the opposite, we bent over backwards to accommodate any available resources who wanted to work in the public sector.

And whether or not that has in fact continued to happen since you were Minister, you would certainly urge it as a - as a very sensible approach?-- I'm sorry, Commissioner, you're not going to get me into commenting on what's happened since, I don't know.

No, that's my point?-- I don't think there's been a change of policy. I'm not aware of a change of policy. I'd be very

surprised if there's a change of policy. We really used to go to every length we could to get a suitably qualified, preferably Australian specialist into any position we could, and if that was half a position or a full position, that was where we went.

And that-----?-- And now, it could be if you had two cases - if you had two people applying for the one position and one of them was wanting to work full-time and the other only part-time, then you would take the full-time.

Yes?-- Because that would fill the entire position where you might need two people to fill the part-time, but I also recall incidences where two doctors sort of filled the same position, that's not unheard of.

And let me make it clear, I wasn't trying to get you to pass comment on what's happened since you ceased being Minister, which is why I said whether or not that's continued to be the case, you believe very firmly that it's important to be flexible?-- I think there are advantages of having both.

Yes?-- One of the advantages that we saw and I say "we", we, the department and myself acknowledged having VMOs involved, it meant it gave you after hours encouraged not just the public system but across the board, so if you had four surgeons in a particular region or four orthopaedic surgeons in a particular region, one of whom was full-time at the public hospital and three of whom part-time, even if they were doing one session a week, they would often share in the after hours responsibilities in traumas et cetera that came in. That meant that people were doing one in four or rather than one in one or one in two which is very difficult to manage and still have a life.

Thank you. Ms Dalton?

MS DALTON: Thank you, Commissioner.

CROSS-EXAMINATION:

MS DALTON: I've got just one of two questions. Ms Edmond, I'm Jean Dalton and I act for Dr John Scott, who I think was your senior executive director as I calculate probably something less than six months before you stopped being the Minister; is that right?-- Yes, but he's well known to me because before that, he was Director of Public Health.

That's right. And you worked with him in that capacity in the department?-- Mmm-hmm.

Did you also have dealings with him in relation to your interest in doctors for the proportion of rural doctors generally? No, you don't recall that?-- That's going back a

long time because doctors in the bush came in, I think was the first in Australia of that proposal, it was about 2000.

Or even earlier than that perhaps?-- It might have. I mean, the discussions et cetera started not long after I became Minister and the work-up for the proposal, and but I think it was in 2000, January 2000 we signed up the first ones. I'm sorry, please don't hold me to that date.

No, no, that's all right. But you don't recall him anyway from that context apparently. Do you recall that he had quite an interest in rural health work?-- He certainly had a wide interest in rural health and certainly particularly in getting programs such as breast screening to rural, you know, the small rural communities, all of that, those programs, make the public health programs - he was particularly committed to making sure they were available to people in no matter how remote a community.

And you were aware, no doubt, that he'd spent long years working in hospitals or as a GP in rural hospitals himself?-- Yes, I was.

One of the things somebody's passed comment in giving their evidence here that he was more a bureaucrat, I think the words were "He wasn't a real doctor"?-- I have to say it was considered rather amusing when I met Administerial Health Councils that I used to have more doctors on my side of the table than the rest of the Council put together because so many of the senior bureaucrats in Queensland did have long and extensive experience as clinicians.

Mmm, and in Dr Scott's case, as a rural clinician for many years?-- Yes.

Now, you explain in your statement the process I think when you - and you've given evidence here about how you would go to Cabinet and that Cabinet Budget Review Committee to fight your hardest for your department?-- Mmm-hmm.

And you didn't always get what you wanted?-- I think that's a fair comment.

The process, I suppose, preceding that is that the districts would each year, each budget cycle put in what they called their bids for the money that they wanted each year?-- Yes.

So-----?-- It goes up the chain. I think everybody has a say. I think the units, the various units in a hospital and in the community et cetera would put their bids into the District Manager who would collate those and put - and do any extra work that needed to be done with them and prioritise them and put those bids into the - into the zonal manager.

Yep?-- And yes, it did work up the chain but it also meant that people right down at the grass roots in many cases had input into that process in identifying what the needs were.

Yes. And that input would be people acting in their own interests so if you're a cardiologist at Prince Charles?-- Yes.

You're going to be bidding your level best for cardiology at Prince Charles and that will feed into the system which ends up does it not with the department coming to you prior to you going to the Cabinet Budget Review Committee?-- Mmm.

So that all of the bids and submissions from Queensland Health end up with the senior bureaucrats in health-----?-- Yes.

-----coming to you and saying this is what the department wants?-- Yes.

And I suppose when you come back from Budget Review Committee, they don't get what they want either?-- Yes, and there's an important - but there's an important second part of that, I'm Minister for Health in Queensland right across Queensland.

Yes?-- And the health department has a responsibility as do - did I at the time to ensure that services were provided as far as possible equitably across the State.

Yes?-- It's not about looking after - while the submissions may be, I guess being pushed, you know, various people obviously pushed their barrow they see that as most important.

Yes?-- But you have to balance the needs right across the State, you can't sort of say we're only going to look after North Brisbane or we're only going to look after Cape York, it has to be across the board and doing the best you can with the budget you've got in the fairest possible way to meet the needs of people in Queensland and to meet the greatest needs first.

And when town or Charlotte Street goes back to the districts after the budget process and says, "Well, you asked for X but you've got X minus Y"?-- Mmm.

"Sorry about that"?-- Yes,.

It's not because the bureaucrats in town don't recognise that the bids were legitimate and don't recognise that the clinicians who have put them in sincerely want or need what they've asked for, it's because of that process, there's a limited pie to cut up, isn't there?-- There's a limited pie at State level and there's a limited pie at the department at level.

Mmm?-- Yes.

Were you able to observe Dr Scott interacting with other staff while you were Minister in either of the two roles he held? Were you-----?-- Oh quite, I did a lot of work with Dr Scott in both of his roles.

Mmm. See, there's some evidence before the Commission that

his manner is bullying, attacking, overbearing and intransigent; can you comment on that so far as you've seen him?-- Am I allowed to say that the staff in my office fell about laughing when they read that in the paper because he is such a gentle person, that he is one of the people that staff in my office, if they had a health issue, often went to for advice, but-----

You mean a personal health issue?-- Yes, I'm just sort of saying he was one of the persons who as he very approachable.

Mmm?-- The idea of him bullying actually was something that caused something of amusement to people in my office.

I think one of the people he is supposed to have bullied, or a person in a group he is supposed to have bullied is a fellow called Darren Walters, who is the Director of Cardiology at Prince Charles. Have you come across him in your travels?-- I am not sure I know - is that Dr Walters?

Dr Walters, yes?-- I don't think I know Dr Walters.

That's all right. I will ask you also, in your dealings with him while you were Minister, was there ever an occasion when you were seeking information from him and it wasn't provided to you promptly and fully that you are aware of?-- I think the only occasion we had some issues about the tobacco action plan when I think - but that was when he was in the position of Director of Public Health - about - I guess there was a difference of opinion from some of the people in his - in that area and myself, and the briefs I kept getting kept saying the same thing, and I kept saying, "No, that is not where we're going. That is not what the government wishes to do." And there was some difficulties, but that's the only time I can actually recall that.

That was-----?-- That wasn't Dr Scott, that was more people in a particular unit within the public health area.

And by the sounds of it, it wasn't a request from you to provide factual information, such as some discussion this morning as to waiting list numbers, or that sort of thing, it was a difference of opinion as to where the policy should go, by the sounds of it?-- Yes, about how something should be done, yes.

I was concerned to ask you that because it was suggested to you this morning that senior bureaucrats within the Charlotte Street office might have tried to impede your access as minister to information about, well, in particular, waiting lists and the numbers of people on waiting lists?-- I don't think I had a reputation for being easily bowled over or swamped. If I didn't get the information I wanted, I would perhaps more rigorously ask for it.

And I suppose specifically, so far as Dr Scott was concerned, did you have any difficulties getting information from him when you requested it?-- No.

And I think the other suggestion that was put to you this morning was that there might have been some advice coming to you from senior bureaucrats in Charlotte Street that you ought not to be talking about waiting lists, and, again, asking you about Dr Scott. Was there that sort of comment coming to you from him?-- No, there was a lot of advice that I couldn't be talking about waiting lists, that was a daft idea, et cetera, when I first put the proposal up.

That's back in 19-----?-- In opposition. That was back when I was in opposition.

I see?-- I made a policy commitment, and I certainly had to negotiate that carefully. Because you have to understand, up until then, this was political dynamite. Once a month there would be a scurry of activity to try and find out leaked numbers from different hospitals so that the media could run with those, you know, the elective surgery waits at varying hospitals. By publishing them, that sort of - there was a bit of excitement for a while and then that disappeared. But it was a risk that I took, and some people thought it was a bigger risk. I think it was, "Brave decision, minister", was some of the things that had been said to me.

People that have watched Humphrey Appleby on TV?-- Mmm.

You said that one of the things you hoped was that by publishing waiting lists you would depoliticise the issue?-- Yes.

