Submissions

Queensland Cabinet

SUBMISSION TO THE PUBLIC HOSPITALS COMMISSION OF INQUIRY ON BEHALF OF CABINET

1. This document responds to the Commissioner's invitation on 14 October 2005 for submissions as to potential adverse findings which might be made concerning various Cabinet decisions. Those findings appear at pages 6088-6089 of the Transcript. This submission addresses two matters.

2. First, it is submitted that the proposed findings ought not be made because such findings lie outside the terms of reference of the Commission of Inquiry. This is not surprising because the nature of Cabinet, and its special position in responsible Westminster government, does not lend itself to incidental findings of the kind foreshadowed.

3. Second, the submission sets out the reasons why the potential findings are neither made out on the evidence nor warranted in any event.

CABINET AND THE PUBLIC INTEREST

4. The potential findings proceed upon the basis that Cabinet decisions, otherwise regularly made, can be criticised or called into question incidentally by the Commission of Inquiry for being contrary to the public interest. That, by reason of Cabinet's position and the terms of reference of the Commission, is not so.

5. Cabinet answers to Parliament and through it to the people of Queensland. These accountability mechanisms, and well-established conventions, leave to Cabinet judgments as to what the public interest is, being the interests of Queenslanders as a whole. Cabinet is uniquely placed to make such judgments and it is no part of the functions of the Commission, in accordance with its terms of reference, to make a judgment about whether political decisions made by Cabinet were or were not in the public interest.

6. The question of what is and is not in the public interest is something elected representatives are best placed to decide. That is because the term bears different meanings in particular contexts. It involves a "*discretionary value judgment ... by reference to undefined factual matters*"[1]. There must always be an element of conjecture in a decision as to what is in the public interest[2].

7. It is a question which Cabinet, being comprised solely of elected representatives responsible to Parliament[3] is best placed to judge. As Bowen CJ said in *Minister for Arts, Heritage and Environment v Peko-Wallsend* (1987) 75 ALR 218 at 225:

> *It is to [federal] Cabinet that the highest decisions of policy affecting Australia are brought. Often the questions arising involve intense conflicts of interest or of opinion in the community. In Cabinet these conflicts have to be resolved. Decisions have to be taken in the public interest, notwithstanding that the lives, interests and rights of some individual citizens may be adversely affected by the decision.*

8. There is no general rule that disclosure of material such as the Hospital Reports is always in the public interest. The question involves weighing competing tensions: the interest of the public in citizens being informed of the processes of their government and its agencies on the one hand and the public interest in the proper working of government and its agencies on the other[4]. It is inherent in Cabinet deliberations that they often involve consideration of more than one controversial path, even though only one may, despite differing views, prove to be sufficiently acceptable[5]. But the decision must be, in the end, one which Cabinet as a whole supports. That must, given the nature of Cabinet in the Westminster system, be the end of the matter as far as the Commission is concerned.

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1 See the discussion of the wide scope of "the public interest" in the context of decision making by public bodies in *O'Sullivan v Farrer* (1989) 168 CLR 210 at 216-217; *Harburg Investments Pty Ltd v Mackenroth* [2005] QCA 243 at [3] per McPherson JA.

2 *Re Howard and Treasurer of the Commonwealth* (1985) 3 AAR 169 at 1777

3 *Constitution of Queensland Act* 2001 s 42(1)

4 *Harris v Australian Broadcasting Corporation* (1983) 78 FLR 236 at 246

5 *Commonwealth v Northern Land Council* (1993) 176 CLR 604 at 615-616.

9. It would be a surprising thing for an Executive to establish a Commission of Inquiry one of whose tasks was to inquire, incidentally, whether particular decisions of the Executive were or were not in the public interest and then to make a finding accordingly. This Executive did not do so and none of the terms of reference actually justifies an inquiry of that kind.

10. The widest of the terms of reference is paragraph 2(d) which, in its opening paragraph, requires that inquiry be made as to "[t]he appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) ..."

