STATEMENT OF STEPHEN MICHAEL BUCKLAND – SECOND STATEMENT

1. I am the former Director-General of Queensland Health. I was Director-General from 29 April 2004 to 26 July 2005.

2. My first statement dated 30 August 2005 outlined how I came to learn of concerns relating to the clinical practices of Dr Patel at the Bundaberg Base Hospital, and what I did in response to those concerns. That first statement contained eight attachments marked 'SMB1' to 'SMB8'. Therefore, the attachments to this Statement commence with the numbering 'SMB9'.

3. My first statement was provided to the "Bundaberg Base Hospital Commission of Inquiry" on 30 August 2005.

4. On 1 September 2005 a further statement was provided by me to that Inquiry. This statement replaces and supplements my statement of 1 September 2005.

5. On 23 August 2005 the former Commission of Inquiry (COI) announced that it proposed to deliver a report in relation to systemic issues by 30 September 2005. On 24 August 2005 the Chairman of the former Commission stated that there was no intention of making any findings – either positive or negative – regarding my responsibility or the responsibility of my predecessor as Director-General (Professor Stable), the former General Manager of Health Services (Dr Scott) and the former Ministers for Health (Ms Edmond and Mr Nuttall) in connection with systemic issues. This statement is made on the understanding and that had there been any change in that situation, I would have been given appropriate notice of it.

6. This statement has been provided to the COI in circumstances in which I have not received notice from it (or the former COI) of possible adverse findings against me, and this statement is given in the expectation that I will be afforded procedural fairness before I am required to respond to any such allegations.

The structure of this statement

7. This statement will initially outline:

   (a) My professional qualifications and experience;

   (b) The structure of Queensland Health at the time of my appointment as Director-General ("DG");

   (c) The role of DG;

8. By way of background I shall briefly outline the health system structures under which I have worked, including the current zonal system.

9. Next, I shall address a number of matters that confront the public health system in Queensland, including the shortage of Australian trained medical

practitioners, its reliance on overseas trained doctors (OTDs) and concerns about safety and quality.

10. In the course of dealing with those issues I shall address a number of topics that Counsel Assisting the Inquiry has asked me to address.

11. I shall then address the balance of topics that Counsel Assisting the Inquiry has asked me to address.

12. In dealing with the issues that I have been asked to address by Counsel Assisting I am conscious that some of the topics that I address are provided by way of background and also to respond to some general issues that have been raised before the Commission. I have done so within certain time and other constraints that have been the subject of correspondence between my legal representatives and Counsel Assisting.

13. Given the number of issues that I have been asked to address, this statement is unfortunately fairly lengthy, and the annexures to it are voluminous. I was encouraged by Counsel Assisting to respond to the matters raised by him in as much detail as was reasonable in the interests of limiting the time that otherwise would be occupied before the Commission in giving this evidence orally.

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A. BACKGROUND

My professional qualifications and experience

14. My qualifications are:

    (a) Bachelor of Medicine and Bachelor of Surgery from the University of Queensland. I graduated in 1976.

    (b) General registration as a medical practitioner in Queensland since 1977.

    (c) Fellow of the Australian College of Occupational Medicine, now the Australasian Faculty of Occupational Medicine of the Royal Australasian College of Physicians, since 1985.

    (d) Specialist registration in Queensland in the specialty of occupational medicine since 15 May 1991.

    (e) Masters in Health Administration from the University of New South Wales. Graduated in 1990.

    (f) Associate Fellow of the College of Health Service Executives since 1990.

    (g) Member of the Royal Australian College of Medical Administrators since 1999.

15. My experience as a medical professional is:

    (a) I was a Resident Medical Officer at Mackay Hospital in 1977.

    (b) From 1978 until March 1987, I performed a number of clinical and teaching roles with the Royal Australian Air Force both in Australia and overseas. During this period I also worked at Hawkesbury Hospital and in a variety of general practices in a locum capacity.

    (c) I also was recognised as a specialist medical practitioner in Occupational Medicine in 1985.

(d) From April 1987, I was Deputy Medical Superintendent at Ipswich Hospital and continued clinical practice as well as private surgical assisting.

(e) I was appointed Medical Superintendent at Redcliffe Hospital from December 1989 upon completion of my Masters Degree in Health Administration from the University of New South Wales. Under the Regional Structure, while remaining Medical Superintendent, I was also the Executive Officer for the Southern Sector of the Sunshine Coast Regional Health Authority. I was District Manager and Medical Superintendent at Redcliffe-Caboolture Health Service District from July 1996 to August 1999.

(f) From the end of August 1999 until July 2002, I was Southern Zone Manager.

(g) From 29 July 2002 to 1 November 2003, I was General Manager of Health Services ("GMHS").

(h) I was Acting Director-General from 1 November 2003 to 29 April 2004.

(i) On 29 April 2004 I was appointed to the position of DG. I remained DG until 26 July 2005.

(j) Since 1991, I have remained as a registered medical specialist in Queensland as well as being registered on the general medical register.

(k) I have recently resumed work as a medical practitioner.

The structure of QH at the time of my appointment as DG

16. At the time I was appointed as DG on 29 April 2004, the executive team of QH was made up of 15 senior executives. A copy of the organisational structure of QH as at April 2004 is attached to exhibit **'SMB9'**.

17. As a result of my experience as GMHS and Acting DG, I had formed the view that the organisational structure of Corporate Office as it stood in April 2004 was not flexible and sensitive to the requirements of delivering a modern healthcare service. After consultation with the senior executives in QH, I put forward a proposal for the restructure of Corporate Office to create:

(a) 5 Directorates, each headed by a Senior Executive Director.

(b) A Board of Management constituted by the 5 Senior Executive Directors and myself.

Attached and marked **'SMB9'** is a copy of the letter from myself to the Acting Public Service Commissioner dated 7 June 2004.

18. I met with Premier Beattie on 22 June 2004 to discuss the proposed changes to the organisational structure of QH. He approved the changes at the conclusion

of the meeting. Attached and marked **'SMB10'** is a copy of a letter from the Acting Public Service Commissioner to me dated 29 June 2004 in relation to the changes.

19. The new organisational structure took effect on 1 July 2004. Attached and marked **'SMB11'** is a copy of the structure of QH as at May 2005 which incorporates the organisational changes.

20. A key aspect to the new organisational structure was the creation of the Innovation and Workforce Reform Directorate ("IWR"). IWR took over the responsibilities of the former Organisational Development Branch but also took on the responsibilities of safety and quality, the Skills Development Centre, the Clinical Practice Improvement Centre and the Patient Safety Centre. IWR was created in recognition of the challenges facing QH.

21. In addition, the role of the Chief Health Officer was separated from corporate governance to concentrate, amongst other things, on clinical governance, audit and performance and the promotion of research.

Strategic plan

22. At the same time as altering the structure of QH, I led the development of a new strategic plan. Attached and marked **'SMB12'** is a copy of QH's strategic plan.

23. For QH, like many other organizations, the last decade has been one of financial compliance and the culture surrounding economic rationalism. In making that observation, I am not denying the importance of financial compliance and the need for accountability in the use of public money. This is a requirement across all government departments and agencies as a matter of proper corporate governance and to meet the requirements of the *Financial Administration and Audit Act* 1977. But the focus on fiscal management has the potential to lead to lazy decision making at a local level. For example, if a doctor had a good idea it could be dismissed with a simple excuse "There is no money in the budget for it".

24. The second and most important phase of the reform process is that of clinical governance. The structure at District level does not necessarily encourage good clinical governance. Clinical performance and health outcomes are the cornerstone of quality health care. This requires individual clinician accountability as well as systems accountability. It was the rationale for the establishment of the IWR.

25. The medical indemnity "crisis" in combination with financial compliance had focussed the organisation on a legalistic accountability framework of blame. This culture is reinforced by the media scrutiny of health which seeks to attribute blame. This culture of blame is contrary to the culture required to deliver safe and quality services. IWR therefore, in conjunction with the CHO, has a critical role to play in cultural reform.

26. One of the most important developments in improving safety and quality was the adoption in June 2004 of a new Open Disclosure Standard which sets out a process of more consistent and effective communication following adverse events. This initiative was endorsed by the then Health Minister in June 2004.

27. The Standard aims to promote a clear and consistent approach by hospitals to open communication with patients and their nominated support person following an adverse event. This includes a discussion about what has happened, why it happened and what is being done to prevent it from happening again. The open disclosure of adverse events is critical to ensuring clinician accountability. It also encourages the adoption of practical measures that are designed to avoid similar adverse events in the future. I cannot overstate the cultural shift represented by the Open Disclosure Standard. I recognise that it will take time for the Standard to alter the culture of the health system that prevails in Queensland and other places. The implementation of the Standard has major and long-term implications for patients. Attached and marked **'SMB13'** is a copy of the Standard.

28. The IWR was designed to improve clinical performance and achieve improved health outcomes. In very simple terms, it had three goals:

    (a) to make the system safer and of higher quality;

    (b) to look at the way that we do our work, and by whom it is done, facing the reality of workforce shortages;

    (c) to obtain good ideas from our workforce.

29. Dr Waters and Dr Wakefield have given evidence to the previous COI about some of these matters, including systems that are designed to improve safety and quality and increase clinical accountability.

30. The second goal, as I saw it, of IWR, was to accept the reality of workforce shortages and to reform who does what in our system. This may involve changing professional boundaries, as in the case of the creation of the role of Nurse Practitioner. These changes inevitably meet resistance.

31. The third aspect of tapping into ideas developed within our workforce was equally important. QH has a well-educated and diverse workforce. It is probably the most well-educated and diverse workforce of any industry in Queensland. The challenge is to capture ideas that originate throughout the QH workforce. Some of those ideas may have a local application. Others have a widespread application. It was critical, in my opinion, that those good ideas not be thwarted simply because a local manager or immediate superior did not agree with them, or rejected them for some inadequate reason. The proposal was to enable people with good ideas to communicate them directly to the IWR. A good idea developed by one person in one particular district or unit may have widespread application in other districts or other units, or across the whole state. The IWR was designed to provide a funnel into which these ideas could be fed.

32. If I had to sum up the objectives of the IWR in some simple phrases, they would be:

- make it safe;
- improve its quality;
- face the reality of workforce shortages;
- get good ideas from the workforce, or, in three words "pick their brains".

33. These initiatives require a major cultural and organisational shift. My predecessor as DG, Professor Stable, during his time as DG had established a high degree of discipline and professionalism in QH, which it lacked during earlier periods. This provided a platform to initiate the changes that I have outlined. In addition, Professor Stable had the vision to establish the Skills Development Centre as the most comprehensive skills development centre in Australia.

The role of Director-General

34. Attached and marked **'SMB14'** is a copy of the position description for the role of Director-General.

35. In my letter of application I set out clearly my strategic view of the challenges facing QH and my strategies to lead the organisation to respond to those challenges. Attached and marked **'SMB15'** is a copy of my letter dated 29 March 2004 to George O'Farrell, Acting Public Service Commissioner, applying for the position of Director General.

36. The role of the Director General set out in the position description does not involve the day-to-day management of patient care or complaints in each QH facility. This is because it is impractical for the Director-General to be involved at the micro level of the organisation given the size of QH and the range of services and complexity of issues to which QH responds. As a result, the Director-General is reliant on local and zonal management to run the day-to-day operation of health services. I also relied on the specialist units within QH to give me advice and to implement policies relating to issues that fell within that unit's expertise. The structure depends on local and zonal management and specialist units coming to me when issues arise that have an impact at the macro level, or are of sufficient seriousness that the DG should be apprised of them.

37. The key responsibilities of the Director General are:

(a) Providing advice to the Minister for Health. This advice is provided in a number of ways:

(i) Formal Submissions and Briefings.

(ii) Direct access to senior executive and their staff (without filter by myself) either by phone or in person.

(iii) Personal briefings and conversations with the Minister on a frequent basis (approximately three times/week with me).

(iv) Direct access by Ministerial staff to me personally as well as staff of my office.

(b) Providing assistance to the Minister and his staff:

(i) When Mr Nuttall was appointed as the Health Minister, QH increased its resources to the Minister's Office to assist in the rapid acquisition of information about QH by his staff by placing a senior officer with clinical knowledge inside the Minister's Office.

(ii) QH also had set up a secure website for Ministerial staff to view such things as performance against election commitments and centralised briefing/submission electronic mail box.

(iii) QH also had regular, structured weekly meetings with the Minister and the Minister's staff. The Minister, Mr Nuttall, decided to discontinue these meetings in early 2005.

(iv) QH also had meetings with the Minister and the Minister's staff, when requested.

(c) Setting strategic direction for QH and ensuring that direction is consistent with community needs and Government policy.

(d) Liaising with other public and private health provider organisations, Commonwealth and State government agencies and national bodies. For example, as DG I met regularly with representatives of the Australian Medical Association Queensland ("AMAQ"), the Queensland Nurses Union ("QNU") and medical specialist organisations such as the Australian Orthopaedics Association ("AOA") and the Royal Australasian College of Surgeons ("RACS"). At a national level, I was a member of the Australian Health Ministers Advisory Council and attended the Australian Health Ministers Council. I was Chair of the National Public Health Partnerships and a Board Member of the Limited Public Company which has been established to oversee the National eHealth agenda. At a State level I was a member of many Chief Executive Officer forums and Government Champion for the Yarrabah Community. This latter role I took most seriously as I remain passionate about and appalled at the morbidity and mortality of indigenous Queenslanders. I also had a close liaison with the Cape York Institute and Noel Pearson.

(e) Overseeing clinical and organisational governance. The Director-General is ultimately accountable for the management of the delivery of health services by QH.

38. Despite views to the contrary, QH is not averse to commissioning reviews which may expose system failings. Two recent examples have been the Review of Mental Health Sentinel Events and the Review of Birthing Services.

39. Last year I commissioned an external review of Fatal Mental Health Sentinel Events by Dr Michael Bolton. I received the report: *Report of the Queensland Review of Fatal Mental Health Sentinel Events* in 10 March 2005. The report is 158 pages long excluding references and annexures and I have not included a copy of it as an annexure to this statement. I received the report under cover of a letter dated 8 March 2005 (attached and marked **'SMB16'**). Whilst I was DG, I proposed that the Executive Summary of the report be released. I forwarded copies of the report to the Minister and to Linda Dawson, Acting SEDHS, to ask the Acting Director of Mental Health, Dr David Crompton, to provide me with advice in relation to actioning the recommendations. I received:

(a) A submission from the Mental Health Unit dated 21 March 2005. In my comments regarding that submission, I asked that a detailed project plan be resubmitted for approval by 1 June 2005.

(b) A submission from the Mental Health Unit dated 31 May 2005 setting out the project plan for the implementation of the key recommendations of the Sentinel Events Report. That submission was then discussed by the QH Board of Management on 10 June 2005.

(c) I wrote a letter to Dr Bolton asking him to facilitate the amalgamation of alcohol, tobacco and other drug services with mental health services.

40. The report by Dr Bolton is an example of QH commissioning an external review which was likely to be critical of QH and its clinical service delivery. The same is true of the external investigation commissioned by QH and undertaken by Dr Cherrell Hirst AO into birthing services throughout Queensland.

41. The volume of correspondence and paperwork that needs to be dealt with by the Office of the DG is substantial. I am informed that in the year 2004/2005 it totalled in excess of 3,000 items of registered correspondence, memoranda, submissions and the like. Additional documents were brought to my attention when people came into my office with documents to show me during the course of an oral briefing.

42. My daily routine as DG consisted, typically, of meetings with staff, the Minister, and major stakeholders including the AMAQ, Unions, Colleges such as the College of Surgeons. These rounds of meetings do not leave much time during the day to deal with paperwork. As a result, it was my practice to take

documents home and to do paperwork after hours. This consisted of reading reports, briefs, submissions and correspondence and dealing with emails.

43. I address the structure and size of the system in the next few sections of this statement.

44. Because of the duties that a DG must perform, and the structure and size of the system over which the DG has to oversee and provide strategic direction, it is imperative that most operational decisions are made by others in the system, for example by those with responsibilities at a hospital, district or zone level, or by the CHO in the case of certain investigations. As an example, I have explained in my first statement the role of the CHO in the investigation of Dr Patel prior to my involvement in the matter on 22 March 2005.