And you said that, in fact, it became a punching bag?-- Oh, no, that's actually not true. It actually did take a lot of it out of it, and, in fact, for a long time people - after we started publishing them for a while, dealing with - putting out press releases reactively for quite - you know, for a couple of years, after a while we stopped even doing that because, basically, they would go out, they were there and that was it. But then - but then what I said was it would educate people. Where I really feel I failed was I was also trying to educate people that elective surgery is really only one part of health. It is only one part of the services that hospitals provide. There are far - there are a whole range of other very, very important services that never get a mention, and the media always seem to be obsessed with waiting lists. I felt there were all sorts of other areas that we wanted people to get involved with and interactive with, the good things that were happening, the change - the dramatic change from what was causing our ill-health, which I was pleased to see that finally as being in The Courier-Mail today. Hopefully it means that some time we could have a rational debate about it and where we're going, without saying if politicians raise it, that they're blaming the patient. We're not blaming the patient, we're blaming society, as it were, all of us. Look at me. I need to lose 20 kilos. I know it, my knees know it. If anyone knows how to do it, Commissioner, can I please get a recipe? I think Sir Llew is the only - the one. But these are issues that we are facing that are lifestyle issues. It is not a case of blaming the patient, it is about blaming the changes in society that have led to this situation, I guess.

Yes?-- Sorry.

No, no. Look, the other thing I think you said this morning was that when you first became the minister, you considered whether to reinstate some sort of regional autonomy back to the hospitals, and I think you probably got a bit side-tracked. You were going to explain why you didn't?-- No, okay. It wasn't so much after I became minister. When I was in opposition, I spent a lot of time going out, talking to

health authorities, talking to academics, talking - I went interstate and looked at systems they had, researched what was on - you know, what I could find on NHS, New Zealand systems, et cetera, to look at if there was a better way. The feedback I got around the State was they really wanted outside - if you took Brisbane and the south-east corner out and went around the State, virtually the entire rest of the State wanted to go back to a regionalised process. They felt that they got a better deal under regionalisation than they did under the districts and more centralised system. They felt that the number of districts had broken it up to such a degree that there was complaints. I mean, I talked to people in Roma who said, "We have patients that we need to transfer to Toowoomba, but Toowoomba says to us 'Our budget is overrun, you are going to have to take them to Brisbane.'" And, you know, arguments like this across the board, because the districts were largely too small to be in any way self sufficient. I really felt that the ideal would be to go - I think the 13 regions, I think it was, that were there were too many, but I thought that 39 was absurdly too many. I thought that probably the number of regions should be in the order of nine or 10, or even perhaps less than that. I discussed these issues with the DG after I - and other senior health bureaucrats after I became minister, but I'd already formed the opinion also that the workforce in Queensland Health were change exhausted. If I came in and tipped it all upside-down, set up a new system, et cetera, not only would there be significant cost in the changeover, but also that the staff didn't know whether they were Arthur or Martha already. They would next be thinking they were Debra. They didn't have - there really had been a lot of massive change in that period, and people would say to us, "Oh, we've just implemented this and now we have to implement a whole new system." So I discussed it with them and said, "Look, I would like to take it to, say, not nine or 10 regions, but perhaps six zones, on the basis that that would give us coordination." But they were across areas, across districts, but at the same time it would give a level of self-sufficiency. They would be big enough to be self-sufficient and autonomous, and the decision was made - and it was a compromise because it was the one we could do with minimal change - was to have three zones and each of those zones would have a tertiary centre; Townsville in the North, Royal Brisbane on the North - for the central zone, and PA Hospital on the southern zone, and then within that there would be the referring secondary hospitals, and then outside that would be the smaller rural hospitals and remote centres and everything. As well as that, of course, there are Statewide services that are provided right across the board. We thought that was a reasonable compromise, which also had the benefit of having minimal disruption to them. In terms of the - Queensland Health already had divided the districts into that, from a management point of view, and it made sense to then - and it meant not a big increase in staff. In fact, it was basically the staff that went into these zones came out of those management areas within Queensland Health. So it really wasn't an extra layer, it just provided - it wasn't an extra layer in terms of bureaucrats in numbers, et cetera, but it did provide an extra layer in terms of coordination, and both

in how you responded to situations and how you provided care across the State.

All right. Thank you. And one last topic which relates to foreign-trained doctors, I think to summarise the evidence that you have given, you say that you were well aware of issues as to competence, as to language skills, as to cultural issues-----?-- Yes, yes.

-----well before you became the minister?-- Yes.

And that you strove very strongly to increase training places as a way of addressing that?-- Yes.

And while you were the minister, you communicated with my client - I don't mean to the exclusion of others, but just because I am representing his interest - but with Dr Scott about those issues and he, too, because of his interest in rural areas and rural medicine, had concerns about those three things; competence-----?-- Yes.

-----language skills, and cultural issues?-- Yes.

And he fully and frankly talked about that with you regularly-----?-- Yes.

-----during your time as minister?-- I don't think these were things that any of us at the senior level, either on my side or on the department's side, were unaware of. We were concerned about these issues. We really felt that the only relief from these issues would be when we started seeing an increase in the number of local graduates. The numbers of foreign doctors - the figure sticks in my mind of about 1,200 when I - at any given time when I became minister. I think I saw a figure recently that it is about 1,600 now, but that was the figure.

Yes. Thanks Ms Edmond. Thank you, Commissioner.

COMMISSIONER: Thank you, Ms Dalton. Mr Couper?

CROSS-EXAMINATION:

MR COUPER: Thank you, Commissioner. Before I start asking you some questions-----?-- Sorry, may I ask who are you representing?

I represent Professor Stable, Ms Edmond?-- Sorry.

Before I ask you questions, Commissioner, I should place a matter on record. Ms Edmond's statement touches on a large number of issues. Professor Stable has been requested, by those assisting this Commission, to prepare a statement and eventually give evidence about a large number of issues which

essentially overlap with those of Ms Edmond.

The consequence is I need to ask her some questions. It shouldn't be taken that in doing so, my client accepts that many of those topics are within the Terms of Reference of this Commission of Inquiry.

The reason I place that on record is that it may become an acute problem if, as may be the case, timing issues become a matter of difficulty. By that I mean this: that judging by the time which has been taken with Ms Edmond today, given the size of her statement, one could well see that if we move at the same speed, that is to say he could be in the witness-box for five or six days. Part of that may occupy matters which one can submit, with a fair degree of force, fall outside the Terms of Reference. I don't intend to pursue the issue now. The issue may not arise. Professor Stable intends to assist the Commission to the full extent he can, but I don't want it thought that he acquiesces in the view of all these topics which have been raised that aren't within the Terms of Reference.

COMMISSIONER: Mr Douglas, my inclination is that Mr Couper and his client can't have their cake and eat it. If Mr Couper wants to contend that matters fall outside the Terms of Reference, he should do that now rather than taking up time with cross-examination, which I was told could go for an hour, on things that he is then going to tell us are irrelevant?

MR DOUGLAS: Certainly, it would seem appropriate that the matters - on the one hand, the matters that are the subject of any objections being outside the Terms of Reference ought be identified as early as possible. On the other hand, Mr Commissioner, I am alive to the fact that this Commission is reaching the latter stages of its life in terms of the hearing dates, and given that the issue may not ultimately be a problem, as Mr Couper has identified, given the stated willingness on the record of Professor Stable to assist the Commission, given that it is only a prospect that there may be a problem at a later time, I am inclined to the view, by way of submission, that Mr Couper be at liberty to proceed at this particular point, and that any difficulty that might arise can be dealt with as and when it might arise.

I am certainly satisfied, from my dealings with Mr Couper and also Professor Stable, that there does seem to be a distinct willingness to assist this Commission. I can only state that by way of my dealings. But having said that, the matters you just raised with me, Mr Commissioner, are not matters I have had a chance to discuss with Mr Andrews, nor to consider in any great detail. But those are the competing considerations.

COMMISSIONER: Yes. My concern at this stage is we've only got, after tomorrow, two weeks of sitting available.

MR DOUGLAS: Yes.

COMMISSIONER: And a maximum of 24 hours in each day of that

two-week period. If there are some time bombs that are going to explode, I think it is better we know about them now, than wait until to hear them later. But I will accept your assessment of the situation and allow the matter to proceed.

MR DOUGLAS: Can I just augment by submission to some extent: again, I will consider the matter further with the passage of the afternoon. Mr Commissioner, I anticipate that on arrangements that have been discussed with - between myself and Mr Couper, that by some time next week there will be - probably the middle of next week, but there are no guarantees been given, that there will be a very lengthy statement forthcoming from Professor Stable. That will be in the hands of counsel assisting and all the parties certainly several - as I anticipate, several working days in advance of the anticipated date on which Professor Stable will give evidence, namely the 5th of September, the first day of the next week of the Commission's hearings.

COMMISSIONER: Yes.

MR DOUGLAS: And, with due respect to the present witness, Ms Edmond, I would like to think that matters would be - have advanced to a stage whereby the detail of that statement may in fact provide greater economy of examination rather than an augmentation of it - or amplification of it to unnecessary degree.

COMMISSIONER: Indeed. That's certainly my hope as well. Yes, Mr Couper?

MR COUPER: Thank you, Mr Commissioner. I should say, in amplification of what my learned friend said, Mr Stable and those advising him have spent something like 16 hours in conference with those assisting this Commission as a step towards preparing a detailed statement. I emphasise it is not his intention to seek to thwart the Commission. I merely raise, as a matter of potential difficulty, something I hope would not come to pass. Nothing more than that.

Ms Edmond, can I ask you some questions first about the circumstances in which you, as minister, came to look for budget allocations for Queensland Health? I take it you were well aware when you became minister, or shortly thereafter, that health expenditure in Queensland at that time was about 15 per cent below the national average?-- Yes.

Yes. And we're told it is now about 20 per cent below the national average now?-- I am sorry?

We're told it is now about 20 per cent below - I said Queensland has spent 15 per cent or more below the national average at the time you were minister?-- My understanding is the spending on - I mean, this is really a difficult one to do from memory, but my understanding is the spending came up on hospitals certainly to around the national average during my term as minister.