11. Even the word "appropriateness" does not justify a view that the Commission is enjoined to make findings that decisions of Cabinet were or were not in the public interest. Whether particular decisions had some kind of effect may well be a matter of relevant inquiry; but whether the decision was in the public interest when it was made is not.

12. It is therefore submitted that, while it is open to the Commission to consider the effect of any particular decision that has been taken, so long as the effect is a matter within its terms of reference, it is no part of the function of the Commission of Inquiry to make and publish a judgment about whether decisions of Cabinet were or were not in the public interest.

SUBMISSIONS ON THE EVIDENCE

Measured Quality Reports

13. Cabinet considered submissions concerning these documents on 11 November 2002 (Phase 1) and on 10 June 2003 (Phase 2).

14. Preparation of the reports was overseen by Mr Collins who was the Manager, Measured Quality Services within Queensland Health. The program's main

objective was to improve the quality of services provided by Queensland Health to the public. Mr Collins explained to the Commission that the program involved a sample of hospitals being taken and their performance identified and measured against certain indicators. He said 80 per cent of the data was drawn from existing records in Queensland Health and that the remaining data was sourced through surveys.

15. Two levels of reports were brought into existence:

    (a) annually, reports concerning individual hospitals (**the Hospital Reports**);

    (b) biennially, a general report containing an overview of trends across Queensland Hospitals (**the Aggregate Reports**).

16. The Aggregate Report was publicly released. This was in accordance with recommendations made to Cabinet.

17. With respect to the Hospital Reports which Cabinet was asked not to make public, Cabinet also chose to act on the recommendation.

18. The potential finding raises these questions:

    (a) whether it was contrary to the public interest for Cabinet to adopt recommendations made to it not to publicly release the Hospital Reports;

    (b) whether it was contrary to the public interest for Cabinet not to adopt a recommendation made to it that the Phase 1 Hospital Reports be disseminated to district and zonal managers within Queensland Health;

(c) whether it was contrary to the advice of Queensland Health not to disseminate to district and zonal managers within Queensland Health the Phase 1 Hospital Reports.

Public release

19. Cabinet, in deciding not to release publicly the Hospital Reports, acted on advice and in accordance with the recommendation put to it. Cabinet is a deliberative body which relies on the recommendations of those involved on a day to day basis with the relevant matters. Mr Collins says of the Phase I reports "it was decided to advise Cabinet that it was not intended to release the Phase 1 hospital reports publicly"[8]. His oral evidence was that it was never intended the Phase 1 Hospital Reports would be released publicly[9].

20. As Mr Collins pointed out in his oral evidence, there may be good reasons (which are not addressed in the Reports themselves) for the variations between the data for individual hospitals, including the size of the hospital and the ability to garner the services of surgeons, nursing and other essential staff[10]. The public could not be expected to know these matters. Without that information, the Hospital Reports would be meaningless and be more likely to cause confusion than inform the public.

21. Communications at higher levels of government are more likely to involve sensitive issues[11]. Disclosure which will inhibit frankness and candour in future pre-decision communications is more likely to be considered not to be in the public interest. The same applies to disclosure which will lead to confusion and result in misinformed debate.

22. There are other good reasons why releasing the Hospital Reports publicly would not have been in the public interest:

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8 Collins addendum statement Ex 378 para 30.
9 Transcript p 5920 ln 35.
10 Transcript p 5903.
11 *Re Howard and the Treasurer of the Commonwealth of Australia* (1985) 3 AAR 169

(a) Mr Collins's evidence was that there was a tension between what clinicians and hospital managers need to be provided with for the report to have real effect, and what the public required in order to have a proper understanding of the data[12]. This is correct. The clinicians and managers have the benefit of experience in the particular hospital and knowledge of the issues it faces. The public of course do not have that background, requiring those matters to be properly explained if the report is to be understood in proper context;