45. If the DG had to make or approve the decisions that are made by local and zonal managers or by specialist units, then the system would be unworkable. The DG would have difficulty is performing his or her duties, including advising the Minister, setting strategic direction and liaising with health provider organisations.

Past and present QH structures

46. I have worked under the following QH structures:

(a) Hospital Boards;

(b) Regional Health Authorities;

(c) Health Service Districts ('HSDs');

(d) Zones.

It would occupy an enormous amount of time and space in this statement to write about the features of these structures. The following few paragraphs do not purport to be a detailed or definitive account of how each structure operated. They are based on my experience in working under those structures.

47. Between 1976 and 1991, I worked at various times for the Mackay, Ipswich and Redcliffe Hospital Boards. There were enormous problems for clinical staff under the Board model. From a patient care perspective, the key problems were:

(a) Medical staff had little say in the running of the health service. Services could not be changed, staff could not be appointed or moved and equipment could not be purchased without approval from the manager or Central Office. Increases in staff occurred only once a year on application. The staffing allocation was not based on a team approach, for example, a sessional VMO might be appointed but with no increase in nursing or other staff.

(b) As Medical Superintendent, I was not allowed to see the budget and could not alter the medical or allied health workforce to respond to clinical needs or changes in workload.

(c) There was little strategic service planning for health services.

(d) Hospitals and community-based services such as mental, oral and child health services, were not integrated, which denied the patient continuity of care.

(e) There were no mechanisms for monitoring quality and safety.

(f) There was a lack of coordination between hospitals.

48. The Health Service Districts (HSDs) and District Health Councils were introduced in 1996. Around the same time, Funder, Purchaser, Provider Models were introduced and the Performance Management Unit was established. This was part of the philosophy of economic rationalism that has dominated health and other government services during the last decade. It has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community. The effect of these changes were:

(a) All 38 HSDs reported directly to the Deputy Director General Health Services.

(b) The District Health Councils were delegated certain Ministerial responsibilities.

(c) The HSDs gave medical practitioners a greater say in changes to the service profile of the HSD, purchase of equipment (for example CT scans), employment of medical staff and capital works (although major capital expenditure was determined centrally).

(d) There were no formal clinical networks so that transfers of patients between facilities remained largely based on individual practitioner's clinical relationships.

(e) One of the drawbacks to this model was that the Performance Management Unit and Funder Purchaser Provider Models created a focus on money and not patients.

49. Zones were established in 1999. From QH's records I understand that:

(a) Dr Peter Brennan of MA International Pty Ltd and Mr Ray Blight of Bankers Trust Australia were appointed in January 1999 to assist the Health Strategy Advisory Project in advising Cabinet on strategies to address current and future health issues in Queensland.

(b) On 15 June 1999 Cabinet endorsed various recommendations including a recommendation in the Brennan & Blight report for the creation of three Senior Managers at zonal level with a Northern, Central & Southern Zone with Corporate Office being responsible for policy.

50. Although I was not involved in the establishment of the Zones, I was the first Manager of the Southern Zone.

51. As a number of HSDs are within a Zone, Zones are able to fill the gap in the linkages between HSDs that were experienced under the Hospital Boards and Regional Health Authorities by creating formal clinical networks. Formal Clinical Services Networks allow for patients to be managed on a clinical escalation basis through different health services.

52. Formal Clinical Services Networks were set up in the Southern Zone while I was the Manager. They have also been set up in the Northern Zone.

53. The Zones are intended to play an important role in implementing the Service Capability Framework.

54. Both Clinical Services Networks and the Service Capability Framework play a significant role in improving patient care because they link the types of services which can be delivered at a certain facility with a network of clinicians who are aware of the capability of the referring facility. The Clinical Networks are based on clinician agreement about the types of services which can be provided in each facility or service and when and how a patient who needs greater expertise, technology or support services is to be managed or transferred.

The size of the system

55. QH provides a broad range of health services including acute hospital, outpatient specialist services, mental health, oral health, child health, women's health, pathology, radiology, cancer screening (including Breast Screen and the Pap Smear Register), sexual health, school-based programmes and respite care. In addition, QH provides other health related services including, for example, monitoring the use of restricted drugs, policing compliance with the new tobacco legislation and policing food safety.

56. I was provided by the Senior Executive Director of Resource Management, for the purposes of the 2005 Estimates Committee hearings, the following staff profile of QH:

    (a) 40% are nursing staff

    (b) 11% are allied health professionals (physiotherapists, occupational therapists, speech pathologists etc)

    (c) 8% are medical practitioners (medical staff and VMOs)

    (d) 19% are operational staff including wardspeople, catering staff and cleaners

    (e) 2% are technical staff (theatre technicians, respiratory technicians etc)

(f) 17% are District Clinical Support and Administration including medical records, ward clerks, clinic receptionists and administrative support

(g) 3% are Corporate Office staff.

Attached and marked '**SMB17**' is a graph of the staff profile.

57. One aspect of workforce reform that has been pursued in recent years is to relieve doctors, nurses and other providers of patient care of administrative tasks to free them up to provide care to patients by having administrative officers employed to attend to paperwork that the doctors, nurses and other providers of patient care would otherwise have to do.

58. As Mrs Edmond explained in her evidence, such an initiative actually increases the number of administrative staff that work in QH. In percentage terms, it reduces the overall percentage of the staff that are nursing staff, allied health professionals or medical practitioners. However, such an initiative is intended to assist those groups so that they can spend more of their time providing care to patients.

B. CHALLENGES FACING QUEENSLAND HEALTH

59. The challenges in providing adequate healthcare for Queenslanders in the future are set out in detail in '*Health 2020: A vision of the future*' (attached and marked '**SMB18**'). I wish to focus attention on some of them in this statement.

Decentralised State

60. The process of planning where to place health services and the appropriate level of each health service should be based on population, community health profile and influenced by the practical realities of workforce availability. The complicating factor in Queensland is the decentralised nature of our population spread. This requires duplication of infrastructure, other physical resources and human resources. This duplication imposes real challenges on service delivery and, more importantly, on safety and quality. As technology advances and the cost of providing technological infrastructure increases in investigative, diagnostic and treatment arenas, there needs to be greater investment for the same outcome in a less decentralised setting, or the same investment for a lesser outcome. In terms of human resources, two separate but inextricably linked forces are at play. Firstly QH provides services where the medical workforce does not live in sufficient numbers to have either the necessary skills or infrastructure or are of such small numbers that 24 hour coverage is arduous, unsustainable and unsafe. Secondly and more importantly, volume – or critical mass of patients – and quality of outcome are linked. To provide all services as close as possible to where people live will result in a poorer quality outcome.

61. In reality, decisions about service placement are often determined politically. There is a public and political expectation that the broadest range of services

be provided to the population as close as possible to where they live. For example, QH maintains hospitals at both Hervey Bay and Maryborough.

62. Queensland is the most decentralized state in mainland Australia. More than 48% of the population of Queensland resides outside of major cities. Attached and marked **'SMB19'** is statistical data from the Office of Economic Statistical Research and a summary compiled by QH from the "*2001 Census of Housing and Population: Comparison of Remoteness Areas for Selected Australian States*".

63. As a result of the decentralized nature of Queensland's population and public and political expectations, there is a:

    (a) Duplication of health service infrastructure. For example, there are tertiary hospitals in both Townsville and Cairns even though based on the population of North Queensland region, one tertiary facility would normally be adequate. However, because of the vast distances between places in North Queensland and the spread of population, there are two tertiary facilities to ensure that key services are readily available to the population.

    (b) Dilution of the medical workforce across the State. Among other things, the spread of health services over vast distances results in greater on-call loads for practitioners because the load cannot be shared between facilities.

64. The decentralized nature of QH's services should result in higher fixed costs. However, AIHW data released on 27 May 2005 demonstrates that QH has the lowest recurrent cost per casemix adjusted separation at $2,885 (compared to Victoria at $3,285) in the 02/03 financial year. In my view, this is because QH is efficient, has low administration costs and is significantly underfunded.

65. One strategy to reduce the impact of the decentralized nature of Queensland has been the establishment of Clinical Service Networks to support regional and rural centres. The Networks enable patients to be moved from basic care to tertiary hospital care if needed.

Preventable Illnesses

66. Queensland currently records more preventable deaths than any other state in Australia, largely as a result of poor exercise, high fat and sugar diets, and smoking. The majority of our preventable disease burden is in the more vulnerable groups within our communities. This evidence has been well known for decades. The public health message and preventative strategies have not assisted vulnerable groups. The health of these groups is due in part to other social factors such as education, employment, housing and community infrastructure. It is also due to the reality that many of these individuals are in "survival" mode and not "future-proofing" themselves. As a consequence, our preventative strategies and healthier lifestyle promotions largely have failed. QH needed a different approach based on recognisable "heroes" whose

message is more likely to be listened to than our traditional "longevity" message.

67. There are a number of health indicators on which Queensland does not perform well. Burden of disease data from AIHW shows that, in comparison to other Australian States and Territories, Queensland has:

(a) Higher death rates from heart disease, stroke, lung cancer (for males) and colorectal cancer.

(b) The highest suicide rate.

(c) The highest rate of skin cancer.

(d) The highest smoking and risky drinking rates for males.

(e) The highest rates of overweight and obesity.

68. Reliable information is required to make informed decisions about how to best address these problems, and to decide what initiatives in which areas will achieve the greatest possible gains in health. Information of this kind was published by QH in 2004 in a series of publications titled *Health Determinants Queensland 2004*. The information is intended to provide guidance to government, non-government agencies and the community. The main report was *Health Determinants Queensland 2004: Statistical Report*. Attached and marked **'SMB20'** is a summary document *Health Determinants Queensland 2004- At a glance*. In addition QH published *Health Determinants Queensland 2004* in the form of profiles on particular health service districts. By way of example, is the profile on the Logan-Beaudesert Health Service District. Attached and marked **'SMB21'** is a copy of that document.

69. I consider that information of the kind that was published in *Health Determinants Queensland 2004* is necessary to inform and elevate public discussion about priorities in health care. I publicly expressed the opinion during my time as DG that QH had a vested interest in preventing chronic disease. I made the point that, for example, in areas like Logan the major causes of death, at much higher rates than the national average, are smoking, heart disease and obesity. The information given to me indicated that an estimated 9,000 children are overweight or obese in the Logan area, while the rate of socio-economic disadvantage in the area is almost 30% compared with the state-wide average of 20%. Now attached marked **'SMB22'** is a copy of the edition of "Health Matters" for October 2004 in which I made these points.

70. I agree with the evidence recently given to the COI by Dr McNeil when he endorsed the urgency in having preventative strategies to try and decrease the incidence of coronary heart disease (T4751). As he remarked, "Unless we can prevent illnesses, specifically smoking and obesity, diet/lifestyle related illnesses ... we are going to be flooded".

71. Perhaps the greatest initiative taken during my time as DG to save lives and prevent future illness was the passage of anti-smoking legislation. Mr Nuttall

deserves credit for supporting this initiative through Cabinet. It is encouraging to read the evidence of an acute care specialist like Dr McNeil that he considers the recent legislation "is probably going to do a lot more good for the health of Queenslanders than a whole lot of other direct incentives" (T4751).

72. Anti-smoking initiatives are only one part of public health and reducing the incidence of preventable illness. Without a major focus on preventable illness, the public hospital system will be swamped.

Funding

73. With the advent of economic rationalism and since the introduction of Funder Purchaser and Provider Models in 1996, I believe there has been too great an emphasis within QH on meeting budget targets. Although accountability in the use of public money is a necessity (as required under the *Financial Administration and Audit Act 1977*), I believe that too great an emphasis on compliance with budget targets can stifle creativity and innovation. When I first commenced in the role of DG, I publicly expressed this view.

74. After becoming DG, I worked with Strategic Policy and Finance to develop a 5 year financial forecast to give certainty of funding for new services and to fully cost in the subsequent years the escalating impact of any new initiatives. These forecasts have been accepted by Treasury and were included in the latest Ministerial Portfolio Statement for the first time this year.

75. When I became DG, it was difficult to understand whether District budget overruns were due to growth pressures or management issues. Districts would carry their deficit into the following financial year. This had two significant effects. It reinforced the focus on budgets for District Management and it impeded the financial planning by QH in trying to understand the causes of budgetary difficulties.

76. In the 04/05 financial year I retired all District debt and funded the "growth in debt" that occurred during 03/04. This was to allow monitoring of District budgets to determine the cause of any pressures, to be able to address those issues in the 05/06 financial year and to better understand the true impact of growth pressures. I discuss this in more detail below.

77. The Productivity Commission's Report on Government Services 2005 records at page E8 that Queensland has the lowest recurrent health expenditure per capita of any State or Territory. The gap may be as high as $400 per person. For demonstration purposes only, assuming 4 million Queenslanders, the under-funding of the entire health system in Queensland could be as high as $1.6 billion.

78. Mr Forster's Queensland Health Systems Review Interim Report (page ix of Executive Summary) reveals public hospital expenditure is some 20 percent or $183 less per person than the Australian average. Again for demonstration purposes and assuming 4 million Queenslanders, this equates to $732 million recurrently just to bring our public hospital funding up to the national average.

Given the decentralisation of the State's public hospital services, the expenditure should arguably be greater than the national average.

79. The $732 million shortfall does not include funding for community based health services, aged care services and other non-acute hospital services, such as public health measures, health promotion and illness prevention.

80. In his Interim Report, Mr Forster further notes (page vii) "the recurrent budget has grown by an average of 7 percent per year since 1996/97 which broadly reflects the escalation of health costs and population growth over the same period". While this may imply funding is keeping pace with growth, it does not mean that the base funding in 1996/97 was adequate. If the 1996/97 base was inadequate, then a 7 percent compounding increase results in an increasing gap between what is required and the funding that is provided.

81. For demonstration purposes, if the base funding was assumed to be $3 billion and needed to be $3.5 billion in 1996/97, then a 7 percent compounding increase from 1996/97 to 2005/06 would result in the $3 billion becoming $5.51 billion and the $3.5 billion becoming $6.43 billion ie a difference of $920 million. This would also equate to $6.9 billion underfunding between 1996/97 and 2005/06.

Decisions about health funding and its allocation

82. In the next section I describe in general terms the process by which funding decisions about health are made by the State government. The State government has finite resources, and also is heavily dependent on Commonwealth Government funding to support State-supplied services like health. The State is also constrained by the conditions imposed on it by the Australian Health Care Agreement. The State Government has to make hard decisions about competing priorities across the whole of government.

83. Virtually the whole of the State budget could be consumed by spending on health alone. The purpose of this section is not to argue that any particular amount or percentage of the State budget should be spent on health. Instead, it sets out my understanding of the process by which decisions about health policy and funding priorities are made.

84. Budgets have traditionally been allocated annually, based on historical allocation, with additions for specific government programs or election commitments and some adjustment for growth but usually adjusted for budget overruns.

85. The budget review process for the 04/05 budget cycle was abnormal in the sense that it was affected by the State election in February 2004. In any event, I only became Acting DG part way through the budget cycle and became DG after it had been completed. Therefore, my first involvement as DG in the budget review process was for the 05/06 budget cycle. It was also the first time that I had stewardship of the process within QH.

86. My understanding and recollection of the budget review process is as follows:

(a) In about October, Treasury advises departments that they are moving into the budget cycle and advise of the timetable for putting forward budget proposals.

(b) Finance staff in QH first put together a submission of all of the known issues that will arise in the following financial year. For example, in the last budget, the fact that a new enterprise bargaining agreement was going to take place in the 05/06 financial year was costed and put into the submission.

(c) The next internal process was to deal with emerging pressures that would require QH to actually bid to CBRC for extra funding to respond to those pressures. My understanding, albeit limited, was that in the past this was not a comprehensive formal process. I initiated a formal internal process for the 05/06 budget cycle whereby I put a call out to all of the QH directorates asking them to consult widely in their directorate and collate all of the budget pressures and issues that their directorates would be facing in the next five years. I felt that we needed to have a better understanding of all of the needs across Health to know what submissions should be made to CBRC. The directorates collated this information and each put a submission to QH's finance committee which refined the issues and requested more information. The result of that process was then put to the QH Board of Management which again requested more information and settled on a range of packages. The agreed range of packages was then sent to the Minister who could add to, delete or alter before signing off on it.