We will come back to that. Can I ask you a little more about the budget process that my learned friend Mr Applegarth touched upon? There were a number of components to the health budget, is that right?-- Yes.

There was first the historical-based budget?-- Yes.

Now, in respect of that, in any given year there would be an allowance for an increase based upon enterprise bargaining costs?-- Yes.

And usually, if not always, the amount allowed for that component was less than the actual costs of the enterprise bargaining increases?-- Yes, it was discounted.

Yes. With respect to the non-labour costs, the approach of Treasury was to allow an increase at the rate of CPI?-- Yes.

Which was usually, if not universally, less than the actual increase in cost in the health sector?-- Oh, yes, that was an issue at both the State and the Commonwealth level.

So, with respect, both the wage costs and non-wage costs, the general increases allowed by Treasury never kept base with the real increases in costs?-- That's a fair comment.

Right. Then one had what might be called new funds, and can I suggest to you those new funds fell into two categories: the first was what was termed guaranteed funds, and they were something less than one per cent of the total health budget?-- I am not sure what you mean by guaranteed funds. There was an element of growth funds.

Yes, yes?-- Is that what you are talking about?

Yes?-- Oh, yes, okay. The growth funds, yes, was basically there are a whole range of areas where it had such election commitments and all the rest of it where it had to be funded.

Yes?-- Over and above there was an area of growth funds which was to deal with new initiatives, increased population in an area, a new service, things like that to deal with pressure areas around the State.

With respect to funds which went beyond the historic-based funding, was the process something along these lines: that in - late in the year preceding a new budget there would be something called short-form bids submitted to Treasury?-- Yes, that's a summary bid, yeah.

A summary bid. People would - within the department, would work out those priorities for at least new expenditure in health and would make summary bids?-- Yes.

And the outcome of that would be some time around January Treasury would send the word back, "Don't bother any further with these, they have no chance. These you can proceed with, a long-form bid."?-- Yes.

And if it got to the stage of a long-form bid, there was a reasonable prospect that some funds would be allocated from the budget, but not necessarily the funds which were asked for?-- Yes.

And for the long form bids, those were the moneys you had to go and argue for before the CBRC?-- And you had to put in a very detailed submission.

A very detailed submission, yes. The process of determining what funds would be prioritised in health was a lengthy and difficult process?-- It was a lengthy difficult process that took up - it wasn't just something you did in the month before the budget, it would take up many months.

Yes?-- And it would also take up observation time when you were out places, you know, sort of talking to people and seeing where their pressures really were.

Yes. When you are talking about going around to talk to people, Dr Stable used to accompany you on the community cabinet meetings?-- Yes.

Around the State?-- Yes.

And he'd take those opportunities to visit hospitals in the districts?-- We would and other health facilities.

Yes. And you are aware that Dr Stable also travelled to districts on other occasions keeping in regular contact?-- As I did, yes.

As you did. It was your policy and his to keep as much grassroots contact as you both could?-- Absolutely.

And that contact involved, both for you and him, speaking to clinicians and nurses in hospitals?-- Yes, it did.

And speaking to others in the health system at the district level?-- Yes.

One of the byproducts of that constant communication was a list or note which Dr Stable kept on the spreadsheet of spending?-- Yes.

Requests, if I can put it like that?-- Uh-huh.

Part of the process of determining what to ask for from Treasury involved seeking to prioritise those spending requests as well as matters the government wanted money spent on, and so forth?-- That's right, and equipment. When we went around, it would sometimes be that they would show us that a piece of equipment was not working properly, or inefficient, and that having a different piece would change it. So, yes, he kept a running sheet.

Right. With respect to the budget process - we will take it

one step further perhaps. Was it the case that in each year when Dr Stable was Director-General, he was required - or the department was required to find something called an efficiency dividend which really involved losing some millions of dollars from the budget on the basis there would be some efficiencies found?-- Yes, that - I think all the departments had to deal with the efficiencies.

And are you aware that there was a need to estimate with a good deal of precision what the weekly expenditure over the course of the year would be from the allocated budget?-- Yes.

If I can amplify that, was part of the reason this: that if the weekly cashflow was acceded by a particular percentage, then Treasury would charge interest to the Department of Health at short-term money market rates for the amounts overdrawn, and, indeed, on the other side of the coin, if not enough money was expended in the week, interest would also be charged on the basis of being withdrawn from the market and not used?-- I have to admit I wasn't aware of that.

There might be some evidence about that.

COMMISSIONER: Mr Couper-----

WITNESS: I don't recall discussing it in those terms.

COMMISSIONER: Mr Couper, I am not sure why we're going through this process. In the 10 minutes or so you have been asking questions, I don't think you have raised anything controversial. I assume that we're going to get a statement from Professor Stable which deals with these issues, which speaks for itself. I don't know why we have to sit through the process of having something that Dr Stable can tell us about put to a witness who was at a very high level in government but in a different position, and therefore not intimately involved in the details in the way that your client was?

MR COUPER: One reason, Commissioner, is that I am alive to suggestions made to other witnesses that one approach to reform the system might be to have someone independent, like Treasury, allocate money to the various districts, and I was, against that background, wanting to ask Ms Edmond what she thought of that idea?-- That would be a tough call. I think I would prefer to rely on the process, no matter how difficult it is, of going in and arguing your case than simply relying on Treasury handout. I think while I was the minister, this is a tough process, going in to CBRC. I am not sure that there have ever been any health ministers on CBRC. CBRC, Commissioner, is made up of Treasury - the Treasurer, the Premier and a couple of senior ministers, plus departmental people. To review the proposals you are putting forward, would it be fairer for treasury to simply handover the money, certainly on a national level I think what should happen is that Queensland should get its fair share of health funding on a formula and then hand it over without trying to blend two different systems and - which leads to costs shifting blaming

backwards and forwards, et cetera, but from a State level, I would prefer to go in and argue because I think I always got more than their first proposal.

COMMISSIONER: And I don't think anyone has suggested, in any part of the proceedings to date, that health through the health minister should not continue to be in the position of pushing for more funding. The question is simply how the health pie, the $530 million is split up, and whether there is-----?-- I am sorry, how much did you say?

530 billion. 5.3 billion, yes?-- 500 million for what?

For health?-- 500 million?

D COMMISSIONER EDWARDS: 5.3 billion?-- Sorry, I thought you said 500 million. I was going to say, I think that's back in the dark ages.

No, 5.3 billion this year?-- 5.3 this year is it. I think it went up to 3 billion to 4.6 billion, I think, while I was there at least.

COMMISSIONER: The question is not whether health should have an opportunity to fight for a bigger pie each year but what is an equitable system for splitting up that pie between regions and zones?-- Mmm-hmm.

And whether an independent body like Queensland Treasury might be available to provide guidance in that?-- Oh, perish the thought. Sorry, that was facetious. I think divvying up the cake as it were around the regions is a very complex matter. It needs to take into account a whole lot of interactions about what resources are there, how you are getting those resources out. For example, in remote areas we have - we have teams of specialists going out performing surgery and cataracts but they're not funded particularly from those regions. They're funded centrally. So you need to understand all of those difficult, complex areas before you can decide how to get the best and fairest spread of resources and allocations across the state. It's very complex.

MR COUPER: Could I ask in that context about this notion of historical budgeting. I gather it's been said that historical budgeting means that there's a maintained discrepancy between things such as per capita funding for district A versus district B. If one were to attempt to shift to a resource allocation model based on population and demographics and the like?-- Mmm.

Would that almost inevitably involve a loss of services and perhaps even hospitals in rural and remote regions?-- Probably. And that's what - exactly what happened in Victoria when that took place when there were arguments about fairness and discrepancy in funding from one district to another and one of - that came up while I was a Minister. What we would do is have somebody very experienced or a couple of people very experienced go into that district to try and determine what the problems were. Was it there were difficulties arising because they were growing far more rapidly than we expected. There are certainly anomalies such as having a higher level of disadvantaged people in that area therefore having a higher reliance in the public sector a whole range of issues and determine whether they needed adjusting. We didn't just sort of say, "That's your budget. If you can't manage on that, tough." If there were problems, Queensland Health provided experienced people to go in and try and help sort them out, find efficiencies if they were there and, if not, if there were anomalies, to try and address them and that led to the Gold Coast Hospital put forward a case and they - their budget base was changed as a result of that and also Bundaberg

put forward a case at one stage and had a budget adjustment. By that I mean an adjustment to their base rather than adding dollars but also adding services at that time. It took into account the fact that there was a problem there and tried to meet that problem.

So that at what one might call the corporate level, there was ongoing attempts made to ensure that resources were allocated where they were most needed?-- Yes.

Right. Can I ask you about one other aspect of financial matters or financial accountability. Do you recall the existence of the requirement that the Queensland Health produce a risk management report every year? If you don't, I'll pass on to something. It is something I can take up with other people?-- Are you meaning a clinical risk management?

No, I mean pursuant to the financial accountability standards. The government required all departments, including Queensland Health, to produce a risk management report?-- I'm not sure I was aware of that.

All right. We'll move on. Can I take up with you, it's the issue that Ms Vider raised, about VMOs versus staff specialists?-- Mmm-hmm.

It will be fair to say, wouldn't it, that the decision whether to engage a VMO or a full-time staff specialist depends upon the circumstances of the particular hospital and particular district?-- Yes.

The required patient workload, the role delineation of the hospital, all those sorts of things?-- Sure.

It is a case by case decision who should be engaged?-- Absolutely. And who is available.

And who is available. It is right to say, is it not, that VMOs are more expensive than full-time staff specialists?-- Yes.