(b) Mr Collins said, with these considerations in mind, his team split the reports into the two levels with a view to "meet the needs of clinicians and managers as well as the public"[13]. The clinicians would have the data for the relevant hospital to identify problems, and the public would have the relative performance data at a Statewide level;

(c) Queensland Health sought to create a constructive "blame-free" environment in which to disseminate the results in the Hospital Reports "so that genuine quality improvement can be achieved"[14]. In Mr Collins's mind were what he said to be numerous Australian and international studies showing that in order to meaningfully and effectively engage clinicians in quality and safety improvement processes, a blame-free environment was necessary[15] and that this would be impossible were the hospital reports to be released to the public without first allowing investigation[16]. That constructive process was proper because, in the end, the primary objective of the Hospital Reports and the Measured Quality program as a whole was to improve the levels of service provided by Queensland Health. It was necessary for the reports to be able to be given effect to in a constructive manner, removed from fear of unfair or misinformed reprisal;

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12 Addendum Statement of Collins Ex 378, para 8
13 Addendum Statement of Collins Ex 378, para 9
14 Para 20 of the 10 June 2003 Cabinet Submission
15 Addendum Statement of Collins, Ex 378 para 4.
16 Addendum Statement of Collins, Ex 378 para 6.

(d) the team of which Mr Collins was manager comprised relatively junior members of staff who fulfilled more of a data collection role albeit with some analysis of the results. They should not be understood, however, as being in any sense specially qualified to make findings and recommendations in any overarching sense. Their role, on the approach adopted, was more limited and contained. It allowed individual hospitals to correct any erroneous conclusions which had been reached without the benefit of all necessary background information;

(e) when the Hospital reports were released to the particular districts, Queensland Health made available staff to "assist ... with interpreting the results"[17]. The release of the data without this explanation could have resulted, the submission relied upon by Cabinet observed, in misinterpretation of the results. Not only would the public not have had this assistance, the reports would have been read by them without the background knowledge and specialist expertise which district managers and others possess. It would have caused misinterpretation, confusion and misinformed debate in the sense that issues would have been ventilated which were in fact false issues or simply misunderstandings. Mr Collins said as much. The reports were prepared on the basis of data which had been collected before the Hospitals had had an opportunity to investigate the results.

23. A decision of Cabinet made in these circumstances cannot be the subject of the potential finding.

Release to district and zonal managers

24. It is not as if the Hospital Reports were never used or disseminated. Mr Collins said the Hospital Reports were used in this way[18]:

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17 Cabinet Submission para 20

18 Statement of Collins Ex 377 para 19(d).

(a) zonal management within Queensland Health were briefed by MQS project officers on the results for specific hospitals within their zone. This approach was adopted because face-to-face communication was considered to be more effective than simply delivering the report itself to the hospital;

(b) after 2004, each District Manager was provided with an electronic copy of the reports;

(c) more recently, the reports were available to district managers (and staff under them with district manager approval) on a secure website;

(d) there was then a process in place whereby comments would be made on the reports by the district including for identifying areas where further monitoring of the Hospital was required.

25. It is only in the case of the Phase 1 Hospital Reports that Cabinet did not adopt immediately a recommendation made to it that the reports "be released to each of the District Manager and Zonal Managers within Queensland Health for dissemination and action where necessary". Cabinet, just as it is entitled to adopt recommendations, is entitled to reject them. It would be wrong, however, to say the recommendation in this case was rejected outright. Two members of Cabinet were vested with the task of managing dissemination of those reports. Dissemination took place, albeit after some months (mid 2003 according to Mr Collins[19]). The timing was not critical, because fears had been held even at the time Phase 1 Hospital Reports were being prepared that the data was out of date[20].

Cabinet decision contrary to advice of Queensland Health?

26. The terms of the potential finding, in saying Cabinet's decision in late 2002 was contrary to the advice of officers of Queensland Health, is unfounded because the

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19 Transcript p 5909.