(d) The next step in the process was that QH sent the agreed range of packages in the form of "short forms" which essentially set out each issue/ package on one page. Treasury considered the funding requests from a financial perspective and, as I understand it, consulted with members of CBRC about the political priority of the funding that had been requested. Treasury then sent back to QH a list of what issues CBRC would consider - this list being significantly smaller than the list put forward by QH as to the funding needed.

(e) QH then worked on the reduced list of packages as requested by Treasury/ CBRC. This formed the Cabinet Submission which was signed off by the Minister prior to formally being sent to CBRC.

(f) I, along with a Senior Executive Director, Ms Anne Turner, and the Minister, then attended the CBRC meeting where we effectively had half an hour to "pitch" to CBRC why QH needed the additional funding.

(g) CBRC then provided formal notification of its decision about the additional funding and packages approved. The notification typically includes a spreadsheet of the packages approved and the amount approved for each package. It might also advise of any areas in which the department had to make savings for the following financial year.

The notification would be sent under a covering letter and usually contained very little reasoning behind the decisions that it conveyed.

87. As a result of undertaking the 05/06 budget review process, I became aware that QH had limited ultimate say in obtaining funding for emerging needs, the amount of that funding and where that funding should go.

88. There may be requests for additional funding that occur outside the budget cycle process, such as the VMO pay negotiations. I do not have access to those documents to be able to provide them to the Commission, as they would have been submitted to CBRC.

89. Election promises fall outside the budget review process that I have just outlined above. They have not usually been fully modelled, and the cost of delivery in the subsequent years usually exceeds what has been allocated. I completely accept that a key priority of any government is to honour election commitments. The only point that I seek to make is that some commitments do not necessarily deliver the best health outcomes in an environment in which public funding of health can never be enough to keep up with demand. For example, it may not be the best policy or the most sensible allocation of limited resources to establish a new facility in a specific location, and the significant capital and recurrent cost of doing so may be better allocated to upgrading and operating an existing facility at a nearby centre. But if an election commitment is made to establish the new facility, then the obligation to honour election promises means that the new facility will be established.

90. Attached and marked **'SMB23'** are copies of the State Government's 2004 election commitments with respect to health.

91. Government policy plays a significant role in determining the allocation of QH resources. This is evident in the election commitments and the locations at which they are to be delivered. The allocation of funds is often determined by a policy which has not been developed or costed by the Department. This means that many of the funds are "tied". This may be a source of frustration to clinicians and others. But it is the political reality of election commitments influencing service delivery. Another example is the frustration expressed by senior medical staff over travel entitlements. QH Policy is consistent with government policy and in the case of overseas travel the policy is determined by the Premier's Department.

92. Further examples of the influence of government policy include, but are not limited to, the VMO's Agreement and Enterprise Bargaining. There is a widely held belief that conditions of service, salaries and wages are determined by the DG. There is little understanding, if any, of the political processes required to be satisfied. Industrial matters must be agreed by the Departments of Industrial Relations, Premiers and Cabinet, Health and Treasury. The matters then are considered by the Cabinet Budget Review Committee. The DG's role is to implement the decision and negotiate within the parameters defined by CBRC or Cabinet. The general health workforce and the VMOs in particular tend to blame the DG and senior staff for any

outcome or for not advocating on their behalf. But the ultimate decision on whether a proposal advanced by QH will be accepted lies with the Cabinet.

93. The Cabinet process in relation to proposals that involve funding requires consensus prior to final submission. Frequently this is consensus with the Department of Premiers and Cabinet and/or Treasury. The original position of QH may not be reflected in the final submission or QH's priorities may be altered. The final submission from QH may not reflect the policy position and priorities that QH would wish to advance because QH has received an earlier indication during the budget process of the type of proposals that will be favourably considered and those that will not. This makes proper policy development and debate, especially those related to the challenges facing health, very difficult.

94. In the end result, the government's preferred position, rather than QH's policy advice and priorities, may be already incorporated at the point of information or submission generation by QH. It makes no point to bid for funding for a project or service which QH already knows will not be supported. Indications about which bids will find favour shape QH's submissions.

Funding of public hospitals

95. When I became Director-General, I took a number of steps to address the problems associated with the funding of public hospitals and health in general. I have briefly referred to some of them above.

96. One of the problems as I saw it with the funding of districts, and therefore public hospitals, was that debt from one financial year was carried over to the next financial year for each district. The effect of this meant that a district which had spent more than their budget in one financial year had less to spend in subsequent financial years. From my perspective, this meant that it was difficult to determine the true picture of the financial needs of a particular district and whether or not the financial pressures on a district were caused by a population growth and therefore an increased demand in health services or by poor management by the district. If we had that knowledge, I felt it would have been easier to make a case for more funding for those districts which had experienced significant growth in population and demand.

97. As a result, I caused all historic debt for each district to be wiped from 1 July 2004. I also caused all growth in debt that occurred during the 03/04 financial year to be funded. What I mean by this is that if the net debt of a district increased during the 03/04 financial year, the district would be funded an additional amount equivalent to that growth. For example, if a district had a net debt of $5m at 30 June 2004 and that debt had increased from $3m from the previous financial year (that is, an increase of $2m in the 03/04 financial year), the district's debt of $5m was retired as at 30 June 2004 and the district was funded an additional $2m. This was to ensure that all districts would commence the financial year on an equal basis.

98. Queensland Health should now be in a position to implement the second phase of this process which is to assess the 04/05 financial year for each district and

identify the true financial needs of each district and make a case for additional funding for particular districts in the next budget cycle. I strongly believe this process should continue so that health funding, and public hospital funding, is granted in accordance with current need as opposed to historical need.

99. I agree with the general proposition about which I have been asked by Counsel Assisting to comment, that there is an inadequacy of beds in tertiary hospitals. It is probable that across Australia, health services planning has under-estimated the number of beds that would be required in the future. This is particularly true for the North side of Brisbane and I will use this an example of the process and the steps that have been taken.

100. In or around 2004, the Central Zone commissioned a planning study by Phillipa Milne as to the adequacy and future need of hospital beds in North Brisbane. This was completed in about September 2004. At about the same time as this report was completed the government announced increased bed numbers for the Prince Charles Hospital. Where a report identifies a shortage of beds, the next steps that would ordinarily have been taken would be to review whether some hospitals in the region had a surplus of existing, but unopened, beds and an application would have to be made to CBRC as part of the budget process for the funding to open those surplus beds. If that would not meet the need, the capacity of the private sector in both the short and long term would need to be reviewed and QH could consider purchasing, with CBRC's approval, services from the private sector. If there was a need to build additional beds in public hospitals, QH would have to make a submission to CBRC for capital funding to build those beds and recurrent funding to open and use those beds. I understand that the usual process was not required following the Milne report because of the government announcement.

Medical workforce changes

101. There have been a number of changes in the medical workforce over the last 15 or more years that have impacted significantly on QH:

(a) Shortage of Australian trained medical practitioners:

(i) By the time I became GMHS and then DG, the shortage of Australian trained medical practitioners and specialist training places in Queensland was a well accepted fact.

(ii) Future planning for numbers of Commonwealth funded medical school places and specialist training positions in Queensland is largely done at a national level. The States and Territories participate in the planning process through the Australian Health Ministers Advisory Council ("AHMAC"), which is a consensus forum. As such, all decisions of that body must be unanimous.

(iii) Most medical practitioners who train in Queensland go on to practice in Queensland.

(iv) The number of Commonwealth funded medical places in Queensland universities remained unchanged at 232 between 1997 and 2002. As a result of the growing population in Queensland and other changes in the medical workforce, the number of medical practitioners in proportion to the population of Queensland has declined:

A. From 1997 to 2002 the number of medical practitioners in Queensland only increased 1.75% in comparison to an average increase nationally over the same period of 12%. In 1997 there were 8,024 medical practitioners in Queensland and in 2002 there were 8,159.

B. In 2002, Queensland had the lowest number of registered doctors per head of population of any State or Territory. Between 1997 and 2002, the number of medical practitioners decreased from 236 per 100,000 people to 220 in 2002. In contrast, there was an increase from 260 to 275 per 100,000 nationally. By 2002, Queensland had 55 medical practitioners per 100,000 people less than the national average. In 2003, Queensland had 236 full time equivalent practitioners per 100,000 population. This is 62 per 100,000 less than Victoria or 620 less per million people. Assuming a Queensland population of 4 million people, this equates to 2480 doctors less for the same population in Victoria which does not have the rural, remote, indigenous or decentralised difficulties experienced in Queensland. In hours worked there is 5.8 million hours less practitioner time per year in Queensland than Victoria for the same population. Between 2000 and 2003, the number of full time equivalent primary care practitioners actually fell from 90 to 86 per 100,000 population. This is 190 per million less than Victoria.

C. Attached and marked **'SMB24'** is a copy of the recently released geographic comparisons between states and territories of medical practitioners, which was compiled by the Australian Institute of Health and Welfare.

(v) There is also a shortage of medical practitioners in other Australian states and internationally. There is a reported shortage of 200,000 doctors in Europe and the USA.

(vi) The shortage of Australian trained doctors has made it particularly difficult to recruit medical practitioners to rural and regional areas.

(vii) The shortage of Australian trained medical practitioners has led to a reliance by QH on Overseas Trained Doctors (OTDs) who are also referred to in various documents as International

Medical Graduates (IMGs). Because the term Overseas-Trained is used in the Commission's Terms of Reference I have referred to them in this statement as OTDs. Attached and marked **'SMB25'** are copies of tables setting out a breakdown of OTDs and non-OTD medical staff per QH health zone and facility for the pay period 14 to 27 March 2005.

(viii) During the period I was a District Manager and Medical Superintendent, the OTDs that were recruited were primarily from the United Kingdom, South Africa and Ireland, which are countries with medical training standards comparable to Australia.

(ix) In recent years there has also been a shortage of medical practitioners worldwide. Attached and marked **'SMB26'** is a copy of an article from the BBC News website dated 15 March 2005 regarding the number of foreign doctors practicing in the United Kingdom, which raised important moral issues about the increasing use by the UK of medical practitioners drawn from developing countries in Africa.

(b) Change in the position of medical practitioners in the public system

(i) At one time VMOs were honoraries who provided health services to public hospitals for free.

(ii) In the 1970s when I trained to become a medical practitioner, there were few full time specialists. At that time, the availability of a surgeon determined when and where they would perform surgery. Medicine has become more complex so that today the availability of the anaesthetist and other support staff will impact upon when and where surgery can be performed.

(iii) The expectations of governments and patients have also changed the way in which health services are run and surgery is prioritised. For example, elective surgery classifications and priorities have been introduced nationally to base access and treatment on clinical priority rather than to just meet government election commitments. In addition, as stated above, there is an expectation by the public that a broad range of services will be delivered as close as possible to where the population resides.

(iv) Remuneration for medical practitioners is now determined by enterprise bargaining agreements.

(c) Changing expectations of the workforce

(i) Many medical practitioners now want more of a work/life balance.

(ii) There has been a drop in the number of hours medical practitioners will work within the system. The number of hours worked by medical practitioners in Queensland has fallen from 46.6 hours per week in 1997 to 40.8 hours in 2002.

(iii) One of the most important matters in attracting medical staff is ensuring there is a critical mass of medical practitioners in a health service. This critical mass is not just related to the raw number of doctors available. It also requires evaluation of the skills available, the subspecialisation eg gastroenterologist cf general physician, the number of hours available to work, whether the doctor is resident in the community and distance/time from the facility for recall purposes. This enables workloads, particularly on-call loads, to be determined and appropriately shared where possible.

(d) Increased specialisation of the medical workforce.

(i) There has been an increasing tendency for the medical workforce to sub-specialise. Originally, the majority of specialists in regional Queensland in particular were generalists or GP specialists. Over time and with increasing complexity of knowledge, skills and care, this has changed with dramatic impact on service costs and delivery. For example, a general surgeon would cover procedures as diverse as acute neurosurgery, urology, abdominal surgery, varicose veins and ingrown toenails as well as trauma management. Today we have sub-specialists in all these areas.

(ii) The impact is not just on the specialists themselves and how they can be supported after hours. The greater impact on public health services has been in the area of training. Where once a surgical trainee might cover disciplines such as orthopaedics, trauma, urology, vascular and general, they are now only "allowed" by their supervising college to cover one sub-speciality eg vascular or urology but not general or general but not orthopaedics. This has resulted in significant duplication of effort and cost borne by the public hospital system for no greater throughput of patients. It also results in difficult rostering coverage for such small groups of individuals. This leads to the constant tension between the employer and the Colleges over the number of "training posts".

(iii) Nursing and allied health professions likewise are following the medical model into sub-specialisation of work.

(iv) Few of these training costs are borne by the private sector yet it receives a substantial part of the benefit of the training.

102. I have been asked by Counsel Assisting to address what steps were taken during my term as DG to address medical workforce shortages, and whether I can recommend any further steps that would address this issue.

103. Steps taken to address the issue of workforce changes included:

(a) Commonwealth funding has been provided for further university medical training places at:

(i) Griffith University Medical School - 70 graduates. The first set of graduates are scheduled to complete their degrees this year.

(ii) Bond University – 65 graduates. The first set of graduates are scheduled to complete their degrees in 2009.

(iii) James Cook University - 63 graduates. The first set of graduates are scheduled to complete their degrees in 2006.

(b) The Queensland Government has recently announced that QH will fund 35 undergraduate medical places at Griffith University in 2006 and 50 in each of the four years after that. This is groundbreaking action for the public and university sectors. The intention is to plan from the very start of selection for training as a doctor, a pathway to specialist recognition in rural and remote practice. It will stop the constant bickering about who is responsible for what and allow the State to influence the type of curricula and the work readiness of graduates. As part of the scholarship agreements with each of the students, the students will be required to work for QH for 10 years following their graduation. This will enable QH to direct them to work in areas where there is the greatest need. Attached and marked **'SMB27'** is a copy of the press release from the Premier dated 1 July 2005.

(c) QH has entered an agreement with the Royal Australasian College of Surgeons to train specialists in some private hospitals. Attached and marked **'SMB28'** is a copy of the agreement between QH and the Royal Australasian College of Surgeons. The Productivity Commission has recently commended this agreement on page 19 of its Issues Paper on the study commissioned by the Commonwealth Government into the Health Workforce released on 3 June 2005. Attached and marked **'SMB29'** is a copy of page 19 of the Productivity Commission's Issues Paper on the Health Workforce study.

(d) Creation of the IWR Directorate. The reality of the workforce crisis facing health is still not well appreciated by media observers and health commentators – particularly as it relates to Queensland. The way forward requires better informed and resourced recruitment and retention strategies, redefined roles, skills and training and reshaping of the workforce to better match the community need and the skills

required. This must be done in a safe and quality guaranteed environment. The IWR Directorate was established for this role.

104. In terms of what future steps I would recommend, I believe that the IWR directorate needs time and funding to progress its work as it is best placed to assess the situation. As discussed, essentially what needs to occur to address the medical workforce shortage is that we need to define what services QH will need to provide in the future, we need to assess what skills and competencies are required to deliver those services, we need to assess which of our current staff have those skills and competencies, we need to identify who of our current staff we can better utilise and train them up and then we need to assess what is the ultimate gap between what the future health needs are and what capacity exists after all current staff are trained. This is the role of IWR to conduct this process and come up with innovative ways to address the gap. This role of IWR has already led to QH buying more training places at Griffith University and has raised the prospect of Nurse Practitioners. There is much more that needs to be done.

105. I believe that another major step that should be taken to address the workforce shortage is that additional funding be given to QH so that it can improve salary and other working conditions of medical staff so that Queensland can become competitive at the national and international stage. QH attempted to do this during my time as DG. I attempted to do this recently by approving and submitting to CBRC an increase in the award for VMO's. Dr Scott had the conduct of negotiations on behalf of QH with the VMOs. Unfortunately the required funding was not forthcoming, and therefore no agreement was able to be reached during my time as DG.