If I can be a bit more concrete. The cost of providing about - providing five VMO sessions a week is approximately the same cost as providing a full-time staff specialist who might do 15 sessions a week?-- Yes.

So that if one was faced with a situation hypothetically, perhaps like the one Ms Vider raised, where a hospital was trying to find a full-time staff specialist and is offered, say, two VMO sessions a week by a VMO, the effect of that would be that 40 per cent of the available funds for that position would be taken up by a VMO and might preclude the appointment of a full-time specialist?-- And it might put off somebody who wanted to come as a full-time specialist because they only had a part-time job there.

Yes?-- Yes.

So one would want to look with care at each particular situation before arriving at a conclusion about whether a VMO position was taken up or not taken up-----?-- Yes.

COMMISSIONER: Mr Couper-----?-- The VMO payments were one of the major reasons Queensland was able to perform more efficiently, as it were, compared to other states. In some other states, almost all of their specialist services are provided by VMOs, a much higher level.

Mr Couper, I'm wondering how a staff surgeon performs 15 sessions a week if there are only 14 sessions, if you have sessions on a Saturday and Sunday.

MR COUPER: I apologise for numbers, Commissioner, but the point I'm trying to make seems to be the point accepted by the witness, there is a significant cost difference between providing VMO sessions and providing full-time staff specialist sessions.

COMMISSIONER: Are you aware of studies being done in New South Wales that negate what Mr Couper is putting to you that show that the effective cost when you add any on-costs of superannuation and sick leave, long service leave, holiday leave and so on, the costs are fairly comparable?-- No, I'm not but may I say that New South Wales had different employment programs to what we had. In Queensland we largely covered public indemnity and different areas like that whereas in New South Wales, that had to be paid for by the individual.

Yes?-- So there were a whole range of different areas that didn't equate. We also, think I, gave VMOs proportionate study leave and different things which I don't think was the case. I think in New South Wales they were paid as a - almost a casual session by session basis and their costs compared to Queensland's overall were significantly more.

Yes. So-----?-- From memory, if you look at the case weighted costings, I think New South Wales was the most expensive of all the states by a long shot.

I'm just wondering whether it's a simple matter where you can say the cost of having a surgeon doing five sessions as a VMO is equivalent to the cost of a staff surgeon doing even 10 sessions a week, which I guess would be the outer limit?-- Commissioner, none of these things are simple in health, though there are compares done. Commonwealth produces documentation which compares the costs of providing different services across the different states. That's the - they're the figures that I'm relying on. And in Queensland and South Australia, where we have a higher proportion of staff doctors compared to VMOs, the costs of those procedures are significantly less than in New South Wales and Victoria, where they rely much more heavily on private VMOs to provide almost all their services.

D COMMISSIONER EDWARDS: It is also whether it's operating sessions or ward sessions.

COMMISSIONER: Yes.

D COMMISSIONER EDWARDS: It is a very complicated thing.

MR COUPER: Ms Edmond, can I, as briefly as I can, take you back to the issue of the Lennox report. In preparation of your statement, could I ask whether it was - you were shown a letter from Dr Buckland to Professor Toft, who was then the President of the Medical Board of Queensland, which is Exhibit DRO10 to Mr Lennox's statement, asking for the views of the Medical Board of Queensland about the proposal in the annexed report?-- I saw that letter in the preparation. I'm not sure. I can't recall if I saw it beforehand.

Were you shown a letter from AMAQ to Dr Lennox apparently dated the 12th of September 2003 commenting upon the Lennox report which the AMAQ had received?-- I don't think - may I have a look at that letter; I'm not sure.

I can show you my copy if it isn't otherwise available. What I'm going to ask you to comment on is the suggestion I'll make to you that on a fair reading of that letter, it called for things which would require a substantial reconsideration and at least - at least a re-writing in part of the report before its acceptance by AMAQ?-- No, I don't think - no, I don't think I've seen this letter before but I would have been surprised if the AMAQ would be fully supportive of that report because I would have thought it would impact on their - they had a recruitment agency which largely provided short-term locum - overseas doctors for short-term locums, GP practices, et cetera, and it would have significantly impacted on that recruitment agency. I don't - I actually don't think I've seen this letter at all. May I - I'd love to have a copy of it.

I'll make certain that you do. Can I just point out perhaps one aspect of it. The last paragraph of the first page, "Although the document foreshadows a private sector integrated OTD process, any proposed accreditation system to allow and support such private sector involvement must be defined now and incorporated into the paper to ensure the viability of any such future private sector venture." Would you agree that suggests that the AMAQ was talking about an amendment of the report before further steps were taken?-- Yes.

If it were the case - and I'm not critical of the evidence, I haven't been here, but I'll be corrected if I'm wrong I'm sure. If it were the case that by the time this issue emerged in late October there had been no re-writing of the report, and perhaps there had been no response from the Medical Board of Queensland, would it be fair to say that the description of the report as having unofficial status and not accepted or endorsed by Queensland Health executive was accurate?-- I would say, indeed, it was a draft report until it had had those amendments or at least the consideration and the appending to the report those qualifications from the AMAQ.

Thank you. I'll get back my copy of that, Ms Edmond. I'm sure the Commission will be able to supply you with one?-- Would you mind if my counsel had a look at it because I don't think we have seen it.

Not at all. Can I ask you more generally. It was suggested to you by the Commissioner, I think, that there had been evidence to say that there was an approach in Queensland Health of burying bad news and shooting the messenger. In your time as Minister, I want to ask you whether you ever observed any sign of that approach from the Director-General Professor Stable, or Dr Stable as he then was?-- I would say it was more a case of with bad news you had to front up and manage it and that usually meant me in the firing line rather than anyone else. I don't think I could say that I saw any evidence of shooting the messenger. I know concerns had been raised about districts having budget issues and how that was managed and - et cetera, but in all fairness, people were given enormous support before any other actions were taken. We put in a team to try and help them through those difficulties rather than just discarding them or taking any action.

I want to suggest and ask you to comment that Dr Stable's approach was far removed from a bullying approach; he went out of his way to make himself accessible and listen to comments from all levels of the Queensland Health system?-- I would agree with that.

Thank you, Commissioner.

COMMISSIONER: Thank you. Mr Tait.

MR TAIT: Thank you, Commissioner.

CROSS-EXAMINATION:

MR TAIT: Ms Edmond, my name's David Tait and I act for the AMAQ?-- Thank you.

It was you, I think, who first introduced the system of-----?-- I'm sorry.

I'm sorry. It was you who first introduced the system of releasing the waiting list figures as mentioned in your statement?-- Yes.

Before that, that hadn't been public?-- That's right.

And you discussed with other counsel before me that this seemed to diffuse it because it was public rather than this anticipated leak each month?-- I think that was right, yes.

Yes. And did those numbers on the waiting list for the waiting list reduce during your term as Minister?-- I have to say I don't know. I don't know what the last figures were when I left.

All right. But nothing like 100,000?-- I don't recall ever seeing anything like that figure.

COMMISSIONER: Do you recall any figures other than the 36,000 in your press release back in the first few months of your ministership?-- No, I don't think I saw - I don't recall any total figures but certainly the figure of 100,000 plus that I saw recently surprised me.

MR TAIT: It must have come as a shock?-- Yes. My first question would be, if I was still Minister, is, "Where are these figures coming from and how accurate are they?"

Yes. But your recollection is that you kept publishing them month after month while you were Minister?-- I didn't keep publishing month after month. The waiting times for - or the waiting lists for outpatients, the figures we published were those for patients who had been assessed and were ready for surgery.

Oh, so the 20 - the bigger list didn't get published, only the little one, is that what you mean?-- We published in accordance with the requirements of the Commonwealth and the requirements of the Commonwealth were that you compared patients who had been assessed - assessed and ready for surgery.

When you first published the waiting list, you made a point, I thought in your press release, that you were publishing the entire one, including those who were waiting for assessment?-- No, I didn't.

Oh?-- I made - I made the point that the figures that we were publishing did not include the figures for people who were waiting for appointments, except to say that there were a substantial number of people waiting for appointments and I gave a figure, an approximate figure on that.

Excuse me a second?-- In fact, Mr Tait, maybe I can assist you. In the press release of 30th of July it actually says that what I will be publishing are the number of people waiting in each surgical speciality for each hospital, the number of people in each urgency category and the number of people waiting longer than clinical desirable. You have no idea which urgent category they've been in until someone has been seen, so it is impossible to add those figures in until they have been assessed and ready for surgery. When I say ready for surgery, that often means clinically ready for surgery.

You released a list - I'm looking at a press release dated the 16th of October 1998, a report of that date, I'm sorry, quoting you, "Of the 36,000 people waiting, around 8,500 have

not yet been given an appointment"?-- Mmm-hmm.

So was it 8,500 of the 36,000 - I'm sorry, I withdraw that. Of the 36,000 waiting to see someone or waiting for an operation?

COMMISSIONER: Both, Mr Tait.

MR TAIT: Yes.

COMMISSIONER: If you look at the second-last paragraph: "Data collected so far shows that 36,000 people are waiting to see a specialist, roughly the same number of people waiting for surgery."

MR TAIT: Yes.

COMMISSIONER: So you have got a total of 72,000, of whom 36,000 have an appointment for surgery, 36,000 waiting to a specialist and of those 36,000, 8,500 haven't yet been given an appointment.

MR TAIT: Yes, thank you, Commissioner?-- May I point out these press statements were accompanied by a booklet with all of the data from hospitals around the state attached to them.