20 Evidence of Collins, p 5932 lns 25-30

only advice Cabinet received was that contained in the relevant Cabinet submissions.

27. It would be misplaced to rely upon communications between officers of Queensland Health and Mr Brad Smith to find that Queensland Health "advised" Cabinet. Recommendations to Cabinet are made by Ministers. That is the advice upon which Cabinet acts. In *Minister for Arts, Heritage and Environment v Peko-Wallsend* (1987) 75 ALR 218 at 225 Bowen CJ said:

> *... there are recognized channels for communicating arguments or submissions. Each Minister has the support and advice of a Department of State.*

28. In any event, Mr Brad Smith is not the "Secretary of Cabinet" (contrary to what was suggested by Senior Counsel assisting[21]). Communications with him are not communications with Cabinet.

29. In summary, the decision to prepare two levels of report was taken before the relevant Cabinet decisions were made. One level, the Hospital Reports, were prepared on the basis that they would not be publicly disseminated. With that in mind, the higher level report was prepared to be released publicly. That is the context in which the reports came to Cabinet. And it is not as if the Hospital Reports were withheld. They were sent (albeit with some delay so far as Phase 1 was concerned) to the public officials who had a direct interest in their contents. They had been written for an audience of this kind and written for the purpose of those people considering the report and making changes to the way they provided services to the public with the aim of improving those services. Not only then were the Hospital Reports not "withheld" by Cabinet, they were made available for the particular purpose for which they had been prepared. And in the end, the reports were used with a view to improving services delivery to the public and not in a manner contrary to the public interest.

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[21] Transcript p 5927.

30. For the reasons set out, provision of the reports to the public without proper background and explanation had a real likelihood of causing confusion and uninformed debate. The focus was improving service delivery and having individual hospitals act on the results, not on embarrassing particular hospitals and in doing so creating a defensive response from them which would have distracted from the primary focus of improving hospital performance. The worst that might be said is that there was delay, and regrettable delay, in the dissemination of the Phase 1 Hospital Reports to individual hospitals.

Waiting Lists

31. It is correct to say that between 1998 and the present time, Cabinet released to the public the elective surgery lists, and that Cabinet, between 1997 and 1998, did not permit the disclosure of such information.

32. The Cabinet in existence in 1997 and 1998 was not a Cabinet of this Government and, consistent with well-established convention, the present Government does not seek to defend or explain why Cabinet at that time made the decisions it did. The fact remains, however, that Cabinet under a Labor government has made available more information than had Cabinets under the previous the Coalition Government.

33. The potential finding, so far as it has relevance to the present Cabinet, is that it was misleading and contrary to the public interest to disclose the elective surgery lists without what the Commissioner has described as the "anterior lists", namely a list of people who had not yet been assessed for elective surgery.

34. What is said above in relation to Cabinet decisions not being susceptible to findings of acting contrary to the public interest is relied on in connection with this potential finding also.

35. Contrary to what the potential finding suggests, disclosure of the so-called anterior list would have misled the public. This emerges once the basis upon which such lists are prepared is fully appreciated.

36. The Queensland Government measures and reports elective surgery waiting lists as part of a national agreement (known as the Australian Health Care Agreement) which has the objective of securing public access to public hospital services. Each State Government and the Commonwealth is a party to that agreement. Its significance is that it applies National Health Dictionary Definitions which in turn provide a common platform for there to be a sharing of data and some meaningful comparisons made. The agreement forms one of the bases upon which the Commonwealth provides funding to Queensland for use towards its public hospital services. If Queensland were not a party to this agreement, or did not comply with it, this component of Commonwealth funding would not be paid and Queensland would not be able to participate in the data sharing arrangements.

37. Each party to the Commonwealth agreement is required to report certain performance indicators and to agree to that data being published in order to improve the transparency of the public hospital system's performance (Schedule C Clause 4). One set of such performance indicators are waiting times for elective surgery (Schedule C, Attachment A). The reporting is required to adhere as closely as possible to the National Health Data Dictionary.