Safety and Quality

106. Safety and quality issues have always been prevalent in both the clinical and administrative roles I have held. Like all humans, medical practitioners are prone to error.

107. The 1995 report by Wilson RM, Runciman WB and Gibberd RW, *"The Quality in Australian Health Care Study"*, found that about 16% of hospital admissions in Australia were associated with an adverse event, many of which were preventable. This report was the impetus for people within health care to recognise the extent to which safety and quality was an issue. The report also resulted in the Commonwealth investing in a safety and quality agenda in the late 1990's.

108. Both as a doctor working in the hospital system and as a medical administrator, the fundamental rule is to "Do No Harm". That rule was borne out in the 1995 report.

109. Attached and marked **'SMB30'** are copies of:

(a) An article from the Medical Journal of Australia by Thomas Faunce and Stephen Bolsin titled *"Three Australian whistleblowing sagas: lessons for internal and external regulation"*.

(b) An article from Clinical Governance: An International Journal by Jeffrey Braithwaite et al titled *"How important are quality and safety for clinical managers? Evidence from triangulated studies"*.

110. From a safety and quality perspective, the issue of the vetting of OTDs is critical. However, I do not think the discussion of safety and quality can be limited to only OTDs. The real issue is creating a safe system and individual performance evaluation regardless of where medical practitioners are trained.

111. Any discussion of OTDs should not be limited to the public sector because there are also significant numbers of OTDs in the private sector. Attached and marked **'SMB31'** is a table compiled from QH records setting out the numbers of OTDs scheduled to commence in the private and public sectors between 1 October 2003 and 30 September 2004, their sponsor organisation and type of position. The issue of overseas trained doctors can be addressed if the solution applies to all doctors. Therefore developing parallel systems of recruitment assessment, training and performance for Australian trained and overseas doctors will lead to a duplication of effort and a waste of resources.

112. Healthcare systems throughout Australia and the rest of the world encounter similar safety and quality issues as Queensland.

113. There are a number of problems with monitoring clinical performance of medical practitioners:

(a) I received advice, including from Professor Bruce Barraclough, that if you try to mandate the recording and review of performance by individual clinicians, it actually will lead to non-compliance and that individuals will not engage unless the review process is privileged. However my concern has always been that practitioners who most need to be monitored will not comply if it is voluntary. An example is the surgical audit issues in Western Australia. Attached and marked **'SMB32'** is a copy of the Weekend Australian article by Andrea Mayes titled *"Surgeon who lost 48 patients can't be named"*.

(b) It is very difficult to actually monitor individual performance and outcomes and there do not appear to be many good consistently applied national or international criteria or parameters that allow this to happen.

114. Traditionally, the health system values the independence and skill of individual medical practitioners. Medical practitioners are trained to value their autonomy and judgment, and are expected to stand alone in the decision making process. This is particularly the case in general and specialist practice where there is not much consultation with other health providers. Bernheim once said 'that managing doctors is like herding cats'. The training provided to doctors runs counter to the requirements for multi-disciplinary behaviour and accountability that is central to safety and quality.

115. Both systems and individuals are accountable for the quality and safety of health care provided within a health service.

116. There has not been a systematic approach to embedding safety in the health system. In contrast, the airline industry has developed a systematic approach to safety. Whether a person is a senior or junior pilot, the hours of work are set, the set of behaviours and the training mandated are the same. As reported in '*The Australian*' on 20 August 2005, the AHMC has reviewed the Australian Council on Safety and Quality and found that "it was asserted by many that there is little evidence that Australia has made any measurable progress in improving safety and quality since the 1995 Quality in Australian Health Care Study." Attached and marked **'SMB33** is a copy of the article.

117. Currently, safety systems in QH are reliant on peer review of reported incidents. The problems with peer review are that:

(a) Junior doctors and nurses may not feel confident to raise concerns with or against a senior doctor.

(b) It is retrospective.

(c) The incidents that are reported are generally only the serious ones.

118. The culture of safety focuses on identifying and rectifying problems and not on blaming individuals. This is because if the focus is on identifying who is to blame, people will be less likely to admit to or report errors. Safety is about encouraging people to come forward and admit their mistakes.

119. Health is a highly specialised field that involves high risks and the only way to address those risks is with systematic risk management strategies. Those strategies need to be embedded in the day-to-day behaviours of clinicians.

120. The service capability of a particular facility and the clinical privileges given to medical practitioners are also significant safety and quality issues. For example, while I was Southern Zone Manager, concerns were brought to my attention about the infrastructure available to support the newly set up Redlands Hospital birthing service. At that time, the Redlands Hospital had no Blood Bank or staff properly trained in neo-natal resuscitation of newborns which meant they did not have the capacity to deal with a birthing emergency quickly. The concerns were raised with me by a nurse manager who had come in off leave to meet with me during an informal tour of the Hospital. As a consequence, I arranged for Dr Frank Fiumara to do a review of the Redlands Hospital birthing service. As a result of his review, Dr David Tudehope from the Mater was engaged to run neo-natal resuscitation courses for the doctors and the Pathology service at the hospital was upgraded. This infrastructure was put in place to ensure the birthing service was safe.

121. The safety and quality agenda nationally was largely project-orientated rather than outcome focussed. In effect, this meant that various issues related to safety and good outcomes were addressed but the issue of how to change the behaviour of clinical staff and embed safe and quality practices at an

organisational level was not addressed. In my opinion, the focus on organisational and clinical staff behaviour change should have been given greater importance.

122. At the time I became GMHS, the Organisational Development Unit of QH had developed a range of strategies to address safety and quality but a number had not yet been implemented. In late 2002, I commissioned Dr Frank Fiumara and Dr Suzanne Huxley to do an internal review of the Quality Improvement and Enhancement Program to examine which projects were worth continuing. One of the reasons I asked for the review to be conducted was that the Health Care Agreement between QH and the Commonwealth was up for review and QH needed to identify what needed to be done better than had been done in the past.

123. Dr Fiumara and Dr Huxley provided me with a report *"Quality Improvement and Enhancement Program Review"* dated April 2003 (attached and marked **'SMB34'**).

124. The *"Quality Improvement and Enhancement Program Review"* report found, among other things:

(a) The Project Managers of quality and safety projects were acting in semi-isolation and that a more coordinated and integrated approach needed to be adopted. They recommended a Quality Unit should be created.

(b) Quality projects needed to be implemented across QH through a quality management framework.

(c) 15 of the 23 projects should continue.

125. I adopted these recommendations and took steps to implement them. This report informed the basis for my establishment of the IWR Directorate and a more focussed approach to patient safety and furthering the Collaboratives under the guidance of Professor Michael Ward.

126. After becoming Director-General, the steps I took to embed safety and quality mechanisms at an organisational level and change the behaviour of clinical staff included:

(a) creating the IWR to move Safety and Quality into implementation;

(b) creating the Patient Safety Centre;

(c) expanding Clinical Collaboratives through the Clinical Practice Improvement Centre;

(d) introducing on 1 July 2004 a sentinel events policy co-ordinated by the Patient Safety Centre;

(e) expanding the role of the Skills Development Centre to include OTDs;

(f) introducing the Clinical Service Capability framework in mid-2004 which attempts to address quality issues by specifying:

(i) the level of clinical services that can be provided by a particular facility;

(ii) the infrastructure necessary to run a particular type of service.

127. Guidelines for reviewing practitioners to determine their medical credentials and granting them clinical privileges were introduced by QH about 10 years ago. While I was a District Manager and Medical Superintendent, I was responsible for implementing the policy within my HSD/Regional Health Authority. Also:

(a) While I was Southern Zone Manager, I implemented a Statewide Credentials and Clinical Privileges Program to improve consistency in the application of QH's Credentials and Privileges Policy. The responsibility as sponsor of the project was given to me by Dr John Youngman, then GMHS. My role was to supervise the Project Managers actioning the project. Attached and marked **'SMB35'** are copies of memorandums I sent to District Managers and Medical Superintendents regarding the Credentials and Clinical Privileges Program dated 18 September 2000 and 6 November 2000.

(b) While I was GMHS, I approved the QH *Credentials and Clinical Privileges: Guidelines for Medical Practitioners, July 2002* which was developed as a result of the Credentials and Clinical Privileges Program. Attached and marked **'SMB36'** is a copy of a memorandum I sent to all District Managers and Medical Superintendents dated 13 September 2002 enclosing the *Credentials and Clinical Privileges: Guidelines for Medical Practitioners, July 2002.* The Policy Statement (Policy No. 15801) is also part of 'SMB36'.

128. As I stated in paragraphs 26-27 of this statement, one of the most significant developments during my period as DG was the adoption of a new Open Disclosure Standard. It sets out a process for more consistent and effective communication following adverse events to patients, professionals and staff. It encourages clinician accountability and aims to minimise the risk of recurrence. It marks a significant cultural shift in the culture of QH and has major long term benefits for patient care.

Workloads of Clinicians and Patient Safety

129. The workloads of doctors in both the public and private sector are well known to all. I believe that a response to the issue must be taken from a standards perspective as opposed to an industrial perspective. For example, by analogy, pilots cannot fly for more than a specified number of hours. Taking an industrial approach will not solve the issue as doctors in the private and public sectors fall under different industrial instruments and often work in both sectors. As a result, I believe that there should be a regulation of hours that

applies to the public and private sectors and is imposed by the Medical Board of Queensland as a standard.

130. On or around 8 March 2005, I spoke with Mr Jim O'Dempsey of the Health Practitioners Registration Board and expressed this view. I followed this up with a letter to the Board and advised that I would be prepared to contribute funding to employ a project officer to undertaken whatever work may be necessary. The Board accepted this offer. A Ministerial Briefing was prepared. Attached and marked **'SMB37'** are copies of:

(a) my letter to the Board dated 9 March 2005;

(b) the Board's letter in response dated 23 March 2005;

(c) Ministerial Briefing and attachments thereto, which were noted by the Minister on 5 April 2005.

131. I am optimistic that this review by the Medical Board of Queensland will go a significant way to address the issue of workloads for clinicians, and thereby enhance the safety and quality of patient care.

Skills Development Centre

132. In late 2002, Cabinet approved the establishment of a Queensland Health Skills Development Centre ("SDC"). The planning processes for the SDC were conducted during 2002 and 2003 with additions to its role still taking place. The SDC was opened in September 2004.

133. The purpose of the SDC was and is to provide a world class training centre for Queensland's health professionals with communication skills laboratories, clinical skills laboratories and electronic technologies that allow support to be given to doctors and health professionals in rural and regional areas. Even in its planning phase it was recognised that the SDC would play an important role in the assessment and training of overseas trained doctors. See attached and marked **'SMB38'** which is the detailed proposal for the SDC dated 23 July 2002. Also attached and marked **'SMB39'** is a copy of the SDC brochure which gives a summary of the services provided by the SDC. The Commission will note that the Centre for International Medical Graduates forms part of the SDC.

134. The business plan for the SDC for the financial year 2004/5 sets out the objectives for the SDC for that year (see attached and marked **'SMB40'**). I note that the front page refers to the 05/06 financial year but the balance of the document relates to 04/05. Many of the objectives related to the opening of the centre and formalisation of policies that would allow the centre to operate. I draw the Commission's attention in particular to objective 6 of the 2004/5 plan which articulates the SDC's goal to secure new project funding to establish improved recruitment, assessment and placement processes for OTD's. This plan was named the "RAPTS" (for Recruitment, Assessment, Placement, Training and Support) Program. Work on implementing this program commenced in or about November 2004. Attached and marked

'SMB41' is a copy of the RAPTS Program initial plan which I understand was approved in November 2004.

Safety and Quality issues in relation to OTDs

135. Problems in relation to safety and quality associated with OTDs is one aspect of larger challenges confronting safety and quality in an under-funded health system in a decentralised State like Queensland.

136. As I have outlined above, there is a shortage of a trained medical workforce, particularly Australian trained medical practitioners, to provide a critical mass to adequately service the number of HSDs, particularly HSDs in regional Queensland.

137. The amount which QH can pay its employees and VMOs is not determined by QH, but is the subject of directives by the Cabinet Budget Review Committee and the Minister for Industrial Relations. Ultimately it depends on the amount of public funding that is available for the health system as a whole and decisions about the allocation of funding.

138. As Mrs Edmond explained in her evidence to the former COI (T5054, T4943 to T4950) QH did not seek to employ OTDs in preference to Australian trained graduates. Mrs Edmond personally made known her strong views about the moral issues involved in recruiting OTDs from countries where there was a great need for their services. It was the shortage of Australian trained medical practitioners and demands on the system that led to greater reliance on OTDs. During a time when QH was not able to pay its highly trained medical staff enough to stop a drain of staff from the public system (a point made by Dr McNeil in Ex 300 para 28, and at T4748) QH, like many other health systems, came to rely on OTDs to overcome workforce shortages.

139. These workforce shortages would not have been so severe had there not been a cap on the number of Commonwealth funded medical places in Queensland universities between 1997 and 2002.

140. The initial briefing to the incoming Minister, Mr Nuttall (Ex 319, Attachment 4) stated:

> *"Employment of overseas trained doctors provides a short-term solution to doctor shortages. However, this approach brings with it a range of skill and competence issues."*

The briefing in relation to OTDs continued:

> *"Overseas trained doctors: Queensland Health has a high reliance on overseas trained doctors (OTDs) with approximately 30 percent of the Queensland Health's medical workforce being overseas trained. Due to the increasing competition in the international medical labour market, many overseas doctors recruited under various arrangements have difficulty with English language and cultural assimilation.*

Queensland Health will fund and manage the Centre for Overseas Trained Doctors from July 2004, to facilitate the processes of screening, recruiting and preparing OTDs for employment in Queensland Health Public Hospitals."

141. QH became aware in 2003 that the Centre for Overseas Trained Doctors ("COTD") had lost its Commonwealth funding. The primary role of the COTD was to help OTDs who were Australian residents to prepare for their AMC exams. The COTD had been operated by the University of Queensland and funded partly by QH ($108,000 per annum), partly by the Commonwealth government and partly by fees charged by the Centre.

142. In early 2003, the University of Queensland put in a submission to QH for additional funding to cover the funding withdrawn by the Commonwealth to keep the COTD open and also to expand the services to be provided by the COTD.

143. During 2003, the SDC's board recognised that the SDC could play an important role in the training and assessment of overseas trained doctors. See attached and marked **'SMB42'**. A decision was made at some point during 2003 that the COTD should be integrated into the SDC. The SDC would hold world class facilities in which the communication and clinical skills and competency of overseas trained doctors could be assessed at no risk to patients. Attached and marked **'SMB43'** is a copy of a submission to Dr John Scott, then Acting GMHS, in which funding of $108,000 for 3 years and the relocation of the COTD to the SDC was approved on 2 December 2003.

144. At no time did QH's funding to the COTD decrease during 2003 or otherwise. I understand from the documents provided to me that QH provided the usual annual funding of $108,000 and an additional one-off payment of $118,000 during 2003, the latter to cover some of the shortfall caused by the loss of Commonwealth funding. Attached and marked **'SMB44'** and **'SMB45'** are copies of submissions which demonstrate the funding provided. I recall that, until it was formally announced that the COTD would be taken over by QH, there may have been some concern by the Centre that the loss of Commonwealth funding meant that it may have had to cease operating even with the annual funding and one-off funding provided by QH mentioned above. This obviously did not eventuate and the Centre continues to be a part of the SDC and it is currently named the Centre for International Medical Graduates.

145. At roughly the same time during 2003 when the role of the SDC was being formulated, QH was participating in a joint OTD/TRD committee with other stakeholders (TRD being temporary resident doctor as opposed to Australian resident OTD). Dr Mick Catchpole, the Principal Medical Adviser (PMA), was QH's representative on this committee. I recall that Dr Denis Lennox also participated on this committee at times when he was Acting PMA. Attached and marked **'SMB46'**, **'SMB47'**, **'SMB48**, **'SMB49'**, **SMB50'** and **'SMB51'** are copies of some correspondence, in chronological order, signed by me or addressed to me in relation to the commencement and membership of this

working group and issues they were addressing. I would forward all correspondence to Dr Catchpole for his action.