When did that stop?-- It stopped at - it stopped being published in booklet form, and I can't remember when, because it had gone on to the net and it came as feedback from people saying that they found the booklets cumbersome. They preferred to have it on the net where they could have a flick and look up it quickly. So information was still available publicly in exactly the same form. We just didn't publish them in hundreds of hard copies which we then posted out to GPs around the state, et cetera, initially and I guess it was a cost saving factor that we were looking at being more efficient.

COMMISSIONER: Ms Edmond though, if we go back to the opening paragraphs of that same statement, the same media release of the 16th of October, the first paragraph you refer to the fact that your investigation revealed a massive unofficial list of would be patients who haven't even made the official list?-- Mmm-hmm.

You said that confirmed your long-held fears but represents a major step towards tackling the issue, and it quotes you then as saying, "I am now working with the whole picture knowing where the real bottlenecks are in the Queensland public hospital system. We can target the bottlenecks with Labor's waiting list strategy and get more patients into surgery faster." So what you were telling the community then was it was a great breakthrough to have discovered these unofficial lists and those statistics that you had then, the extra 36,000 people on the unofficial list, allowed you to tackle the problem. But so far from what you've said in your evidence, that was the only time you ever got those statistics. After that, you gave up on following the unofficial waiting list as

you called it in October 1998?-- What this allowed us to do was to look at where there were shortfalls in terms of services because what we found was some hospitals where there were no people waiting on the surgery waiting lists, it was because there was no orthopaedic surgeon at all there and therefore you might have a very long list of people waiting - wanting to be seen but not being operated on. So the fact that the waiting lists of surgery patients was zero actually could mean that there wasn't a service and that's why they were used as a management tool, to find out where those holes in service delivery were so that we could actively try to get more services into that region, employ another doctor or whatever was needed to address that situation.

MR TAIT: Absolutely. And that's why you would have been keen then to keep collecting that data, even if you didn't publish it, because you say some Australian Standard didn't require you to. But you would have kept collecting it, didn't you?-- I'm not saying it wasn't collected. I'm just saying I don't remember seeing-----

It ever again?-- Oh, no, no, that's not - no, Mr Tait, no. Please don't put words in my mouth. I've been around this game too long to have people tell me what I'm saying. The - it means that there was continuing progress on it, I saw continuing reports, I don't recall the figure when I left. That's what I said.

And no-one has ever seen them outside the health department?-- As I indicated earlier, I think it was still a matter in progress when I left several years ago.

And you can't remember whether it went up or down or stayed the same?-- I don't think it went - I have to say I was surprised at the figure of 105,000 because from my memory, it had remained roughly about the same figure, I think give or take a few thousand. I don't recall it suddenly being a multiplier of three.

Well, if it stayed about the same, it was hardly the great improvement of which you said would occur on the 16th of October, was it?-- I think the other part of the process was that we were actually seeing more patients.

Mmm?-- So the numbers - the numbers that were being seen were going up dramatically but the numbers that were waiting were still there.

All right?-- That was an issue right across the board because we were dealing with increasing demands, rapidly increasing demand.

I wanted to move on to something else. The AMAQ published on the 16th of November a public hospital system report. You recall that. 2000?-- I would welcome seeing a copy of it. They did a couple of system reports.

This was the first one?-- Is that the one where they wrote to

doctors and asked them, "Would you like more money or could you spend more money?" and then said 90 per cent of doctors said they were under-funded.

No, the 90 per cent was the figure that you said were public satisfaction with the services?-- Oh, that was patient service satisfaction survey, yes.

No, that - I don't think it's the one where they wrote that, if they did. But I'm-----?-- Perhaps, Mr Tait, you would be able to provide the survey that went out with that report for the benefit of the Commission.

Well, you'll certainly find out if the AMAQ-----?-- Not just the responses but the actual survey you-----

I understand the question. I've been doing this a few years?-- Thank you.

Yes, I will supply you the survey if we have it. I don't have it with me. Anyway, I wanted to deal with your response to that survey. To make it clear, I'll give an undertaking to look for it tomorrow.

COMMISSIONER: Thank you, Mr Tait?-- I'm sure, Mr Commissioner, that we would - that Queensland Health may still have a copy of it, if Mr Tait can't find it.

MR TAIT: I'll ask Mr Boddice-----

COMMISSIONER: Well, indeed, that's probably easier and, Mr Boddice, while you're at it, based on Ms Edmond's evidence, it sounds like Queensland Health should have waiting lists for the waiting list figures available not just as at the 30th of June 2004, which is the only one we have got, but for the period from October 1998 onwards.

MR BODDICE: And I understand the Commission has been communicating with Queensland Health and we are endeavouring to get any material together that we have in respect of those matters.

MR DOUGLAS: That is so, Mr Commissioner. I wrote to Queensland Health the afternoon before last and I understand they are looking for that information now.

COMMISSIONER: Yes.

MR DOUGLAS: But we were unable to secure it before Ms Edmond's evidence today.

COMMISSIONER: Thank you.

MR DOUGLAS: Thank you.

MR TAIT: Anyway, Ms Edmond, you will recall that - well, the president of the AMAQ at that stage was Shane Sondergeld?-- Yes.

Do you remember him?-- I do indeed.

And you I suggest - I suggest he sent you a copy and offered to meet with you and you did indeed discuss the report with him?-- Yes, I met with the AMAQ whoever the presidents were on a quarterly basis.

I'm sorry, I wasn't meaning you wouldn't see others but I'm suggesting you met with Sondergeld?-- Yes.

And the report mentioned a number of hospitals. One of them was Bundaberg?-- Oh, I would presume so.

Yes. And you-----?-- Perhaps I could save you time and say that I think Mr - Dr Sondergeld put out a press statement in each and every town in Queensland saying that that particular hospital was grossly under-funded.

He may have?-- Well, I'm just sort of saying if you're - if that's where you're leading to with Bundaberg.

No, I wasn't. It-----?-- I think he did it in every single town across Queensland.

No, I didn't know that he did that?-- Well, he did.

Was it? Each hospital under-funded?-- It was based on the fact that every single town some doctor had said they would like more money.

Well, was each one 15 per cent under, the way we've already heard?-- I don't recall the figures.

I see. Anyway, your comment on the report was that it was a predictable selected response, which I presume means culled, selected response from a select group?-- Yes.

I see. And so you were critical of that report and dismissed it?-- I didn't think there was a lot of value to be gained by writing to one section of the health workforce and asking them if they would like more money. I was also probably aware at the time because Dr Sondergeld told me himself that he was writing the National Party health policy or the Coalition health policy, I should say.

Oh yes. Let me tell you what the - the topics were in the report: one was staff shortage; next one specialists, specialties in crisis situation; next one, sufficient medical officers to cover medical requirements, and I might say Bundaberg got a positive mark for that one; another one, bed closures; another one, ward closures; another one, staff cuts; another one low staff morale; another one, reducing patient stays; another one, patients discharged prematurely; it goes on, there are 17. It wouldn't seem it's only "Would you like more money?" Anyway, you didn't think much of this report, did you?-- We thought it was fairly selective.

Yes?-- And not particularly informative.

And so did you know that Dr Leck or Mr Leck criticised it?-- I know Dr Leck.

Did you know Mr Leck criticised it?-- No, I'm not sure that I knew that Mr Leck - I'm sorry, I thought originally you were talking about Dr Locke who was also-----

Well, I'll read you from - you said you got media monitors, this is a media monitor's report from the 23rd of November 2000 from the News Mail of Bundaberg. "Bundaberg failed in 1 of the 17 categories according to the report card released on Monday by the Australian Medical Association. Mr Leck said hospital staff were doing a great job and providing an excellent service which was borne out by ongoing positive feedback from the vast majority of patients. Mr Leck said he was upset by anonymous comments from Bundaberg doctors."; you don't remember ever hearing that?-- Mr Tait, what was the date on that?

The 23rd of November 2000?-- I think I would have had - each day I would probably have one and a half inches of newspaper cuttings to go through.

Sure?-- I would remember some that stood out, but I am pleased that Mr Leck said that things were going well in Bundaberg at that time.

MR DOUGLAS: I apologise to Mr Tait for interrupting.

MR TAIT: Not at all.

MR DOUGLAS: Mr Commissioner, it's a quarter to six. I'm mindful of the fact that this witness desires to finish today. I'm also mindful of the fact that Mr Martin has some obligations tomorrow morning in another place.

COMMISSIONER: No, well I'm happy to keep going.

MR DOUGLAS: I am as well, but the reason I raise - I rise to my feet is this: I've just been given some information along the lines that which was just discussed with the Commission by the Commission with myself and Mr Boddice and it that is, the I've only looked at it for a few seconds, it would appear to be the, if I can coin the phrase, unofficial lists as they've been described in a press release.

COMMISSIONER: Yes.

MR DOUGLAS: I would need to put that to this witness in any event.

COMMISSIONER: Yes.

MR DOUGLAS: I'm reluctant to allow matters to go on and that will have to be distributed to everyone here - Mr Tait's nodding, I see.

COMMISSIONER: Mmm.

MR DOUGLAS: I merely mention that I'm happy for that to be done and as counsel assisting we're happy to sit as late as possible, but I merely indicate that that will have to be distributed.

COMMISSIONER: Well, it's getting on to a long time since any of us has had some fresh air or a bite to eat or a cup of coffee. I wonder whether it would suit everyone to break for a bit longer, for half an hour, say, get out of this pressure cooker environment for a little while but on the clear understanding that during that time copies of this will be distributed and we'll all work as best we can to make sure that Ms Edmond is not inconvenienced by having to come back on another occasion; would that suit you firstly?-- That would, Commissioner. May I ask a query?