38. The point to be made from this can be stated briefly: the elective surgery lists are the only lists prepared in compliance with the relevant National Health Dictionary Definitions. Those definitions, and especially "Hospital Waiting List" requires that the data consist only of patients "assessed as needing elective hospital care".

39. Any anterior list would not follow the prescribed national definitions and would therefore proceed on an entirely different footing from the data published pursuant to the Australian Health Care Agreement. For these reasons, Queensland has one

centrally-managed waiting list for elective surgery prepared in accordance with the National Scheme.

40. An anterior list would not only have no meaning in the context of the national scheme, but it would be misleading because it would proceed on an entirely different basis – at a fundamental level – to what is accepted practice across Australia for recording these matters.

41. But perhaps most importantly, there is no anterior list which is centrally collected to common standards which can be meaningfully compared to the elective surgery list. There is no centrally and consistently collected anterior list. For the purposes of the Australian Health Care Agreement, the only outpatient data collected is for non-admitted patients "occasions of service". This is not prepared at the patient level and therefore is of no use whatsoever in interpreting the elective surgery list.

42. The snapshot of these lists taken by Queensland Health in July 2004 is not a list of the nature of the elective surgery list. It is in a completely different category.

43. Contrary to what the potential findings suggest, disclosure of the surgery list was not misleading but necessary when regard is had to Queensland's obligations under the Australian Health Agreement. To have supplemented that with a list prepared on some alternative and unorthodox basis would have misled the public as to the true position with respect to elective surgery waiting times, and done so by adopting a basis for measurement which was contrary to the universally accepted national standard for such matters.

Dated 25 October 2005

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28 October 2005

Mr David Groth
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Dear Mr Groth

QPHCI - Submissions on behalf of Cabinet

I refer to my letter dated 26 October 2005 attaching submissions to the Public Hospitals Commission of Inquiry on behalf of Cabinet.

Those submissions responded to the Commissioner's invitation on 14 October 2005 for submissions as to potential adverse findings which might be made concerning various Cabinet decisions. The relevant potential findings appear at pages 6088-6089 of the transcript.

Those potential findings did not concern the manner in which persons affected by the conduct of Dr Patel might be compensated.

Since lodging Cabinet's submissions, my office has been provided by the Commission with a copy of the final submissions of the Bundaberg Hospital Patient Support Group dated 26 October 2005. At paragraph 4 on the fourth page of the Executive Summary and paragraph 186 on pages 46 and 47, various allegations are made concerning the fairness and appropriateness of the scheme by which individuals who may have suffered loss by reason of Dr Patel's conduct might be compensated.

Matters of this kind did not form part of the Notice directed to members of Cabinet, and to my knowledge, no notice raising potential findings of this kind has been directed to the State of Queensland.

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It is my respectful submission that findings or recommendations as to these matters would fall outside the Commission's terms of reference. I further submit that should the Commission nevertheless propose to make findings or recommendations about the scheme by which patients of Dr Patel might be compensated, and in particular the adequacy of any scheme of that kind, the Commission should afford to the State an opportunity to respond to the allegations, and to call necessary evidence on the issue.

Yours faithfully

CW Lohe
Crown Solicitor

PRE052/1440:1210610 v2

28 October 2005

Crown Solicitor
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Dear Mr Lohe

Submissions on Behalf of Cabinet

I refer to your letter of 28 October 2005. You observe that in the final submissions of the Bundaberg Patient Support Group dated 26 October 2005 various allegations are made concerning the fairness and appropriateness of the scheme by which individuals who may have suffered loss by reason of Dr Patel's conduct might be compensated. The Commission does not currently propose to make findings or recommendations about the scheme by which patients of Dr Patel might be compensated. If this intention changes, I will alert you so that the State has an opportunity to respond to the allegations and to call necessary evidence on the issue.

Yours sincerely

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