146. During 2003, I received consecutive submissions about making changes to QH's recruitment process for OTD's from the PMA and his team. I understand they arose out of the PMA's consideration of these issues at the committee meetings. Attached and marked **'SMB52'**, **'SMB53'** and **'SMB54'** are three submissions to me on this topic. I do not know if I actually saw the second submission marked **'SMB53'** as it does not contain my signature or any written comment by me. However, I understand that the final submission was approved by Dr Lennox before coming to me and it contained as an option the proposal raised in the second submission. I do recall having a meeting with Dr Lennox and possibly Sue Norrie where they white-boarded the concept.

147. I raised the options contained in the final submission at a weekly Zonal Managers' meeting in or about mid August 2003. The Zonal Managers were concerned that the requirement that the Commonwealth and the MBQ be involved in the recruitment process would make it non-competitive with those of other States. We agreed the MBQ's involvement in the appointment process through its obligations under section 135(2) of the *Medical Practitioners Registration Act* should be an adequate check that practitioners were being appointed to positions they had the skills to undertake. The Zonal Managers decided they would prefer, out of the options provided for in the submission, a panel of recruitment agencies to be selected through a panel arrangement. The handwritten comments of the Southern Zone Manager, Karen Roach, are on the reverse side of the first page of the briefing. It reflects the recommendations made by the Zonal Managers. I accepted the decision of the Zonal Managers for the subsequent year as they represented the operational arm of QH and they were in a better position to assess what would operate best at the District level.

148. The decision of the Zonal Managers was put into a briefing from Leanne Chandler dated 3 September 2003. I approved the submission for a tender process to be undertaken for a panel of preferred recruitment agencies for IRMs (attached and marked **'SMB55'**). Part of the basis for the tender process was that QH would be able to identify recruitment agencies able to meet the requirements and expectations of QH.

149. I received a briefing from Leanne Chandler, A/Principal Project Officer, Health Advisory Unit, dated 17 September 2003 (attached and marked **'SMB56'**) that confirmed that the tender process had been initiated.

150. I believe that at about the same time in late August 2003 Dr Lennox, who was Acting PMA at the time, prepared a paper on the integrated management of OTD's for the joint committee's consideration. He gave me a briefing dated 28 August 2003 attaching the paper he prepared for the committee and requesting that I sign a letter to the MBQ formally requesting that the MBQ commit to mandating the OTD management process as a condition of special purpose registration. I consequently signed the letter to the MBQ on 8 September 2003. Attached and marked **'SMB57'** is a copy of the briefing I

received from Dr Lennox, my letter to Associate Professor Toft, then President of the MBQ, and the paper. I cannot recall if I received a response from MBQ because soon after this time I commenced acting in the role of Director General and took on different responsibilities.

151. Unfortunately, my recollection is such that I do not recall any details about the status or progression of any particular report, who it was or wasn't provided to or what involvement I had, if any, with answering any media requests in relation to particular reports. The sheer volume of issues, reports and paper that I dealt with on a daily basis means that I cannot provide that sort of particularity. I can, however, answer generally. Firstly, where a report touches solely on QH practices and procedures and makes suggestions for change, it will only be regarded as official once it has been fully costed by QH's Finance Committee and Treasury and approved by the Director General and the Minister/ CBRC where relevant. Where a report requires the consent and participation of other non-government bodies, it cannot be formally adopted until it is agreed by all stakeholders. As I have said, I do not have any specific recollection about the Management of International Medical Graduates report as a document per se except to say that my understanding was that it was never a QH document as such but a document prepared by Dr Lennox for the committee and subject to agreement by all the members of the committee. I do not understand that the agreement of all of the committee members was obtained or that expenditure required to be made by QH had been approved by QH's Finance Committee or by Treasury.

152. Also, I can say from a broad perspective that QH was very aware of the issues surrounding the use of OTD's. As discussed above, the SDC was established to address issues with quality and safety in clinical practice amongst all medical practitioners, including OTD's. The issues and proposals suggested in the various submissions prepared throughout 2003 informed and contributed to the development of the programs being run by the SDC. The Centre for International Medical Graduates offers more programs than its predecessor to address many of these issues. In addition, aspects of other options raised in the submissions have subsequently been adopted by QH with the implementation of the RAPTS program by the SDC in November 2004. The opening of the SDC provided QH with a new opportunity to consider and implement these options. It was and is my view that SDC is best placed to perform this role as it is the centre of training and assessment for QH without being a part of the administrative arm.

Waiting Lists - Background

153. Understandably, media and public attention is given to the issue of waiting lists. One recent contribution to that debate was from Professor Peter Brooks, the Executive Dean of Health Sciences at the University of Queensland, based at Royal Brisbane Hospital. In the lead letter to *The Courier-Mail* on Saturday, 20 August 2005 he wrote, amongst other things:

> '*Waiting lists, at least in the public health system, will always be with us. They are a form of rationing and are there because Australians have decided that they do not wish to spend more*

than 8 per cent of the national Budget on health care. Rather than focusing on the symptoms (the waiting list), it might be better for the community and newspapers to focus on the cause – the underfunding of the health system at state and federal levels.'

Attached and marked **'SMB58'**- is a copy of Professor Brooks's letter.

154. The description of waiting lists as a symptom of the problems confronting the health system does not suggest that they are not a huge problem in themselves, and I do not understand Professor Brooks to be suggesting otherwise.

155. Waiting lists are a grim reality for the people who are on them, and for the health professionals and services that care for the people on them.

156. Before and during my time as DG, State governments and QH have adopted a number of strategies to reduce waiting lists in the public hospital system. I believe that these are summarised in the statements of Mr Zanco and Mr Walker (Exs 326-328).

157. Mrs Edmond in her evidence (T5078 to T5086; T4873 to T4895; T4906, T4992, T4996 to T5006, T4964 to T4965, T4986 to T4990, T5092 to T5094) has given a comprehensive overview of the issue. Dr Scott has addressed the matter in his evidence and I agree with his analysis of waiting list issues. Before addressing similar issues, I offer the following background.

158. Waiting lists for public hospitals in Queensland are a result of:

(a) the demand for services in that system;

(b) the fact that the demand is partly the result of the failure of preventative health strategies in the past;

(c) the burden of disease in our communities, as I have outlined earlier, particularly amongst socially disadvantaged groups;

(d) under-funding;

(e) the sheer weight of numbers on a system that is not means tested in an era when an increasing number of "middle class" (for want of a better phrase) people turn to the public hospital system in Queensland for health care.

159. I have already said what I want to say about funding of the health system.

160. Even if funding for public health was substantially increased, a number of the factors that produce waiting lists would remain.

161. I do not think that the demands on the public hospital system and the waiting lists that are a symptom of that demand, can be viewed in isolation. As Professor Brooks observes:

'Some issues of fundamental importance to the health of Australians tend to be sidelined if we just concentrate on things such as waiting lists. These include disease prevention and health promotion which are given little 'air play' as we focus on acute hospital-based medicine and the issue of the health workforce.'

Professor Brooks goes on to write that it is becoming very clear that the world has a shortage of doctors and that we have to start looking at different ways of delivering services within the health system. QH has looked at this and a key function of IWR is to progress reforms in an era in which we must face the reality of a global shortage of doctors.

Preventable Illness

162. One of the greatest challenges facing Queensland is preventable illness. Unfortunately, the public health message and preventative strategies that have been employed in the past have not done enough to assist those groups that are most vulnerable.

163. As I have remarked, perhaps the greatest initiative taken during my time as DG to save lives and prevent future illness was the passage of anti-smoking legislation. It is encouraging to read the evidence of an acute care specialist like Dr McNeil that the recent legislation "is probably going to do a lot more good for the health of Queenslanders than a whole lot of other direct incentives" (T 4751).

164. But anti-smoking legislation is only one part of a public health policy that aims to reduce the incidence of preventable illness. Without a major focus on preventable illness, the public hospital system will be completely overwhelmed by the demand for its services.

The demands placed on the public hospital system

165. The public hospital system is being swamped at the moment. There is enormous pressure on it by sheer weight of numbers.

166. When I commenced my medical career in 1977 the typical patient base of people attending public hospitals was the most economically disadvantaged members of the community. Since then, the socio-economic profile of people relying upon the public hospital system has shifted. The most disadvantaged groups in our community have been joined by others. This is a feature of a system that provides free services for all, regardless of their means.

167. The most disadvantaged members of our community rely upon the public hospital system the most because they have no alternative. They are the people who need it the most. Many of these people have difficulty in negotiating their way through the system. For example, an unsophisticated person may be referred to a hospital by a GP but, if for some reason they cannot negotiate their way through the system (even by not being able to find

the right ward in the hospital to attend) they may leave the hospital without receiving the service they were sent there to receive, and never return to it.

168. The sheer volume of demand placed upon the public hospital system, including by people who are more sophisticated and are better equipped to request the services that they require, has a tendency to marginalise the people for whom arguably the public hospital system exists. These are the people who carry the highest disease burden in our society and the highest risk of premature death.

169. The preventable disease burden, particularly amongst vulnerable groups in our society, needs to be confronted. Information in relation to it is summarised in *Health Determinants Queensland 2004* and this kind of information should be the basis for future initiatives. Unless we invest in prevention, the demands on the public system (and the length of waiting lists) will become intolerable and the most disadvantaged groups in our community will become further marginalised.

170. Of all the disadvantaged groups in our State, indigenous communities face the highest burden of preventable illness. I had a particular association with Yarrabah during my period as DG. I also dealt with the Cape York Institute in attempting to develop community ownership of health services in the Cape. During my time as DG I attempted to increase the profile of indigenous health outcomes.

171. Dr Keith McNeil made the simple but stark point that Prince Charles Hospital (where he works as Head of Transplant Services) would not exist if it was not for smoking and obesity (T4751).

172. The disease burden in our community as a whole, and particularly amongst the poor in our community, is what feeds the demands on our public hospital system.

173. The result of this demand are waiting lists to see a specialist in a specialist outpatient clinic (a feature of the Queensland health system not shared by other States) and lists for elective surgery if the specialist recommends that surgery rather than some other treatment is necessary.

174. The fact that people have to wait to see, and sometimes have to wait for excessive lengths of time to see, a specialist in an outpatient clinic, is no secret. This waiting list is known to the people on those lists, their families and their GPs. They are known to the medical practitioners who these people wait to see, and the administrators who have to administer the system.

175. The existence of these lists has been the subject of regular comment and inquiry by Members of Parliament and journalists.

176. The existence of specialist outpatient waiting lists and issues in relation to their administration was known to Health Ministers under whom I have served.

Waiting lists – Specific Issues

177. I have been asked by Counsel Assisting to address the issue of waiting lists and funding arrangements for elective surgery. I do not profess to be an expert about the technical details of these matters but will provide the following explanation to give the Commission my broad understanding of the issues.

178. As other witnesses have described there are essentially two waiting lists in Queensland, namely:

(a) elective surgery waiting list; and

(b) specialist outpatient waiting lists.

179. As I recall, data in relation to elective surgery waiting lists is collected and collated monthly and provided to the Minister for Health and Director-General. Elective surgery figures are provided to Cabinet on a quarterly basis. It is these figures which are published by the government and are required to be reported to the Commonwealth government. The definition of what is elective surgery is determined by the Commonwealth funding definitions for elective surgery as explained by Mrs Edmond. Essentially, they are people who have an appointment for surgery and are assessed as being ready for surgery.

180. As to specialist outpatient waiting lists, I agree with Mrs Edmond that they do not exist in other states because no other Australian state provides specialist outpatient centres under the public health system.

181. Mrs Edmond explained the difficulties associated with collating the numbers of specialist outpatient centre waiting lists. She also explained that in her view total numbers (such as state-wide numbers) are meaningless. Indeed this was the prevailing view before my time as GMHS and Director-General and remains the prevailing view. The length of time a person must wait for an appointment in a particular specialist area also depends on the capacity of that speciality at a particular hospital.

182. As far as I can recall, the numbers of people waiting on specialist outpatient centre waiting lists for each hospital have always been centrally collected and from time to time collated and reported to the Minister and to Cabinet in the form of information submissions, budget submissions or other briefings. I was not personally responsible for the preparation of those documents. When I became GMHS in July 2002 the system by which waiting lists were administered and recorded had been in operation for a substantial period.

183. As GMHS I was responsible for the management of a wide range of health services in Queensland, which were managed through District Health Services and through statewide services. The employees of QH who were responsible for the administration of waiting lists formed a relatively small part of the administration that I was required to manage. Naturally, I relied upon them to administer matters and formulate appropriate briefs to the Minister and to

Cabinet, as required. The job of GMHS involves many demanding tasks. In my case, these included leading negotiations on behalf of QH in industrial matters, for example negotiating the VMOs agreement which expired in February 2005. I was also given the task of managing the fallout from what was described as the "indemnity crisis" which threatened significant service disruption in public hospitals throughout the State. I was required to meet regularly with Colleges and universities to ensure consultation and collaboration with them. I mention these matters simply to explain that waiting lists for elective surgery and specialist outpatient waiting lists was only one part of my sphere of management as GMHS. I do not profess to have the knowledge or experience of those in the former surgical access team who know the system both from having worked in a hospital and having administered the elective surgery program.

184. The following paragraphs of this statement were prepared prior to the recent delivery of statements by Mr Zanco and Mr Walker and, in the interests of completing this statement at the request of Counsel Assisting, I have not had the time to comprehensively read their statements and the annexures to them before completing this statement.

185. My understanding is that from 1999 to 2003, figures for specialist outpatient services were collected manually by each hospital and sent to the Surgical Access Service or Team which collated and reported the figures in a monthly report. Prior to my time, a substantial amount of money had been put towards updating the HBCIS system to enhance its scheduling system so that it could provide automatic electronic reports on specialist outpatient numbers. I met with the specialist outpatient project team from the Surgical Access Team on a monthly basis as GMHS. I recall being advised by members of the Surgical Access Team in about early 2003 that the manual collation of the specialist outpatient numbers each month took up approximately half of their time. The HBCIS electronic reporting had failed for technical reasons and could not produce accurate automatic collated figures so the team had to revert to manual collation. They advised that the figures manually collated were extremely unreliable because it appeared that only a handful of hospitals had actually checked and varied the figures they were sending for some time. This, in addition to the significant variation in the methodology used by hospitals in their reporting, meant that the figures were likely to be inaccurate to say the least.

186. At the same time, QH had entered into a contract with TRAK Health for a software system to replace HBCIS. I was advised by the project team that they were better off spending the time they were spending on manual collation of dubious data on developing the specialist outpatient module with TRAK Health. This is because from 1 July 2005, Queensland would also have to report non-admitted patient data to the Commonwealth. I believe that on the team's recommendation, I approved the cessation of the monthly manual collation of specialist outpatient services. I understood that the Surgical Access Team was still receiving the manual data from the reporting hospitals on a monthly basis. After this time, if anyone, including the Minister, wished

to know the numbers of people waiting for a specialist outpatient appointment, the team could manually collate the data and provide a report.

187. The Policy Framework for Specialist Outpatient Services was approved in early 2004 and its implementation plan was approved in about mid 2004. Part of the implementation plan for the policy framework was to set-up the new data collection system and allow for the re-commencement of reporting. I understand that as part of this process, a comprehensive survey was undertaken by the Surgical Access Team to determine the extent of specialist outpatient waiting lists as at 1 July 2004 to assist in their implementation of the policy framework. I do not recall whether or not I was made aware of the total numbers from this survey. The total numbers could have been provided to the Minister or his staff had they requested them at any time. The Department had no interest in not disclosing to the Minister or to the Cabinet statewide totals, as is shown in Exhibit 323, which I understand is an Information Submission prepared by the Department in July 2005 for Cabinet.

188. The coordination of elective surgery and specialist outpatient centre appointments is done by Queensland Health at the local level – namely, the hospital. I reject the assertion that there is a deliberate policy to minimise the number of specialist outpatient appointments to keep the elective surgery appointment numbers low.

Elective surgery and funding

189. The method by which elective surgery is funded in Queensland is a complex issue and I do not pretend to be an expert on it. My understanding is that in the private sector, elective surgery is funded on a procedure by procedure basis. This means that doctors are rewarded for the volume of procedures undertaken as opposed to the complexity or time intensiveness of a particular procedure. On the other hand, elective surgery is funded in the public health system by means of weighted separation.

