

Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing; and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E.

A culture of concealment

6.6 The fifth problem was a tendency of administrators to ignore or suppress criticism. Recognition of these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* 1992 to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. These problems and their solution are discussed in Part F.

Part B – A grossly inadequate budget and an inequitable method of allocation

Introduction

6.7 In his final submissions to this Commission, Dr Buckland said:

...it is impossible to address the circumstances of the Queensland Health workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:

(a) the budget constraints on Queensland Health in general and on public hospitals in particular; and

(b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.¹

I agree with those statements.

6.8 Consequently, while I have made findings and recommendations against Mr Leck and Dr Keating at Bundaberg, and Mr Allsopp and Dr Hanelt at Hervey Bay, I have borne these matters in mind in making them. These constraints also

¹ Final Submissions of Dr Stephen Buckland, p53

adversely affected the conduct of other administrators; Dr Scott in his dealings with Dr Aroney was an example of this. In fairness to those persons, it is necessary to say something about these dual constraints under which administrators operated; inadequate budgets and an entrenched culture which put throughput and cost cutting ahead of patient care.

- 6.9 Moreover, evidence given in this Commission proved that a root cause of unsafe operation of surgery and orthopaedic surgery units at Bundaberg and Hervey Bay, respectively, was that their budgets were grossly inadequate to enable them to provide adequate, safe, patient care and treatment, including surgery.² Lack of sufficient funds also contributed to the employment of Mr Berg in Townsville, the tragedy in Charters Towers, the dysfunctional emergency department at Rockhampton and the reduction in cardiac care at Prince Charles Hospital.³ The way in which budgets were allocated to and within hospitals also contributed to these consequences. It therefore became necessary to examine the evidence as to how that came about, which led to the identification of the following problems and a need to suggest possible solutions to those problems.
- 6.10 However, it must be emphasised that what is said in this chapter is not intended to be a comprehensive analysis of budget problems, and their solution. That is beyond my terms of reference. It is intended to identify budget problems, the solution of which is necessary, but not sufficient, to prevent the recurrence of what occurred at Bundaberg, Hervey Bay, Townsville, Charters Towers, Rockhampton and Prince Charles and, by inference, other regional and even metropolitan hospitals.

Queensland Health's budget as a whole

- 6.11 Queensland's total operating expenses for 2005–2006 are budgeted at \$25.670 billion.⁴ The amount budgeted on health is \$5.6 billion, or approximately 22 per cent of total expenditure,⁵ marginally behind education, at \$6.3 billion or approximately 25 per cent of total expenditure. By comparison, in 2004-05 the total operating expenses were budgeted at \$24.046 billion⁶ with \$5.1 billion budgeted on health or approximately 22 per cent of total expenditure,⁷ marginally behind education, at \$5.9 billion or approximately 25 per cent of total expenditure.

² Chapters 3 and 4

³ Chapter 5

⁴ *State Budget 2005-06, Budget Strategy and Outlook 2005-06*, p1

⁵ *State Budget 2005-06, Budget Highlights*, p15

⁶ *State Budget 2005-06, Budget Highlights*, p16

⁷ *State Budget 2005-06, Budget Highlights*, p15.

- 6.12 Despite successive Health Ministers announcing yearly increases in health spending,⁸ growing by an average of seven to eight per cent each year,⁹ this is based on the assumptions that the previous year's base budget was adequate and that this increased funding is keeping pace with escalating health costs and population growth, and an increasingly ageing population. These resources allocated to Queensland Health have come under increasing pressure. Demand for services across the community has increased substantially due to population growth,¹⁰ Queensland's increasingly ageing population¹¹ and changes in medical technology and techniques which have made available a wider range of health services accessible to the public.