Please?-- I have to ask where this is - I mean, where these questions are going? The AMAQ regularly ran campaigns across Queensland denigrating the public system and et cetera. I'm not sure what Mr Tait's trying to prove, that they ran one in 2000 or whatever? I'm aware of that, but I can't remember every press release that was ever put out by the AMAQ or myself over that period. There must be thousands-----

MR TAIT: Commissioner, may I assist the witness by saying notwithstanding, she attempted to slur the AMAQ by saying because they had a company which did something, they take a different view?-- Oh, oh I'm sorry, Commissioner-----

COMMISSIONER: No, no, please everyone, everyone, everyone I think that's unnecessary and that's the sort of reason why I thought it might be a good idea to have a break and everyone calm down. Ms Edmond, if after you've had some time for fresh air and you want to come back and say something in response to Mr Tait, I'll give you that opportunity, but may I say it's

probably more sensible to let your counsel handle the situation as he thinks fit and raise those things in re-examination rather than trying to deal with it on the run. It's up to you, totally up to you. I know you're a very experienced person in public affairs and so on, but I think it's in everyone's interests that we follow an orderly process. You do have, and I'll think he'll forgive me for saying so, one of the most competent barristers in the State looking after your interests and I think that's the best way to handle things?-- Thank you.

MR DIEHM: Commissioner?

COMMISSIONER: Mr Diehm?

MR DIEHM: I just wanted to raise the course of proceedings. It seems taking a break now, we're facing a material prospect of being here until 7.30, 8.30 tonight.

COMMISSIONER: Could be, yes.

MR DIEHM: Well, with respect, I understand the witness' desire to get back to her normal life, but the rest of us have also got lives to lead and work to do as well, and it seems, with respect, in my submission, be stretching things to sit on into the night with all of these people giving up their evening with whatever other commitments they may have to do so the witness doesn't have to come back for a couple of hours of evidence on another day.

COMMISSIONER: It's not just that though, Mr Diehm, there are a couple of other things: it is on that we're on a short-term leash in terms of the time available to us and the other thing is to be quite candid, for example, Dr Molloy from the AMA was given the indulgence of giving evidence at a time that suited his convenience, and I don't want it being suggested, and I'm sure Ms Edmond wouldn't suggest it, but I don't want anyone else saying there's been a double standard here, that the AMA gets favours that aren't extended to Ms Edmond. The important thing though is that what - the evidence we've heard today is fresh in everyone's mind, I think it's in everyone's interests that we finish it this evening?-- Commissioner, my agreement to continue on this evening was not purely because I'm keen to get on with my life. It was because I thought that was what the Commission wanted. I'm easy either way. I have nothing on tomorrow that can't be put off for your convenience, so I'm totally trying to do what I can to make myself available to the Commission.

Thank you?-- The choice was whether I wanted to go a bit longer tonight and tomorrow morning and I said I preferred to go a bit longer tonight. If that's not what you wish, I'm happy to come back tomorrow.

Ms Edmond, if it were up to me, I think it's in everyone's interests that we get this over and done with tonight, but you know, my personal preferences aren't the question here. Mr Diehm has rightly raised the fact that we've got a lot of

people sitting in this room who've got their own families to go home to and so on, and if we're not going to be finished in half an hour or an hour's time, then it's going to be inconvenient for a lot of people. Mr Tait, how long do you expect to go?

MR TAIT: I'd be another five minutes.

COMMISSIONER: Mr Allen?

MR ALLEN: Ten to 15.

COMMISSIONER: Mr Diehm?

MR DIEHM: I think I'll be about 10 minutes, Commissioner.

MS GALLAGHER: I actually have no questions, although you haven't asked, Mr Commissioner.

COMMISSIONER: I was getting to you, but you're in the next row.

MS GALLAGHER: Just in case you'd forgotten.

COMMISSIONER: Ms Feeney?

MS FEENEY: No thank you, Commissioner, Mr Couper kindly asked my question.

COMMISSIONER: That was kind of him. Mr Martin? Much re-examination?

MR MARTIN: I don't expect any to speak of at this stage.

COMMISSIONER: Yes, Mr Douglas.

MR DOUGLAS: Right, of the document it's not a lengthy time.

COMMISSIONER: Yes.

MR DOUGLAS: I would have thought 10 minutes.

COMMISSIONER: All right. Well, I think the fairest compromise, Mr Diehm, is if it answers your concern, we won't go past 7 p.m.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: I would expect people around the Bar table to do their level best to finish by then and consistently with the time estimates we've heard, that should be feasible.

MR DIEHM: Thank you Commissioner.

COMMISSIONER: Will that suit your concern?

MR DIEHM: Yes, it does.

COMMISSIONER: And does that suit you, Ms Edmond?-- That's fine. I'm more than happy to do whatever you wish.

COMMISSIONER: We'll now take, perhaps not as long as I said before, but we'll now take 10 or 15 minutes so that this document can be distributed.

THE COMMISSION ADJOURNED AT 5.54 P.M.

THE COMMISSION RESUMED AT 6.11 P.M.

WENDY MARJORIE EDMOND, CONTINUING CROSS-EXAMINATION:

MR MARTIN: Sorry Commissioner.

COMMISSIONER: Not at all, Mr Martin. Is it convenient for you to proceed now?

MR MARTIN: Yes, thank you.

WITNESS: My apologies.

COMMISSIONER: Not at all, not at all?-- We were looking through the new data.

Is it appropriate, Mr Douglas, for Mr Tait to complete his cross-examination or do you wish to deal with these figures now so that Mr Tait, if he has any questions about them, can deal with them at the same time.

MR DOUGLAS: It's probably apt for me to deal with the documents now, Mr Commissioner.

COMMISSIONER: Yes, thank you.

FURTHER EXAMINATION-IN-CHIEF:

MR DOUGLAS: Ms Edmond, there is just, as you heard from the exchange at the Bar table shortly before the break, Queensland Health has now supplied counsel assisting the Commission, at our request, with some information pertaining to what I can colloquially refer to as the unofficial list; can I put a copy of that document in your hands?-- I've got a copy, thank you.

Thank you. Could I just identify to you before you peruse it in detail what it appears to be by way of structure at least.

The first sheet is a document pertaining to the period or should say pertaining to the date 1st July 2001 in respect of the various hospitals in Queensland?-- Yes.

Under various clinical headings. The second sheet is the equivalent document for 1st July 2002. The third sheet, the analogue for 1st July 2003, and the fourth sheet is a summary of the first three sheets except that there is a division or bifurcation of each year's total as they appear on the prior sheets under the headings "With Appointment" and "Without Appointment". So Ms Edmond, just for your assistance, this document hasn't been otherwise explained by the author?-- Mmm-hmm.

But to be fair, it would appear that the summary in fact is augmented with a little more information than appear on the prior sheets and that it pertains to the number of patients who are waiting for specialist outpatients appointments, again by way of summary, those with an appointment and those without an appointment?-- Yes.

Can I also tell you, Ms Edmond, before I ask you some further questions about it, that Exhibit 267 before this Commission consists of some other records in greater detail which have been supplied by the department to counsel assisting the Commission, and what they consist of is a breakdown for each hospital in Queensland as at 1st July 2004, that is, the point in time one year after the document that you have before you now?-- Mmm-hmm.

Giving a similar division as per the summary document of the document you have before you now, namely, a number of patients with an appointment and a number on a waiting list for an appointment. To assist the witness in understanding that evidence, Mr Commissioner, what I propose to do is give the witness an extract from Exhibit 267 for the Ipswich Hospital so she's fully informed as to the character of the document.

COMMISSIONER: Yes, thank you.

MR DOUGLAS: Thank you. And when you've had an opportunity to peruse those, I'll then ask you some questions, Ms Edmond. Can I ask you some questions now?-- Yes.

Thank you. To start with, Ms Edmond, is the format of either of these documents something with which you are familiar?-- I'd have to say that the - I'm not sure that I've ever seen the one from Ipswich Hospital.

Thank you. That's the extract from Exhibit 267?-- Mmm-hmm.

When you say you haven't seen it, you haven't seen it in that format before?-- I haven't seen it in that format before or those figures obviously.

You wouldn't have seen the figures?-- No.

Because they come after your time, I'm not suggesting as

much?-- Or even I can't remember seeing them in that format for previous years either.

Can I please understand your evidence in that regard, you've been asked a number of questions-----?-- Mmm-hmm.

-----by me, by the Commissioner and by some of the counsel appearing in respect of your viewing of documents pertaining to the - what I've described as the unofficial list. Is it the case that after the consideration of the documents which led to your 1998 press releases, that your recollection is that you at no time thereafter saw any information in the nature of figures pertaining to that unofficial list?-- No, I - no, no, no. I said this is a very detailed list at Ipswich Hospital. I don't recollect seeing lists like that. I'm quite - this looks much more like the format that I would have seen.

Now-----?-- The other document.

When you say "this"?-- Mmm.

That is the document which I first put in your hand?-- Yes.

The four sheet document?-- And it's much more of a summary, aggregated numbers, yes.

All right. I should tender that document for the moment.

COMMISSIONER: Yes. The document headed - or the four page document of which each page is entitled "Number of Patients Waiting for Specialist Outpatients Appointments" will be Exhibit 306.