190. The proposition that public hospitals make money out of performing elective surgery is seriously flawed. In fact, the more elective surgery procedures that are performed by a hospital, often, the more money they will lose particularly if the procedures are complex.

191. One of the reasons hospitals were making a serious shortfall in covering the costs of performing elective surgery procedures was that it was, for some surgical procedures, funded at rates set in the past that did not reflect their actual current costs. Until July 2004, certain elective surgery procedures were paid in accordance with rates determined in 1996, 1998 or 2000. This process was confusing and also did not reflect the actual cost for each of the elective surgery procedures. As of July 2004, QH implemented a flat structure where every procedure was funded at its actual cost. Attached and marked **'SMB59'** are two submissions that reflect this change.

192. Another difficulty associated with the old model of elective surgery funding was that it was negotiated between the Surgical Access Team of Queensland Health and the districts. This meant that elective surgery funding was more

influenced by a central office than by the people who were delivering the services. Subsequently, or perhaps as a result, the elective surgery program moved from its initial intent of coordinating the treatment of patients with the greatest clinical need to a system that was more and more rule-bound and caught up in bureaucratic red tape. The program had become obsessed with numbers and had lost the focus on patients and the human face behind the reason QH had to prioritise people awaiting elective surgery. The result was a constant tension between the doctors, the district management and the elective surgery team. The hospitals were having to subsidise elective surgery from their ordinary hospital funds (because the funding didn't cover the cost of the surgery as discussed above) and were being penalised (by, for example, the clawing back of elective surgery funds) for not following rules that were complicated and poorly understood by clerks responsible for entering details into the system, doctors and often hospital management.

193. After I became GMHS, I found myself in the middle. I formed an opinion that there were some (certainly not all) in the elective surgery team who were not fully briefing me on all the issues or options and were not canvassing the practical issues facing the people delivering the services or giving any consideration to the purpose of the program or the patients for whom the services were being provided. This was particularly so in the areas of elective surgery targets, funding withdrawal and emergency surgery. I took my advice from those in the elective surgery team who had significant experience in delivering the elective surgery program from the hospital perspective as well as the head office perspective. I was advised that some of the issues had been carefully considered by my predecessors, superiors and other members of the elective surgery team and had been found to be baseless or insignificant or explicable.

194. The lesson that I learned was that clinicians on the ground and hospital management who were responsible for managing the delivery of elective surgery at their hospital needed more input into the processes, management and funding of elective surgery so that the focus could be redirected to its patient-centric intent. As of July 2004, the funding structure of elective surgery was changed so that elective surgery funding was distributed directly to hospitals as a one line item of recurrent base funding as opposed to multiple program funding given and taken, at the control of the Surgical Access Team, on top of base funding. The result of this change in policy is that funding is not tied to particular types of elective surgery and is managed by zones according to the elective surgery demands placed on their districts. See attached and marked **'SMB59'** (same exhibit as above).

195. The other difficulty with the previous funding structure was that it created the distinction between surgical procedures and medical procedures. I don't disagree with statements by other witnesses before the Commission that the focus on elective surgery is excessive. I believe it creates a perverse driver and leads to poor clinical practice. For example, the focus on elective surgery may create in a particular health district the priority to give funding for a hernia operation where that hernia is not life threatening but that priority may be to the detriment of another patient not requiring surgery but a medical

intervention, such as a stent, where that medical intervention might be life saving to a patient. It is for this reason, along with others, that I approved a submission in April 2005 that disbanded the distinction between surgical procedures and medical procedures so that all elective funding would be for both categories. As a result, from July 2005, funding given to districts are now for elective procedures and hopefully this will take away from the excessive emphasis which has in the past been placed on elective surgery at the cost of elective medical procedures. See attached and marked **'SMB60'**.

196. I have been asked by Counsel Assisting for my opinion as to whether too much emphasis is placed on elective surgery and, if so, where else the funding might be distributed. I agree with the proposition. As I've explained in the previous paragraph, funding should be directed to elective procedures which hopefully avoid the need for surgery (eg cardiac stents and defibrillators) and also preventative health strategies.

C. OTHER MATTERS IN RESPONSE TO ISSUES RAISED BY COUNSEL ASSISTING THE COMMISSION

Complaints management compliance

197. This topic has been addressed in QH's initial submission to the former COI. It contains an extensive discussion of the various complaints mechanisms and refers to all of the QH documentation that exists in relation to complaint management. The submission also identifies potential witnesses who could give evidence in relation to the complaints management processes.

198. During my time as DG, I strongly supported the appointment of patient liaison officers at each hospital to try to resolve complaints and other problems at the point of complaint. Having a patient liaison officer who is able to do so avoids delay. That is not to say that patient liaison officers should be regarded as the first or only source for a complaint. QH is subject to regulation and oversight by numerous bodies and complaints can be made to a local Member of Parliament, to the Minister, to the Ombudsman and to various persons at different levels in QH.

199. So far as complaints to Members of Parliament are concerned, in accordance with a direction I received from the Minister for Health, I sent a memorandum to all Zonal and District Managers requesting that District Managers ensure all complaints from Members of Parliament be dealt with in a proactive manner. Attached and marked **'SMB61'** is a copy of my memorandum to Zonal and District Managers dated 7 May 2004.

200. The issue of complaint resolution is a different one to analysis of complaints that have been made.

201. During my time as DG, I appointed Ms Sandra Abeya to advise me about these matters. As I have noted, complaints come from multiple sources and it is important to analyse the complaints and to see if there is any pattern or trend to them, for example, whether there were a large number of complaints in relation to a particular service.

202. I understand that the Risk Management Advisory Committee has been looking into implementing a complaints management system as well as a number of other initiatives that will centralise the collection of data so that trends can be identified and common risks and issues can be addressed. I do not recall what stage the Committee was up to in implementing the systems and whether or not the reporting requirements for districts has commenced or has been complied with. I do not recall whether I briefed the Minister in relation to the implementation or any other issue. I do not recall being told whether or not another member of my staff briefed the Minister or his staff in relation to this issue. There are a number of people within QH who would be better placed to assist the Commission in this regard and I commend them to you.

Dr Nankivell

203. I have been asked to address whether I was aware of complaints by Dr Nankivell about dangerous and unacceptable waiting periods of patients.

204. I have read Dr Nankivell's statement and can say that I do not have any specific knowledge of Dr Nankivell's complaints. I was Southern Zone Manager at the time Dr Nankivell is referring to and although I was generally aware of there being pressure on waiting lists and surgical funding in Queensland generally, I was not aware of Dr Nankivell's complaints.

205. There is a letter attached to Dr Nankivell's statement dated 31 October 2000, from Lindsay Pyne, Central Zone Manger to Dr Nankivell. It refers to Lindsay being in the process of following up the matter with a number of people, including me. I do not recall having any communications with Lindsay Pyne on this issue and can say that it is not something which would ordinarily be discussed between two separate zone managers in any event.

206. I was also unaware of Dr Nankivell's complaints during my time as General Manager of Health Services and Director-General.

Vincent Berg

207. I understand that Vincent Berg ('Berg') was employed by QH in Townsville as a registrar in psychiatry for the 2000 calendar year. At that time I was QH Southern Zone Manager. I had no knowledge of Berg or his qualifications, as he was an employee of the Townsville Hospital, which was part of QH Northern Zone. It was not until December 2002, in my role as General Manager Health Services, that I became aware of the issue of Berg's qualifications. This was two years after Berg had left his employment with Queensland Health.

208. Berg and issues concerning his qualifications first came to my attention, so far as I can recall, in early December 2002 when Senior Departmental Liaison Officer, Jill Pfingst, advised me that Dr Andrew Johnson, Executive Director of Medical Services in Townsville, and Karen Vohland, Senior Media and Communications Officer in Townsville, were intending to hold a public meeting to advise that there had been an unqualified doctor practising psychiatry at Townsville Hospital.

209. I initiated a telephone hook-up with Dr Johnson and Karen Vohland. Also present in my office was Jill Pfingst. In that conversation I asked Dr Johnson and Karen Vohland what they intended to do. They indicated that they wanted to hold a public meeting about Berg to advise that there had been an unqualified doctor practising psychiatry at Townsville Hospital.

210. My immediate concern was the effect that a public meeting would have on the patients concerned. I was concerned that if patients who had been treated for mental illness were first to become aware of the issues concerning Berg through a public meeting, being given the information in that way might have an adverse effect on them.

211. I asked Dr Johnson what he intended to do about identifying the patients, and reviewing the management of those who had been seen by Berg. Dr Johnson informed me that he intended to undertake a patient audit whereby all of the patients who had been seen by Berg would be identified. The clinical notes would then be reviewed by Dr John Allan, Director, Townsville District Integrated Mental Health Services and they were then to prepare a report with recommendations as to how to best manage the ongoing care of those patients.

212. I told Dr Johnson and Karen Vohland that to hold a public meeting without having first identified the patients and understanding what the impact might be on individuals patients was not the right thing to do at the time. It was left on the basis that the public meeting would not proceed until such time as Dr Johnson had reported back to me with an action plan.

213. The former patients were the priority. Assessing the impact on patients of telling them about the Berg issue, and deciding whether and by what means they were to be told were important matters. Decisions about these matters could not be made until the process of identifying the patients and their outcomes and recommendations received from Dr Allan was complete. Therefore, I did not think a public meeting was appropriate.

214. I understand that on the same day Jill Pfingst and Helen Little, Chief Executive Manager to the Director-General, gave the Minister's staff an oral briefing on the issue of Berg and Townsville Hospital's proposed response.

215. At about this time, I was advised by Dr Johnson that the Townsville District were in the process of identifying the patients that Berg consulted with during his term in Townsville/ Charters Towers. They were reviewing all of the medical records to identify if any inappropriate clinical practice occurred. I was also told that Berg's clinical practice would have been scrutinised by Consultants during the time he had been employed with the Townsville Health Service District.

216. In early to mid December, Dr Stable, the Director-General, asked me to advise him of the progress made on reviewing Berg's patient files. I asked Townsville Hospital to provide me with a Ministerial Briefing.

217. The District Manager, Ken Whelan, sought my advice about whether the Berg matter should be reported to the QH Audit and Operational Review Branch

('Audit Branch'). The Audit Branch has an experienced police officer permanently working within it. I agreed and advised him to contact Michael Schafer, the Director Audit Branch, which he did.

218. While I was waiting for the brief to arrive from Townsville Hospital, including the action plan, I had a number of conversations with Townsville management. In those conversations, I asked to be kept informed about how they were managing the audit of the patients and to continue to discuss the best way forward.

219. During this period, I also consulted with psychiatrists in the Mental Health Unit of Queensland Health about the best approach to the situation. My recollection is that I consulted with the Director-General, Dr Stable, with the Minister at that time, Mrs Edmond and her staff and my advice was that it would not be in the best interests of the patients to hold a public meeting and that there was no contrary view put to me by the Minister or Director-General. During this time, discussions centred on whether holding a public meeting would be of benefit to the patients or given the type of patients particularly if they were mentally ill, it may increase their risk rather than add value to their treatment.

220. On 13 January 2003 I received a briefing to the Minister prepared by Dr Johnson and others (attached and marked **'SMB62'**). I considered that the brief was incomplete in that it did not address the Medical Board of Queensland's responsibility in relation to Berg's registration and action against him in light of the revelations about his potential misrepresentation of his qualifications. I therefore wrote on the brief that it was incomplete in that, while the College of Psychiatrists' opinion was provided it did not include the Medical Board's position on Berg which needed to be included so that the Minister could consider all facets of the issue. I directed that the brief be returned for completion.

221. The second brief arrived in late January 2003 (attached and marked **'SMB63'**). As I considered that the brief was now complete in that it dealt with the Medical Board's position, I instructed that the first and second briefs be combined so that a complete picture was available to the Minister and signed it off on 31 January 2003 to be sent to the Minister via the Director-General.

222. At the conclusion of the second brief direction was sought from me as General Manager Health Services about whether any patients subject to the audit were to be informed of the validity of Berg's claim for qualifications. My advice, as noted on the brief, was that I had discussed the matter with relevant medical and management staff including Dr Allan and Dr Johnson and that my instructions had been clear and had not altered. My view was that the audit process and clinical follow up should proceed. This involved contact with patients and their relatives, as outlined in the briefing to the Minister. But this did not mean that there was an ethical obligation or that it was clinically sound to disclose matters about Berg's claimed qualifications to patients. My advice was that I considered that the process to date had been appropriate, ethical and clinically sound given that the client base had a mental illness and any at risk patients had been identified and managed.

223. I believe that in certain exceptional situations it is appropriate for a medical practitioner to not disclose certain information to a patient if the medical practitioner believes that to do so will cause greater harm than disclosing the information. I consulted with psychiatrists in the Mental Health Unit of QH. That was the basis of the advice that was recorded on the brief in my handwriting. Although I acted on the basis of advice and the discussions that I had with various people about the matter, I accept that the decision rested with me, subject to it being countermanded by the Director-General and the Minister.

224. Reaching that decision was perhaps one of the most difficult decisions I have made as a medical practitioner and as an administrator. There were a lot of unknowns in the decision. For example, if the patients were told, they may well stop their medication, or withdraw from a therapeutic relationship with their existing psychiatrist or doctor and therefore the potential for harm was quite significant. There was also the risk of suicide given the vulnerability of the patients. A number of years had elapsed since the patients had seen Berg, and I was satisfied that those at greatest risk had been followed up and those patients who had seen Berg and who still required care were in a new therapeutic relationship. In those circumstances my view was that the risks to the patients were likely to be less if they were not informed that Berg had not been qualified.

225. An additional factor was the distinct possibility that media publicity might lead to other patients who had received psychiatric treatment in Townsville to mistakenly believe they were treated by Berg. Many mentally ill patients are vulnerable to paranoia and they may not be able to recall who they saw a few years earlier when they attended the emergency department, for example, for psychiatric treatment. The potential harm was therefore not just limited to Berg's patients, but the whole patient cohort.

226. It wasn't simply a clinical and ethical decision about one patient. It also involved a risk analysis across more than 250 patients and even patients who had not been seen by Berg. This type of decision is difficult enough when it concerns one patient. Here there was also the risk that by telling one patient, this issue may be reported to the media and lead to greater harm for all of the other patients.

227. I acknowledge that it is possible that the process of identifying and contacting patients did not locate each and every patient that Berg had seen as a psychiatric registrar but, in my opinion, that risk was outweighed by the greater risk of harm to the patients that would occur if Berg's lack of qualifications had been communicated to patients, particularly through the media.

228. I wish to reiterate that it was not the case that a decision was made not to contact patients. On the contrary, former patients were identified and contacted where considered appropriate by the local Mental Health Service. The difficult ethical and clinical decision I faced was how the patients were to be contacted and what was to be communicated to them.

229. As I have said, it was probably the most difficult decision I have had to make as a medical practitioner and administrator. I acknowledge that other people may have made a different decision when faced with the same situation.

230. Contrary to any perception that might have been generated by the media and by certain comments made during the previous Commission of Inquiry that there was a 'cover-up' and QH did not refer the Berg matter to any authorities, the matter was referred to QH's Audit and Operational Review Branch, and came to the attention of the Queensland Police Service officer who is located in and works in conjunction with that branch. The Audit Branch referred the matter to the Crime and Misconduct Commission.

231. The MBQ was also seized of the matter. The Minister, Mrs Edmond, met with the MBQ on 4 December 2002, which was within a few days of when I and the Minister's office first learned about matters in relation to Berg's qualifications.

The Giblin-North Report

232. I have been asked to address issues that occurred after I had received a report from Doctors Giblin and North titled "A review of Orthopaedic Health Care in the Fraser Coast Health Region" on 6 May 2005. I will initially address the events that involved me and occurred from the time I appointed the doctors to investigate.