Under-funding of Queensland Health by successive Governments

Queensland expenditure per person on health services below the national average

- 6.13 The 2005 *Queensland Health Systems Review*, Final Report, using extrapolated Australian Bureau of Statistics data, suggests that Queensland's expenditure on health services¹² per head is 14 per cent (\$200 per person) below the national average of \$1444.¹³ Dr Buckland expressed the view that the gap may be as high as \$400 per person.¹⁴ This is not a recent problem. It is of long standing, spanning successive Governments.
- 6.14 Because of the rapid growth in Queensland's population, in the years from 2000 to 2003, Queensland recorded annual reductions in health expenditure per person. Professor Stable, former Director-General of Queensland Health, gave evidence that he had had an ongoing argument with Government since 1996 about the under-funding of Queensland Health.¹⁵

Queensland expenditure per person on public hospitals below the national average

- 6.15 A more compelling analysis of comparative funding, for present purposes, is public hospital funding. The Commonwealth Productivity Commission, which seeks to compare government services across jurisdictions, highlights a growing gap between Queensland expenditure per person on public hospitals and national average expenditure. The 2003 Productivity Commission report records that in 2000-01, Queensland recorded the lowest government real recurrent expenditure per person on public hospitals (in 1999-00 dollars) at \$660 per

⁸ See for example: *State Budget 05-06: Queensland Health - Budget Highlights*, p 3 (\$250 million increase) ; *State Budget 04-05: Queensland Health - Budget Highlights*, p1 (\$500 million increase); *State Budget 03-04: Queensland Health - Budget Highlights*, p 1 (\$300 million increase)

⁹ *Queensland Health Systems Review*, Final Report, p 39

¹⁰ See para 6.20

¹¹ See para 6.20

¹² Includes public hospitals (representing approximately 64 per cent of total expenditure), mental health, public and community health and oral health

¹³ *Queensland Health Systems Review*, Final Report, pp 11 and 39

¹⁴ Exhibit 336 para 77 (Dr Buckland)

¹⁵ T5720 line 57 – T5721 line 5 (Prof Stable)

person, well below the national average of \$776 per person,¹⁶ a gap of \$116 per person. This trend has continued. For the 2004 financial year, Queensland again recorded the lowest government real recurrent expenditure per person on public hospitals (in 2001-02 dollars) at \$712 per person, well below the national average of \$895 per person,¹⁷ a gap of \$183 per person.

6.16 Further evidence of the significant under-funding of Queensland public hospitals can be found in *The state of our public hospitals*, June 2004 report, which claims, on different data,¹⁸ that Queensland's recurrent expenditure per person on public hospitals in 2001 was the lowest in Australia at \$322, 13 per cent lower than the national average of \$371 per person.¹⁹

6.17 The most recent data, in *The state of our public hospitals*, June 2005 report, suggests that the gap in under-funding of Queensland public hospitals is growing. Queensland's recurrent expenditure per person²⁰ on public hospitals in 2004 was still the lowest in Australia, at \$440, now 20 per cent (worsening from 13 per cent) below the national average of \$552 per person.²¹

Under-funding of public hospitals is exacerbated by several factors

6.18 This under-funding of public hospitals is exacerbated by several factors which suggest that to provide the same level of services as other states, funding of Queensland Health should not merely be in line with national average but should be much higher.²² These factors are:

Queensland is the most decentralised state

6.19 Queensland is the most decentralised state in mainland Australia.²³ More than 48 per cent of the population of Queensland resides outside our major cities.²⁴ The decentralised nature of Queensland's population necessitates some duplication of health services infrastructure and dilution of the medical workforce across the State.²⁵ As technology advances and the cost of providing

¹⁶ Steering Committee for the Review of Government Services, *Report on Government Services* 2003, p 9.5

¹⁷ Steering Committee for the Review of Government Services, *Report on Government Services* 2005, p 9.4

¹⁸ Commonwealth Department of Health and Ageing data

¹⁹ Australian Government, Department of Health and Ageing, *The state of our public hospitals, June 2004 report*, p17

²⁰ This data is calculated using the following 'weighted' population data – as utilised by the Commonwealth Department of Health and Ageing [NSW 7.0; VIC 5.1; QLD 3.8; WA 1.9; SA 1.7; TAS 0.5; ACT 0.3; NT 0.2] This 'weighted population' is age-weighted by modifying each age group of the population to account for the different hospital usage of that age group. This means a population with a higher than average number of older people will have a higher weighted population to take account of the higher than expected hospital usage of that older population. The weighted populations are also weighted to account for different expected hospital usage by each gender.

²¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p 5

²² See for example: T5061-T5064 (Ms Edmond)

²³ See Department of Premier and Cabinet, *Premier's policy scan*, Issue 13 February 2004, p 4; T5721 lines 22-29 (Prof Stable).

²⁴ Exhibit 336 paras 60-65 and 78 (Dr Buckland)

²⁵ Exhibit 336 paras 60-63 (Dr Buckland)

technological infrastructure increases in investigative, diagnostic and treatment areas, there needs to be greater investment for the same outcome in a less decentralised setting, or the same investment for a lesser outcome.²⁶

Queensland has the highest level of population and of ageing population growth

6.20 Queensland has the highest level of population growth in Australia.²⁷ Moreover the mean age of the Queensland population has increased steadily and consequently health costs have increased.²⁸ The Commonwealth Productivity Commission estimates that expenditure on people aged over 65 is approximately four times more per person than on those under 65 years of age and that that increases to between six and nine times for those over 75.²⁹

6.21 As a result, the Commonwealth Department of Health and Ageing uses age-weighted population to try to standardise the population across states and territories for the purpose of making comparisons more meaningful. The age-weighted population is calculated by modifying each age group of the population to account for the different hospital usage of that age group. This means that a population with a higher than average number of old people will have a higher weighted population to take account of the higher expected hospital usage of that older population.

6.22 Queensland has recorded the largest percentage increase, 14.3 per cent, in age-weighted population³⁰ between 1999 and 2004 compared to a national average of 10.2 per cent.³¹

Queensland has a lower than average number of medical practitioners

6.23 The shortage of doctors and nurses in Australia, and indeed world-wide, is well documented.³² For a number of reasons³³ these staff shortages are more acute in Queensland than in other states.³⁴ Whilst remuneration rates for Australian doctors are low by first world standards, Queensland Health specialist rates are low by Queensland and Australian standards.³⁵

²⁶ Exhibit 336 para 60 (Dr Buckland)

²⁷ *Queensland Health Systems Review*, Final Report, p 92

²⁸ See the *Queensland Government's Submission to the Productivity Commission Study of the Health Workforce*, July 2005

²⁹ Productivity Commission, *Economic Implications of an Ageing Australia*, March 2005, p 147

³⁰ Percentage change in weighted population from 1998-99 to 2003-04: QLD 14.3 per cent; WA 11.7; ACT 11.5; NT 10.1; VIC 9.4; NSW 9.3; TAS 6.9; SA 6.8 [National average: 10.2]

³¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p6

³² See T824 line 8 (Dr Molloy); Exhibit 209 (Dr Young - Chair of the Australian Medical Workforce Advisory Committee); T2863, and T2861 (Dr FitzGerald, Dr Woodruff, Dr Molloy and Dr Lennox); T876 and see Exhibit 28 paras 55 - 64 (Mr O'Dempsey)

³³ See Chapter 2 of this report

³⁴ T700-702 (Dr Bethnell); T899 (Dr Lennox); T2864 line 18 (Dr Young); and T2871-2 (Dr Young)

³⁵ Exhibit 34, paras 6 and 9 (Dr Molloy); Exhibit 35 (Dr Cohn); T575-6 (Dr Molloy); T846, line 40 (Dr Molloy)