ADMITTED AND MARKED "EXHIBIT 306"

MR DOUGLAS: Thank you. Ms Edmond, I do feel obliged to press you. When we are dealing with the unofficial lists, after, say, the end of 1998, is that a list whether in total or by reference to individual hospitals, which you, after the end of 1998, and prior - immediately prior to you ceasing your tenure as Minister, that you considered from time to time?-- It was considered from time to time. It was considered in part of - as part of the consideration of the waiting lists for surgery. It was also as part of that a consideration of looking at workforce issues where - where there were gaps in service delivery. Obviously one of the issues - I haven't gone through these figures - but we had a shortage of urologists. If you have a shortage of urologists - very important to you chaps - you, you know, the waiting times to see them will go up and that will happen, and we would look at those issues and try and address that by recruiting a urologist or if not, having a urologist from one of the major centres go to that particular centre on a visiting basis.

I'll be even more specific. Sometime after the 1st of July 2001, do you recall being told that for the hospitals in Queensland, that the number of persons waiting for specialist outpatient appointments, whether they've been given an appointment or not, was 51,876 patients as at the 1st of July 2001?-- I don't recall those particular figures. As I indicated earlier to you, I thought the figures were roughly in keeping throughout with increasing throughput and increase in demand, and certainly I didn't recall a figure, as I recall saying to you, of 100,000 plus are being on those lists. I thought that if it was of the order of 100,000, I would have remembered that-----

MR MARTIN: Sorry, could I just indicate, I understood the evidence of Ms Edmond and the press releases to be speaking about the waiting list to get an appointment for surgical - on the surgical list.

COMMISSIONER: No, I don't think so, actually. Ms Edmond can clarify that, but I think the point she made very early on this morning was that the 36,000 people referred to in her press release in 1998, was 36,000 people waiting to see specialists of all kinds, not just - not - and I think you've made the point that's why that figure was potentially misleading, because some of those people would be waiting to see medical specialists rather than surgical specialists?-- No, sorry, the number of people waiting, the 105 figure I said was misleading.

Yes?-- Because I thought that that included all outpatient appointments.

Yes?-- The 36,000 in that-----

MR DOUGLAS: Press release?-- -----press release, sorry-----

MR MARTIN: Could I-----

WITNESS: I'm sort of - my reading of that, and I have to sort of say I have to read the press release and try and think back, it says 36,000 of whom 26,000 who were in these specialist categories which were the common, ENT, orthopaedics, general of those 20,000, so if you say-----

MR MARTIN: Sorry, could I just save a bit of time here? Could I take you to the 16 October 1998 press release?

COMMISSIONER: Yes.

MR MARTIN: And if one goes to about a third up from the bottom, "The downside is that I now know that the waiting lists to get on the waiting lists for surgery is almost as long as the waiting lists for surgery.", and then the figures go on showing the 36,000, and I did understand the evidence early today to be the surprise of 105,000 and Ms Edmond querying whether or not that may have combined the lists somewhat.

D COMMISSIONER VIDER: Ms Edmond, can I just ask a clarifying question? I know you weren't there on the 1st of July 2004, but just from the evidence that you provided earlier, if you look at that list?-- Mmm-hmm.

The first part of that is elective surgery waiting lists which is Category A?-- Sorry? Sorry, which?

The one that's the 1st of July 2004.

COMMISSIONER: This is the document in portrait configuration rather than landscape, if that makes sense to you.

D COMMISSIONER VIDER: Which has just been handed-----?-- I'm sorry, I'm not sure I have - am with you. The 2000, is that the Ipswich one?

MR DOUGLAS: It's the Ipswich one that I gave you by way of-----

COMMISSIONER: We've been handed another document which is the full summary.

MR DOUGLAS: No, it's a different document?-- Sorry, may-----

COMMISSIONER: Can Ms Edmond have the full document so that we're all looking at the same things?-- Is this the one we're looking at?

No, we're not, I'm sorry.

MR DOUGLAS: Just a moment, Ms Edmond. The difficulty that I'm having is this: I've taken some further - asked my instructor to - Mr Scott, to speak to Queensland Health about the origins of the last exhibit.

COMMISSIONER: Yes.

MR DOUGLAS: I'm told that the origins of the last exhibit are such - and I don't say this critically - it's just a fact that it has been put together in response to the request which was identified before the break. In fact, I'm told that the document - this document is drawn from some source data. So the difficulty is that I can't be sure, Mr Commissioner, that the form of the document from which it is drawn is not such that that may well have been that a document which this witness may or may not have seen and which may or may not be in the format of Exhibit 267. That's the difficulty in which I'm labouring.

COMMISSIONER: Indeed, Mr Douglas, but I think it suffices for our purposes if I may take over for a moment?

MR DOUGLAS: Yes.

COMMISSIONER: To ask Ms Edmond: do you recall figures like those shown in the landscape document we've got, 1 July 2001,

a total of 51,000 people waiting for - waiting to see specialists, 2002, 54,000, 2003, have you had left by then?-- That would be more in keeping with the figures. I don't recall the exact figures but that would be more in keeping with the figures and some of the other figures that have been mentioned here today, such as the 100,000 plus.

And if the 36,000 figure was - well, are you able to tell us whether the 36,000 figure back in 1998 was merely people waiting to see a specialist as a prelude to potentially having surgery, or whether that was everyone waiting to see a specialist?-- Commissioner, it is a long time ago.

Of course?-- But I think - I think it was in the context of these are people who are waiting for surgical appointments.

Yes.

MR DOUGLAS: Mr Commissioner, to explain the other document that I have handed to the Commissioners and also I have distributed to the parties, the document which is headed "Waiting list 1 July 2004" is a document generated by counsel assisting and my instructors.

COMMISSIONER: It is a summary of those details for each hospital.

MR DOUGLAS: What it is, by reference to the extract from exhibit 267, which is in that format - what has been done for each hospital is to add those figures which appear on each of those sheets a number for appointment, a number on waiting list. From the item "cardiothoracic surgery" - do the Commissioners have that?

COMMISSIONER: Yes.

MR DOUGLAS: Down to but excluding the item "psychiatric surgery", for each of those pages, and the summary rolls from there such that a comparison is then made - I should say that document yields what appears in columns B, C and D on this waiting list 1 July 2004 document. Item A, which is elective surgery waiting list, is derived from material currently appearing on the net published by Queensland Health as to the elective surgery waiting list as at 1st July 2004. So this is a product of those endeavours. You will see, apropos my submission a moment ago, in relation to the form of the document, which has just been tendered, that is the four-sheet document, that the total which I have calculated for all hospitals in Queensland, item D, that is the total weighting lists is 67,052 patients, and that's 1 July 2004.

Now, if one goes to the exhibit that's been produced this evening by Queensland Health, as much as one can compare apples with apples, if one is to say - Mr Commissioner, if one is to go to the sheet for 1 July 2003, that is a year immediately prior to that the subject of exhibit 267, the total that appears in the bottom right-hand corner, as you can see, is 55,684 patients. In order to at least attempt to compare apples with apples by reference to the items that appears on the horizontal axis, if one reduces that sum of 55,684 patients by the medical item of 10,729 items, on the presumption, in this unexplained document, that those are persons who might - are unlikely to go on to surgery, one derives a total of 45,684 patients. You can immediately see

my concern that there is concern as to the validity of this document, because if my calculations are correct, it has gone up by over 20,000 persons in one year.

COMMISSIONER: In one year.

MR DOUGLAS: Now, I am not - I am only seeking to identify the fact that I question - and I am sorry, I don't say that critically of anybody - but I question, in the abstract, the integrity of the document which has been produced tonight. I don't want to be unfair on this witness in that regard, nor to be producing evidence to this unexplained evidence to this Commission which may lack integrity.

MR BODDICE: Well, Commissioner, can I say something in relation to that?

COMMISSIONER: Yes.

MR BODDICE: Because in fairness - and perhaps my learned friend Mr Douglas wasn't given the accompanying letter - but the accompanying letter said, "I am further instructed that the data was provided by the reporting hospitals, those with specialist outpatient clinics, through manual data collection methods, and, as a result, the validity and reliability of the outpatient data provided by the reporting hospitals was considered questionable. The data was not validated. The 2004 data collection resulted in the July 2004 data provided to the Commission was based on a larger number of data items and a specific survey tool which requested more specific and detailed data."

So it was made clear in the accompanying letter that what was being provided for 2001, 2002, 2003 was not on the same surveyed basis as 2004.

MR DOUGLAS: I apologise, Mr Boddice. I wasn't given that document.

WITNESS: Mr Commissioner, maybe I can clarify things. There are several other categories there that don't seem to have been recorded or talked about. One of those is obstetrics and gynaecology. You may be aware that with obstetrics there is a time limit that you can't give-----

COMMISSIONER: So I have been told?-- You can't give people a two year appointment for obstetrics. The other area is paediatrics. And that's measured in different ways, too, and I think counsel assisting perhaps has not taken those into account when you are doing your figures.

COMMISSIONER: Ms Edmond-----

MR DOUGLAS: I didn't do any figures on those, with respect, Mr Commissioner.

COMMISSIONER: Ms Edmond, I think the only thing at the moment I am taking from all of this is a reflection of the - if you

will forgive me for saying so - the wisdom of your proposal right back in 1998 when you said that these - in your statement when you said Queensland Health was collecting appointment waiting list data manually because no computer systems currently were doing that, and you announced that you are asking Queensland Health to improve on that. It seems, however, this it took Queensland Health six years to follow that instruction?-- I can't comment on that, I am sorry. My understanding was, you know, for the first time we started getting - you know, if you refer to this data, that is consistent with - as I indicated before, I had seen data on a regular basis.

D COMMISSIONER VIDER: Can I just clarify one point. It is not specifics?-- Yes.

Looking at this document, "Waiting list 1st of July 2004"?-- Yes.

With the categories A, B, C and D?-- Sorry, is that - okay.

Across the top A, B, C and D?-- Yes.