233. On 6 May 2004, I approved the appointment of Doctor John North and Dr Peter Giblin as investigators pursuant to section 52 of the *Health Services Act 1991* for the purposes of conducting a review into public orthopaedic services at the Fraser Coast Health Service District (FCHSD). The appointment arose out of a submission made by FCHSD to Dr Scott dated 6 April 2004 (attached and marked **'SMB64'**). The reason it was referred to me was because I was the only person who was vested with the power under Part 6 of the *Health Services Act 1991* to appoint investigators. The appointment of the doctors as investigators was as individuals and indemnities were provided to them as individuals. This was done on the basis of legal advice of the Legal and Administrative Law Unit of QH. (attached and marked '**SMB65'**).

234. My subsequent involvement with the issue was only required when changes to the doctors' appointment were formally sought. The review and its process was otherwise dealt with at the district level and possibly with the occasional involvement of the GMHS.

235. The FCHSD made a submission to the Acting GMHS dated 30 June 2004 in which Doctors North and Giblin sought an extension of time to 30 September 2004 to provide their report and the AOA also sought indemnity from the State (attached and marked '**SMB66'**). I agreed to the extension of time but I refused the AOA request for indemnity because there was no need for AOA to be indemnified as it had not been appointed as an investigator and it was not going to be the author of the report.

236. I understand that the doctors carried out their inspection on 2 July 2004.

237. The FCHSD made a submission to me dated 29 September 2004 (attached and marked **'SMB67'**) seeking an extension for the doctors to provide their report by 31 December 2004. On 3 October 2004, I only granted an extension until the end of October 2004 as I was concerned at the delays and could not see any reason for this particularly as the doctors has conducted their inspection on 2 July 2004. I was not made aware that the doctors had raised any concerns about the seriousness of the situation of orthopaedic services at the HBH or that they had any grievance about the failure of QH to provide documents.

238. I understand that the FCHSD then made a further submission dated 14 October 2004 seeking an extension for the Doctors to provide their report by 30 November 2004 (attached and marked **'SMB68'**). I do not recall seeing this document and doubt that I did as my usual practice is to initial documents that I read and the document attached does not contain my marking. I cannot recall if Dr Scott spoke to me about the further submission, although he may have.

239. The next occasion I was involved in the matter was when Dr Scott received a briefing from the FCHSD dated 13 April 2005 (attached and marked **'SMB69'**). Dr Scott notes that he had discussions with me although I cannot recall the precise discussion. I recall the AOA had again approached the FCHSD seeking indemnity and advising that if it was not provided they would not release the report to Queensland Health and that there was some degree of urgency by the AOA in light of the concerns about Dr Patel.

240. In order to resolve the impasse between the Department and AOA I recall that we took the following steps:

(a) I contacted Dr Chris Blenkin of the AOA. I informed him that indemnity for the AOA should not be an issue but he insisted that the AOA be indemnified before releasing the report.

(b) I asked Dr Gerry FitzGerald to contact Dr North to see if he would agree to release the report. The Chief Health Officer advised me that he had spoken to Dr North and that the indemnity issues had been resolved and the report was being delivered to me.

(c) I instructed the Legal and Administrative Law Unit ("LALU") to see if it could urgently progress the matter. LALU sent a letter to Dr Helen Beh dated 22 April 2005 (attached and marked **'SMB70'**) which attempts to clarify and allay concerns Dr Beh had raised in discussions on 15 April 2005. I understand that Dr Beh indicated that after seeing the instruments of appointment and indemnity for the doctors for the first time, there was a misunderstanding on the part of the AOA as to the extent of the indemnity. The AOA also had the misconception that the indemnity I had originally granted to the doctors was contingent on the period of the appointment. This was not the case. The AOA were now satisfied that the report could be provided as long as it was not on AOA letterhead but they indicated it would take another week as one of the doctors was out of the State and could not sign off on the report.

241. I was out of the office in early May and on my return on 6 May 2005 the report was waiting for me. It was at or before this time that *The Courier Mail* referred to the investigation and report. On 6 May 2005 I received 2 e-mails from Dr Terry Hanelt (attached and marked **'SMB71'**).

242. I had serious concerns about the report:-

(a) The doctors made a very significant recommendation that the orthopaedic service had to close immediately. This is a drastic action for any DG to make as it would amount to a denial of a service in the district. So that I was properly informed before adopting such a recommendation, I wanted to ensure that I understood all of the facts upon which the report was based. The report, however, failed to demonstrate the information or evidence on which the doctors based their conclusions. Much of the report only referred generally to the investigators being told certain matters at interviews. It contained no evidence that the investigators had actually observed the three doctors operate and it was not clear whether any clinical cases they referred to were from interviews or an inspection of files. There did not appear to be evidence of the kind that you would normally expect to reach the conclusions and recommendations that were made.

(b) Although the report raised very serious concerns based on interviews, the concerns had not been verified by the type of investigation that would be required before shutting down a service.

(c) The report also failed to indicate whether the investigators had taken into account the fact that the service in HBH had changed since the time the Doctors visited the hospital. Dr Kwon, who is an Australian trained Orthopaedic Surgeon from Sydney, and member of the AOA, commenced work at HBH as Director of Surgery in January 2005. I wanted to know whether their report was up to date because almost a year had passed since their one day inspection.

(d) The report was also defamatory. My concern was that there was no indication in the report that Doctors North and Giblin had afforded the three doctors natural justice or that the adverse comments about the doctors were based on evidence that could be used to defend a defamation action.

(e) I was also concerned about why I had not been given any indication from the doctors that they held such a serious view of the state of orthopaedic services and must have done so if not from the date of their inspection on 2 July 2004 at least from the date of completion of their draft report.

243. As a result, on Friday, 6 May 2005 I sent a fax to Doctors North and Giblin expressing my concern and seeking a meeting as a matter of urgency (see attached and marked **'SMB72'**). I received an acknowledgement from Dr North by fax (see attached and marked **'SMB73'**). The Doctors did not return my calls over the following days and refused to meet with me. I hadn't

formed any firm views about the report and I felt the doctors may have been able to provide me with their raw data or the like that would substantiate their recommendations and allay my concerns about the report. Whilst I highly respect Doctors North and Giblin, I felt I would not be performing my duty as DG if I did not seek to ascertain the factual substance behind the recommendations.

244. On Monday, 9 May 2005 I sent a memorandum to Dr Scott to seek his advice about the report and about whether the two SMO's subject to adverse allegations in the report could be urgently referred to the Skills Development Centre for assessment (see attached and marked **'SMB74'**). Dr Scott responded by memo dated 10 May 2005 and stated that the doctors' observations seemed to be based on advice from a range of parties and not on clinical material. He also stated that he thought the doctors and staff from the FCHSD ought be given an opportunity to respond in order to deliver natural justice. Dr Scott confirmed that he was making arrangements for a clinical assessment to happen. (see attached and marked **'SMB75'**).

245. On about 11 May 2005 I sought the CHO's advice about the report and he advised me that in his view the report identified issues of serious concern that needed attention but that it also included material which was potentially defamatory and that we should obtain a legal opinion prior to any release. I advised him that this was occurring. In addition he told me that the principal recommendation to close the service immediately was unsustainable without first seeking alternatives which provided safe orthopaedic practice. He provided that advice in writing to me in a memo dated 12 May 2005 (attached and marked **'SMB76'**). He advised:

> *"The investigators have used an interview and focus group approach to identify the issues of concern to staff in the hospital. They have not sought or been in a position to validate any of the concerns and ordinarily such concerns would require a more formalised investigation at which evidence is collected and responded to.*
>
> *The principal issues of concern raised by the Inspectors relate to the management and organisation of orthopaedic services at Hervey Bay Hospital. The information collected in regard to clinical standards is circumstantial and not validated at this time."*

He went on to advise that "It would in my view not be wise to take such dramatic action without first recourse to attempts to seek alternative solutions to the issues of concern identified in the report". I sent a copy of the CHO's advice to the Premier's Office.

246. I had discussions with the Minister for Health about the Giblin-North report. The Minister had indicated to me that 'politically we're going to have to close the service'. I advised him not to make such hasty decisions without obtaining all of the facts as I was concerned with the gaps in the report. On 14 May 2005

I received a memorandum from the Minister (attached and marked **'SMB77'**) seeking formal advice from me that day.

247. In response to the Minster's request I telephoned Dr Kwon who was now running the Orthopaedics Department at HBH. I spoke to Dr Kwon to find out what the situation currently was. He went through everything he was doing and he indicated to me the services being provided were safe and he thought he had addressed the concerns raised in the Giblin-North report. For example he advised that he was fully supervising Doctors Krishna and Sharma. He said that he had done a large amount of work to address the problems in such a short space of time. He satisfied me that he could effectively operate the service and that patient safety was not at risk. I provided the Minister with formal advice by memo dated 14 May 2005 (attached and marked **'SMB78'**).

248. I recall reading the briefing to the Minister dated 14 May 2005 (attached and marked **'SMB79'**). It mentions the steps being taken by QH, in particular Dr Scott, to independently assess the clinical skills and competence of the medical practitioners named in the report. Dr Scott and the CHO took up the ball, so to speak, of independently verifying the matters contained in the report (including by audit review of files) and making recommendations on what steps should be taken to ensure the safe delivery of orthopaedic services in the district.

249. On 15 May 2005 I sought advice from Mr Michael Schafer, Director of Audit and Operational Review, about responding to the allegations in the report concerning Dr Naidoo as they raised concerns he had engaged in official misconduct. On 16 May 2005 Michael Schafer advised that the matter should and would be referred to the Crime and Misconduct Commission (attached and marked **'SMB80'**) and an e-mail from Mr Stephen Weston of the same date confirming it had been referred to the CMC (attached and marked **'SMB81'**). I sent an e-mail to Audit on 28 May 2005 (attached and marked **'SMB82'**) to ascertain the status of the CMC investigation because it was impacting on orthopaedic services at HBH. I received e-mails from Ms Rebecca McMahon dated 30 May and 1 June 2005 (attached and marked **'SMB83'**) advising that the CMC had completed their investigation and it had advised that the only issue which may give rise to official misconduct is the allegation relating to an alleged conflict of interest in terms of any relationship Dr Naidoo had with the Link Company but that there was insufficient information in the Giblin-North report to form a suspicion of official misconduct at that time. He advised that it would be a matter for the Bundaberg Hospital Commission of Inquiry to pursue and if further information was obtained which gave rise to a suspicion of official misconduct, it should be referred back to CMC. Rebecca McMahon advised that Audit's inquiries (ASIC searches) had failed to find an obvious private pecuniary connection between Dr Naidoo and the company.

250. Dr Kwon discontinued working for HBH on or about 18 May 2005. In a briefing by FCHSD to Dr Scott dated 23 May 2005 (attached and marked **'SMB84'**) it states that Dr Kwon advised that the release of the Giblin-North report by the Bundaberg Hospital Commission of Inquiry with the recommendation that all orthopaedic services cease made his continuance at

HBH untenable, in light of the AOA being his professional organisation. The withdrawal of Dr Kwon's services meant that orthopaedic services could not continue at HBH so the service was closed until other strategies could be explored in consultation with the AOA.

251. At around this time I understand that work was being undertaken to assess the level of services that could be provided to the Maryborough and Hervey Bay Hospitals due to medical workforce shortages. I supported the recommendations in a briefing by the FCHSD to the Minister dated 10 May 2005 (attached and marked **'SMB85'**). No direction was provided by the Minister and in view of the urgency Dr Scott and I asked the FCHSD to initiate the recommendations by memo dated 14 May 2005 (attached and marked **'SMB86'**).

Rockhampton Hospital Emergency Department Review

252. I have been asked to give details of my knowledge in relation to the quality of services at Rockhampton Base Hospital ("RHB") and a report dated June 2004. Since becoming Director-General, I have had knowledge that there were issues in relation to medical staffing and the range of services being provided at RBH. I also knew that Dr Scott was discussing these issues with RBH on a regular basis. I do not recall Dr Scott seeking my intervention in the matter. I do not recall specific issues in relation to RBH.

253. I was not aware of the report dated June 2004 identified by Counsel Assisting and I had not seen that report before being presented with it by my solicitors when preparing this statement.

Disclosure

254. I have been asked to give details of my knowledge of circumstances surrounding the disclosure of the Bundaberg Hospital review team's interim and draft reports. I understand that by disclosure, the Commission is seeking details of disclosure to two journalists, being Sean Parnell and Hedley Thomas.

255. An audit has been undertaken by the Investigations and Audit and Operational Review Unit of QH in relation to the release of the final report to Mr Thomas (attached and marked **'SMB87'**). The report, however, may also assist the Commission in terms of time frames in relation to the interim or draft report. I can categorically say that I did not disclose the review report in interim, draft or final form to either Mr Parnell or Mr Thomas or any other journalist.

Bundaberg Mental Health Unit

256. I have been asked by Counsel Assisting whether I agree with the account given by Mr Messenger MLA about a meeting that I attended on 11 May 2004. I disagree with part of his account of the meeting.

257. By way of background, on 13 April 2005 I met with Ms Hawkesworth, Secretary of the QNU, as I did on a regular basis (three or four times a year) to

discuss issues of interest to the QNU. Amongst other matters, we discussed the Integrated Mental Health Service (IMHS) at Bundaberg. I advised Ms Hawkesworth that QH wanted to conduct an independent review of the IMHS.

258. I suggested that Dr Mark Waters, then General Manager of the Wesley Hospital, would be a suitable investigator because he was a very experienced medical practitioner and administrator and had overseen the restructuring of services at Wolston Park Hospital. Ms Hawkesworth agreed.

259. I met with Dr Waters on 28 April 2004 to discuss his availability to conduct the review. He indicated to me that he would be willing to undertake the review. I set in train the process for his appointment. His formal appointment as an investigator through Instrument of Appointment occurred on 13 May 2004.

260. On 11 May 2004 I attended a meeting with Robert Messenger, a member for Burnett, with four mental health nurses to discuss their concerns relating to the IMHS. The meeting was arranged by Cameron Milliner, the Policy Advisor to the Minister, following a speech made by Mr Messenger about the Bundaberg Mental Health Unit in Parliament earlier that day.

261. Present at the meeting were myself, Jill Pfingst, Cameron Milliner, Mr Messenger and one of his staff, the four nurses and one of the nurse's support persons. I understood that the nurses had been or were employees at the Mental Health Unit at Bundaberg Hospital.

262. At the outset of the meeting Mr Messenger said that he was claiming whistle blower status for the nurses. I acknowledged his claim.

263. During the course of the meeting, the nurses aired a number of concerns and grievances about the Mental Health Unit at Bundaberg. Most of their concerns were around how they had been treated by other staff and less specifically, by management. Their major grievance appeared to be regarding the leadership of the Mental Health team in Bundaberg. They also raised issues about bullying and security. It was abundantly clear to me that some of the nurses were quite unwell and I was aware that the nurse with a support person was unwell. In those circumstances I was concerned that Mr Messenger was inappropriately using Queensland Health staff who were quite ill for political purposes. I was also concerned to approach the meeting in such way that would minimise the nurses' distress.

264. It was apparent to me from what the nurses were saying that there was friction between the inpatient unit at Bundaberg Hospital and the community based mental health teams.

265. During the course of the meeting, I indicated that it had already been agreed, in April, with the QNU and the Minister that there was to be an independent review of the Mental Health Unit at Bundaberg to be conducted by Dr Mark Waters. This was supported by the nurses, particularly the nurse who was in care. Once I had advised the nurses that the review had been agreed some weeks before, Mr Messenger seemed to become agitated. He seemed to be

annoyed by the fact he could not claim that he had forced a review of the Bundaberg Mental Health Services. After this, Mr Messenger declared that the review should be widened to include the whole of the Bundaberg and District Health Service. I took this as an attempt by him to regain some political advantage. In response, I said words to the effect that *'I didn't come here to listen to petty politics, I am here because I am concerned about the mental health service and my staff'*. At no stage did I slam the table or go into a rage as Mr Messenger has alleged.

266. The meeting ended amicably and the nurses thanked me for the meeting and for arranging the review.

267. I have also been asked by Counsel Assisting about the finalisation of Dr Waters' report. This matter has been the subject of evidence by Dr Waters, and I agree with his evidence (T4674).

268. I met with Dr Waters in or about mid-July 2004 and during the course of that meeting, he provided me with a copy of his report. I went through the report during the course of the meeting and we discussed the recommendations. Dr Waters asked me whether the report covered the terms of reference and addressed all relevant matters and were there any other issues within the terms of reference that I felt had not been covered. I indicated to Dr Waters that I was satisfied with the report and its recommendations.

269. Dr Waters formally provided his report on the IMHS to me under cover of a letter dated 22 July 2004. Attached and marked **'SMB88'** is a copy of Dr Waters' letter to me dated 22 July 2004 enclosing copies of his report

District Health Councils

270. I have been asked to comment about a District Health Council Chairs' meeting that I attended with the Minister. I don't entirely agree with the version of events Mr Chase stated in evidence but say that minutes prepared by Mr Chase accord with my recollection (attached and marked **'SMB89'**). In particular, I note that I said "DMs were to manage the every day issues in the Hospitals, and were not looking for direction in management, but for assistance in being the eyes and ears out in the Community, so that they can be better served."

271. Section 8 of the Health Services Act 1991 provides for the functions of the District Health Councils. The functions do not allow them to be involved in the operation of hospitals as such. But sub-section (e) says that it is the role of the council to monitor the quality of public sector health services delivered in the district. I believe that under this sub-section, the district council had the power and the authority to receive a complaint from a nurse about Dr Patel, such as is suggested by Mr Chase, as it squarely is about quality of health care.

272. I believe that QH needs local community input into health services because there needs to be community ownership of the decisions about the types of services to be provided (but not the how). I think the district health councils can be very effective where you have a defined community, such as Roma and Gympie. They are less effective in urbanised areas because it is more difficult

to define the community that uses the hospital's services. One of the problems of district health councils is often their membership – they are appointed by the Minister and because they access sensitive health data and health is so politicised, often only government supporters are generally appointed. The consequence of this can be that the membership is not necessarily representative of the community.

273. If role of district health councils were to change to include managing the business of hospitals, it would be dangerous because many of the present members would not necessarily have the appropriate skills. If councils were to be involved in the business side of hospitals, the legislation will need to change to specify the minimum level of skills required for members, and that would not necessarily make them reflective of the community either.

Morale amongst doctors and nurses in the public system

274. I have also been asked to address whether I was aware about low morale amongst doctors and nurses in the public system. I have been aware of this issue as it is one that was raised at meetings with staff, the AMA and other groups. I honestly believe it is a complaint that has existed for a long time due to the emphasis in focus over the last 15 years on the bottom line.

275. I have addressed these issues generally in the first part of this statement.

276. When I applied for the position of DG I had no illusions about the fact that the excessive focus on fiscal management had resulted in a disaffected workforce. I said as much in my letter of application. As I have explained in the first part of my statement, for QH, like many other organisations, the last decade has been one of financial compliance, under-funding and the culture surrounding economic rationalism. That culture is not confined to QH. But one of its consequences was a disaffected workforce.

D. RECENT INITIATIVES

277. During my fifteen month period as DG I directed a number of initiatives that were intended to address the challenges facing QH. I do not claim "ownership" of these initiatives. They were developed by a number of highly skilled and dedicated people. It is for others to decide whether they assist in improving the system.

278. I have referred to some of these initiatives in this statement such as:

(a) the adoption in June 2004 of a new Open Disclosure Standard for communication following adverse events (para 26);

(b) the creation of the Innovation and Workforce Reform Directorate (para 28 to 32);

(c) the amalgamation of alcohol, tobacco and other drugs services with mental health services in accordance with the independent and external advice of Dr Bolton (para 39);

(d) Clinical Service Networks, clinical need escalation, shared service providers and other strategies to reduce the impact of our decentralised population (para 54).

(e) adopting a different approach to preventative strategies (para 66);

(f) supporting the passage of anti-smoking legislation, which sends an important message about the public acceptability of smoking (para 71);

(g) introducing five year financial forecasts to give greater certainty for funding of new services (para 74);

(h) retiring all District debt and funding growth in debt (para 76 and 97);

(i) rolling out of the specialist outpatient services policy framework and development of software for automatic collection of data (para 186-7);

(j) changing the elective surgery funding structure so that it:

  (i) reflects today's costs of performing the surgery (para 191);

  (ii) forms a 1 line item in base funding;

  (iii) is managed by districts and zones (para 194); and

  (iv) includes medical procedures (para 195);

(k) "buying" medical places at Griffith University so that we can train Australian medical graduates, especially train them to work in rural and remote practice and other areas of greatest need, during the years that they are required under their scholarship agreements to work for QH following graduation (para 103(b));

(l) reaching agreement with the Royal Australasian College of Surgeons to train specialists in some private hospitals (para 103(c);

(m) embedding safety and quality mechanisms in the organization and changing the behaviour of clinical staff by:

  (i) creating the IWR to move Safety and Quality into implementation.;

  (ii) creating the Patient Safety Centre;

  (iii) expanding Clinical Collaboratives – through the Clinical Practice Improvement Centre;

  (iv) introducing on 1 July 2004 a Sentinel Events Policy co-ordinated by the Patient Safety Centre;

  (v) expanding the role of the Skills Development Centre to include OTDs;

(vi) introducing the Clinical Service Capability framework in mid-2004 which attempts to address quality issues by specifying:

A. the level of clinical services that can be provided by a particular facility;

B. the infrastructure necessary to run a particular type of service (para 126(f));

(n) expanding Clinical Service Networks which try to get professional and operational support from a larger centre to a smaller centre (para 54).

279. These changes individually and collectively, represent a major cultural and organisational change for QH. Many of them are in the early stages of their implementation, and their implementation should be monitored. Changes of this kind take years to come to fruition.

Focus on safety and quality

280. During my time as DG I sought to emphasise the need for QH to focus on safety and quality. My belief was that safety and quality needed to become part of everyday life in QH rather than an "add-on". The creation of IWR was a critical structural change to encourage a unified focus on safety and quality. It attempts to build upon successful models such as the Veterans Health Administration from the US.

281. A critical part of the IWR and the focus on safety and quality was to identify and correct system failures, and to increase clinicians accountability.

Making the best use of ideas generated within QH

282. As explained earlier, one function of IWR is to ensure that that good ideas generated anywhere within QH can be sent to one place quickly and simply. The good idea might simply provide a local solution. But it may have a broader application and if this was so, it is important that it not be lost to the system. If the idea is a "big idea" and requires substantial investment, then the IWR can present it to the IWR Board. I sat on that board and it also included external board members from private industry and the universities. They advised whether proposals should be taken further and given the substantial investment that might be required.

Alternative workforce

283. As I have identified, one of the biggest challenges facing QH are workforce changes. A key problem has been the shortage of Australian trained medical practitioners. I have noted earlier some of the changes that have been made to address these problems. These include the development of the Nurse Practitioner role. An important initiative was the recent announcement that QH will fund undergraduate medical places at Griffith University. In essence, the intent is to "buy" medical places and ensure that the medical graduates receive training that equips them to undertake rural and remote practices. The intent is that scholarship agreements will require graduates to work for QH for

ten years and this will enable QH to direct them to work in areas where there is greatest need. The intent is to increase the number of Australian trained medical practitioners who work in regional and rural hospitals.

Improving connections

284. With all the will in the world, QH cannot improve the health outcomes of Queenslanders on its own and without building connections with other groups. This includes fostering connections with non-government organisations such as the Queensland Cancer Fund and the Queensland Association of School Tuckshops.

285. More generally, public-private relationships need to be developed, so that the public system and the private system complement each other.

286. In towns it involves breaking down the divide between "hospital doctors" and "town doctors". During my time as GMHS and as DG, QH attempted to free up the rules and to encourage the use of local GPs to work in hospitals in rural areas.

287. Encouraging local GPs to work in hospitals can free up and relieve over-worked doctors who are employed by QH. Recently I received a letter from the Medical Superintendent in Stanthorpe who explained how these initiatives had produced noticeable benefits. He says that they helped improve his working situation dramatically. The public hospital is able to use private GPs as part of the public roster to their mutual benefit. He reports that the hospital has revenue coming in from private patients who are being referred there for services like private ultrasound. Eight of the eleven GPs in the town are on the public roster. As a result the Medical Superintendent says "I can leave town and know all services are preserved and well-covered". Annexed hereto and marked **'SMB90'** is a copy of his letter.

288. The improvements in that town are the result of QH in recent years encouraging District Managers to look at changing their approaches, and encouraging local arrangements of the kind undertaken in Stanthorpe. It requires, to quote the Medical Superintendent at Stanthorpe, "the removal of walls between the private and public sectors".

289. In that town innovation has resulted in breaking down the divide between "hospital doctors" and "town doctors", to the benefit of both groups, and, more importantly to the benefit of their local community.

290. This small example illustrates the importance of building connections at all levels between QH and other groups.

E. HEALTH AS A POLITICAL FOOTBALL

The "bureaucracy"

291. This Commission of Inquiry is not able to comprehensively address within its time limits, limited resources and terms of reference the major policy issues that confront the public health system in Queensland. But in response to the

Commission's request, I have attempted to outline some major challenges facing that system. Sensible policy development and informed policy debate is impeded by a political and media culture in which health policy is a political football. That culture makes it easy to blame "the bureaucrats" for the shortcomings of the system.

292. Given financial constraints placed upon it, QH is limited in what it can do to deliver the best health outcomes for Queenslanders.

293. So far as structural changes are concerned, I do not think that the system can return to a glorious past era that never really existed.

294. It is also simplistic to imagine, as some commentators apparently do, that the health system in Queensland has some simple and stark division between clinicians and "bureaucrats". For example, a Director of Medical Services at a major hospital may be an extremely experienced clinician but primarily involved in the management of health services at the hospital. The individual could be tagged as a 'bureaucrat'. But many would think it is a good thing that an experienced medical practitioner who is qualified to undertake such a management role superintends medical services at the hospital. A similar point was made by Mrs Edmond in her evidence to the COI about the fact that, unlike many other States, many senior officers in her department at the time that she was Minister had backgrounds as health professionals.

295. At all levels, whether it be the Medical Superintendent at a particular hospital or at other places in the structure of QH, people like these require administrative support and staff to enable them to function. For example, without substantial administrative and support staff, it would be impossible to undertake any of the executive functions that I performed in recent years. Some level of 'bureaucracy' is therefore inevitable within the public hospital system and in other parts of QH. Ideally, the number of 'bureaucrats' is as few as are necessary to support the system. As Mrs Edmond has already pointed out, sometimes the appointment of administrative staff actually frees up medical practitioners and others to provide health care or to superintend its delivery.

296. But I was conscious during my few years as GMHS and DG that there are some sections of the "bureaucracy" whose primary interest seems to be in producing reports, crunching numbers and attempting to exert and extend their control over health districts and the people who work in them. The "bureaucrats" who seem more interested in reports and numbers than what their reports and numbers mean for patient care are a very small part of the workforce, and so I do not want my comments to be misinterpreted.

297. As a person who has worked as a clinician and later in the administration of our public health system, I hate to see the system and those who work in it demeaned by poorly informed criticism. The overwhelming majority of people who work in the public health system in Queensland work for inadequate reward. Those who work in delivering primary health care perform under extremely stressful conditions. Budgetary constraints place enormous demands on them. At the best of times, public hospitals are places

in which there is the potential for conflict between individuals, between groups that work in the system and within hierarchies. The potential for conflict increases when staff are put under heavy workloads and have limited resources with which to do their work. In an era of economic rationalism and budget constraints, hospital employees are stressed and have inadequate time to avoid and resolve conflicts. Relationships between them suffer. Relationships with patients also suffer. This leads to complaints from patients and poorer health outcomes.

298. The overwhelming majority of people who work in the public health system in Queensland work above and beyond the call of duty. The overwhelming majority of them are hard working, dedicated public servants.

299. I did not create the public health system in Queensland and the 'bureaucracy' that goes with it. No individual did. No individual is especially responsible for its failings. No individual can take credit for its successes. No one group, be they 'senior bureaucrats', 'junior bureaucrats' or groups of health care professionals created the problems, and none of them are capable of fixing those problems on their own. Until we get beyond the culture of blame, of blaming individuals and groups for the shortcomings of a system, we will not get very far.

300. The current intense public focus on the system's failing should not disguise its considerable achievements.

301. I was DG for 15 months. As my application for the job indicates, when I became DG I hoped to shift the focus of QH away from fiscal management. I wanted to address problems that had resulted in a disaffected workforce, a lack of innovative problem solving, strained relationships within the system and with other government agencies and a lack of public confidence in the system's capabilities. But any DG or other health administrator can only work within the political environment and institutional structures that exist.

302. Attempts to change the system encounter resistance. Changes that are perceived as elevating one group of health care professionals at the expense of others are an example. Attempts to shift the focus of QH away from fiscal management and on to the delivery of patient care also encounter resistance.

303. The culture of economic rationalism and the mind-set that government departments are in the business of "purchasing" services is not confined to health. But it was a culture that I hoped to change with the support of the QH workforce.

304. Making changes leads to individuals and groups feeling threatened that their role and influence are being diminished. Decisions have the effect of changing professional boundaries between health care professionals. Within QH, changes in the organisation can be perceived by individuals and groups as being targeted at them, and devaluing the importance of the work they do.

305. Because of the resistance and resentment changes create in some quarters, they are hard to implement.

306. Doing so is not made any easier by a political culture in which health is a political football.

Health as a Political Football

307. None of the initiatives which were taken during the time that I was GMHS or DG could address the two issues which Dr McNeil identified in his evidence:

(a) the under-funding of public health;

(b) the fact that health has become a political football.

308. Dr Keith McNeil is a world-renowned specialist in his field. The Chairman of the previous COI at the conclusion of Dr McNeil's evidence made the point that with so much talk about the Smart State, the medical profession in Queensland is and has for a long time been the standard bearer for what the Smart State is all about, and that Dr McNeil would be at the head of that. The former Chairman stated that it is humbling to have the benefit of input from people of Dr McNeil's eminence. I agree.

309. Dr McNeil's statement (Ex 300) speaks for itself. His oral evidence showed that he is not only an eminent specialist in his field of acute care. He and others like him appreciate the importance of preventative health so that the areas in which they serve the public in the public hospital system are not overwhelmed in the years ahead. (T4751)

310. Dr McNeil also expressed the frustration that people working in all areas of Queensland Health feel about the under-funding of Queensland Health, and that health policy is seemingly determined "on the basis of political expediency and the so-called 'Courier Mail test'". Dr McNeil wrote:

> "*28. Queensland Health is facing a crisis which at the end of the day stems predominantly from a situation of chronic under funding. This has led to a steady drain of highly trained medical and other health professional staff from the public system, placing steadily increasing pressure on those that remain to meet the ever increasing demand.*
>
> *29. Unless the clinical workforce issues (organisational culture, remuneration etc) are addressed as a matter of the utmost urgency, the prospects of the system meeting community expectations now and in the future are dismal.*
>
> *30. Underpinning most (if not all) of these issues, is the untenable situation where health policy is seemingly determined on the basis of political expediency and the so-called 'Courier Mail Test'. Until our politicians stop treating health as a political football, the chances of getting the much needed (essential) long term*

solutions (as opposed to those aimed squarely at the next election) are equally as dismal."

Making health policy bipartisan

311. I venture for consideration the following proposal to reduce the scope for health policy in Queensland to be a political football. I suggest the establishment of a bipartisan Parliamentary Standing Committee on Health. It is for others to consider the merit of such a proposal, and reject it if they think it lacks merit. I simply raise the proposal for others to consider and debate. My personal priority is to resume my career as a medical practitioner and to avoid the politics of the health system from now on.

312. My thought is that the creation of a bipartisan Parliamentary Standing Committee on Health would engage both sides of politics in taking on the burden of trying to resolve the complex issues that confront the health system in Queensland. Based on my understanding of how the Parliamentary Committee system works, such a Committee would be able to request the kind of information that it required to scrutinise health policy and foster informed public debate.

313. Information that was necessary to inform Parliamentary and public debates about these issues would be accessed through the processes and powers of the Parliament.

314. Both sides of politics would take on the burden of trying to elevate the standard of discussion about health policy, and the burden of meeting the challenges that face the system.

315. Both sides of politics would take on these burdens. Both sides of politics would share the responsibility of devising solutions to the problems that confront our communities.

Dated 16 September 2005.

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Stephen Michael Buckland