Your evidence today has been very helpful in clarifying the other States' waiting list data, that is it meets the Commonwealth requirement?-- I am sorry?

Queensland is the only state that has outpatient-----?-- Specialist appointments.

Provided. So we're the only State with that sort of data?-- Absolutely.

By Australian Standards then, on this document, the total number on the elective surgery waiting list is 31,478 and that would be, in Australian terms, the Queensland waiting list. Is that right? That's the elective surgery waiting list. I am not worried so much about the numbers, I am really just looking to clarify to see if I understand the principle. It is the number of people on the elective surgery waiting list?-- Well, I can only comment on this document, too, Ms Vider. I don't have that information at the moment, but I presume that would be about right.

So that would be what Queensland's figure is in the national total?-- Yes.

It is the number of people?-- Who are waiting for elective surgery.

Yes?-- Of whom the bulk are in category 3.

Yes. Thank you?-- Thank you.

MR DOUGLAS: Mr Commissioner, I tender the letter dated 25th August 2005.

COMMISSIONER: I will add that to and have it form part of

Exhibit 306, so that the confusion that occurred earlier can't happen again.

MR DOUGLAS: Thank you.

COMMISSIONER: I don't think, Mr Douglas, we can usefully take that any further.

MR DOUGLAS: I want to take it one step further, thank you. The Commissioner taxed you this morning as to the fact that this information about the unofficial waiting lists might well have been valuable information for you to include in submissions made to cabinet or the cabinet budgetary review committee. Do you recall that exchange?-- Uh-huh, yes.

Can I suggest to you that this information about the unofficial lists, if properly collected, falls to be properly categorised as weighty evidence which could have been so advanced to cabinet to press for more funds to deal with these unofficial waiting lists during your term as Minister?-- I am sorry, you are saying that it would be - I am not sure what the question you are asking me is.

I will put it to you another way: I am suggesting to you if that information about the unofficial lists had have been collected, say, from early 1999 onwards and utilised in the annual budgetary submissions made to health, then it would have been weighty information, information of some moment which would be likely to be seriously considered by cabinet when you are making budgetary submissions in respect of these matters?-- It would have been one of many issues that were taken into consideration in budget. I think probably if I'd hammered that point too hard, it may have meant that Queensland would have looked at what the other States were doing and opted to do likewise, which is move out of providing specialist outpatient services. Certainly that would have been the advice I would have given. If we had to cut services somewhere because of budgetary constraint I think that would have been an area we should have looked at doing to be consistent with the other States, and access the funding from the Commonwealth then through the Medicare arrangements.

Do you think that these unofficial lists, if they had have been published after early 1999, would have been politically embarrassing?-- I don't think the lists changed very much during the time I was there, and if you look at them you will find that that's the case. Even though there were increased numbers of patients being seen, increased - significant increase in the number of patients having elective surgery, and I am sure Queensland Health can get you the data on the increase in throughput over the period that I was Minister. So in the context, I don't think it would have been politically embarrassing, no.

I am not seeking to move into the political sphere?-- I am sorry, I thought you were.

No, Ms Edmond, listen to me carefully. What I am attempting

to identify are the reasons why, to assist this Commission in making its recommendations, this information wasn't collected. Can you identify any reason, whether it be political, departmental in terms of advice you were given why it was that your suggestion, raised in your press releases of 1998, weren't followed up so as to derive this information and utilise it for the best benefit of the people of Queensland?-- Mr Douglas, with all due respect, may I draw you to the attention of the document you have given me, which actually is-----

Which document madam?-- The one that says, "Number of patients waiting for specialist outpatient appointments by clinic grouping Queensland Hospitals, 1st of July." It is my understanding that has been collected. Certainly you have provided me with information that was collected in July - in 2001, 2002, 2003 and - yeah, yeah.

COMMISSIONER: I think what we've been told, though, is whilst these figures were out there, they have only been collated and provided in that form within the last 48 hours.

MR DOUGLAS: That's what we have been told?-- I am sorry, Commissioner, my understanding is that was this document collated by hand. This document is similar, as I indicated earlier, to the ones I saw on a regular basis.

COMMISSIONER: What we have been told by Mr Boddice, who is representing Queensland Health, is that certainly the document that's in the portrait configuration has been produced by inquiry staff. That's not a Queensland Health document at all?-- That's this one?

Yes. You can put that to one side. But the one in your left hand in the landscape configuration?-- Uh-huh.

Was generated by Queensland Health within the last 48 hours.

MR BODDICE: Yes, but, in fairness, I think that's the document we have produced. I don't know whether - I will have to get instructions as to whether we're saying that type of document has never been produced before.

MR DOUGLAS: This is-----

COMMISSIONER: If it has been produced before, we would like to see it.

MR DOUGLAS: This is the very issue I raised before, canvassing the letter. I don't want to be unfair to this witness. It may well be - I am sorry to rehearse this - it may well be that there is some other document in some other format which this witness has seen.

COMMISSIONER: Look, Mr Douglas, despite our best efforts, we're plainly not going to finish by 7 p.m. I think it is in everyone's interest that this matter get sorted overnight. If the documents exist, then Ms Edmond should be given the

opportunity to comment on the actual documents rather than something that's been created or recreated in recent times.

MR DOUGLAS: That's my submission.

COMMISSIONER: And can I say, for everyone's benefit, we're really not interested in political pointscoring, either in a party political sense or in the sense of interest groups such as the AMA scoring political points. Our commitment on these issues is to try and look at ways to improve the system in the future, and recriminations about things that may be criticised in the past really won't help us. So let's try and work on those facts and figures and come back tomorrow morning, hopefully all in a more cheerful spirit to try and resolve this.

WITNESS: Mr Commissioner, can I comment just briefly-----

COMMISSIONER: Please?-- -----on the issue Mr Tait raised?

Yes?-- I think it is important to say I was not casting aspersions on the AMAQ. I was simply saying that my understanding was that they had an employment agency for short term locums, et cetera, and, therefore, that they would have had an interest in responding to that report. I don't see how that can be an aspersion.

MR DOUGLAS: Mr Commissioner, we can do as you say. I know Mr Martin has a longstanding commitment in the Court of Appeal tomorrow morning.

COMMISSIONER: I had forgotten. I do beg your pardon.

MR DOUGLAS: So apropos Ms Edmond's position, it would be more convenient if we could resume her evidence tomorrow afternoon, perhaps at half past one or two o'clock, something like that.

MR MARTIN: 2 o'clock. If the Commission is going to accommodate me, I would appreciate it.

COMMISSIONER: Certainly. How does that affect everyone else? Mr Tait?

MR TAIT: No problem at all. I will be available. The witnesses who we had proposed to call tomorrow, we've dealt with in a different way by distributing the statements and responding to them, so that really frees up part of tomorrow anyway.

MR DOUGLAS: In relation to witnesses, Mr Commissioner, we have arranged - provisionally, thank God - for Dr Joyner to give evidence at 10 followed by Dr Jayasekera.

COMMISSIONER: So 10 o'clock tomorrow morning.

MR DOUGLAS: Thank you.

COMMISSIONER: And Ms Edmond will be returning at 2 p.m.

tomorrow afternoon. Does that suit you? I know you would have preferred to finish today, but given the mix-up that's occurred, is 2 o'clock a convenient time tomorrow?-- I will make it convenient, Commissioner.

MR DOUGLAS: As soon as I can sort matters out, if I can, with Mr Boddice, those documents will be supplied, of course, to everyone at the Bar table.

COMMISSIONER: Mr Applegarth?

MR APPLEGARTH: I am not directly interested in this matter, but I was conscious of the witness - and I excuse myself if I haven't been following the evidence that closely - but this morning the witness also spoke about other documents that went forward to cabinet, or some such thing, that identified particular problems in this area, and wasn't Statewide but was more specific in terms of waiting lists of these characters. So I am just wondering, we should obviously attempt to do as much as we can collectively to further finalise with Queensland Health, it seems to find any Statewide figures, but I am not sure whether they are going to be able to find the documents the witness was obviously referring to as well.

COMMISSIONER: Oh.

MR APPLEGARTH: But they can but try. I hope we can find everything and we don't have to bring the witness back on another occasion because there are further documents.

COMMISSIONER: That's not going to happen. I mean, you know, Ms Edmond's evidence will finish tomorrow and that's that.

MR DOUGLAS: Also, Mr Commissioner, without wishing to prolong the matter, we do need - to take up your point earlier - we need to bear steadily in mind that if it transpires that - it seems from the evidence it is readily apparent that the information wasn't published. It may - it seems it wasn't collected in any formal form. That might change. Once we reach a particular point, the inquiry needn't go much further in relation to that particular issue for the purpose of the Terms of Reference.

COMMISSIONER: When we get into the question of, you know, who's right politically or who did the right thing or the wrong thing, we can go back into history. Ms Edmond, I think, is entitled to the credit as being the first Health Minister in Queensland history who insisted on all surgical waiting lists being published?-- That's right.

Now, it's one thing to say, "Well, she could have taken that further and published more information", but I think that's being a little bit ungracious, frankly?-- I was - may I clarify the situation. I have never - those figures have never been published. You don't need to look for whether they've been published or not.

No, that's not the question. The question was whether they were collated or provided in some documentary form and your recollection is that they were?-- It may not have been as detailed as some of these documents.

Yes.

MR DOUGLAS: Thank you. I was merely just making submissions that might go to some shortening of this process.

COMMISSIONER: Yes.

MR DOUGLAS: Thank you.

COMMISSIONER: 10 o'clock tomorrow.

THE COMMISSION ADJOURNED AT 6.49 P.M. TILL 10.00 A.M. THE FOLLOWING DAY