- 6.24 For this and other reasons outlined earlier, the number of medical practitioners in Queensland in proportion to the population of Queensland has declined,³⁶ and the statistics for nurses are similar.³⁷ Queensland has a lower than national average proportion of doctors in the population.
- 6.25 Dr Buckland has attempted to put these medical practitioner shortages into some perspective:
- 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. ...³⁸
- 6.26 The greater shortage of Australian trained doctors in Queensland, than in other states, has led to a greater reliance by Queensland Health on overseas trained doctors than by other states. By 2003, the proportion of Resident Medical Officers who were overseas trained doctors in Queensland was approaching 50 percent.³⁹ This is an unsatisfactory situation for health services in Queensland, as a growing share of overseas trained doctors are being drawn from countries with different cultures and first languages from ours, from a medical education system which is either less developed than ours or one in respect of which it is difficult to make an informed judgment, and from a medical and hospital system which is less developed than ours, or one about which it is difficult to make an informed judgment.
- 6.27 It seems likely that this shortage of Australian trained doctors, the under-funding of Queensland Health and the decreasing competitiveness of medical remuneration in Queensland⁴⁰ were significant factors leading to the need to employ overseas trained doctors in Bundaberg and Hervey Bay.

Queensland is the only state to provide substantial specialist outpatient services under the public health system

- 6.28 Queensland is the only state to provide substantial specialist outpatient services under its public health system.⁴¹ Former Minister Edmond gave evidence that Queensland was unique in providing a 'specialist outpatient service'. She indicated that in other states, this service is not provided.

If your general practitioner refers you to a specialist, you go privately, the cost of that is picked up by Medicare and what you pay is out of your own pocket.

³⁶ T2864 line 18, T2871-2, T2887; See also *Queensland Health Systems Review*, Final Report, p 13

³⁷ T2887 (Dr Young); See also *Queensland Health Systems Review*, Final Report, p 14

³⁸ Exhibit 336 para 101(iv) B (Dr Buckland)

³⁹ Exhibit 55 - DR12, p 5 (Dr Lennox); See also Birrell B, 'Australian policy on overseas trained doctors', *Medical Journal of Australia*, 2004 181, p 638 – previously published in Birrell B, Hawthorne L, 'Medicare Plus and overseas-trained medical doctors', *People and Place*, 2004; 12(2), p 91-92 - sourcing unpublished data provided by the Department of Immigration and Multicultural and Indigenous Affairs

⁴⁰ See Footnote 35

⁴¹ T5721 line 50 – T5722 (Prof Stable); T4959, line 58 – T4960, line 9 (Ms Edmond); Exhibit 336, para 180 (Dr Buckland).

Queensland is the only State that provides specialist outpatient services prior to people coming to the hospital for a particular function.⁴²

- 6.29 Dr Stable gave evidence that Queenslanders utilise specialist outpatients services 20 per cent above the national average. The provision of these services reflects the policies of successive governments.⁴³ Dr Stable has given evidence that while other states were limiting or ceasing outpatient services, Queensland was continuing to increase them.⁴⁴ Any discussion of the extent to which the Australian Health Care Agreement prevents this from being changed is beyond my terms of reference.
- 6.30 Specialist outpatients waiting lists are large and growing as are waiting lists for cardiac care.

A combination of those factors

- 6.31 A combination of those factors, greater decentralisation, a higher population growth and a higher growth in the ageing population, a lower number of medical practitioners and the provision of outpatient specialist services, appears to require greater expenditure per head of population in Queensland than the Australian average expenditure, to provide the same level of service.

Defective allocation

The allocation process; historical budgets

- 6.32 Successive governments used a 'historical funding model' to allocate health funding annually; that is, each budget was based on the budget for the previous year,⁴⁵ indexed annually for labour and non-labour cost increases and supplemented for specific government programs or election commitments.⁴⁶ However, the amounts allowed for increases in labour costs were 'discounted' and were less than the real costs of enterprise bargaining increases.⁴⁷ And the amounts allowed for increases in non-labour costs, at the rate of Consumer Price Index increases, were usually less than the actual increased costs in the health sector.⁴⁸ As a result, these increases in labour and non-labour costs allowed by Treasury never kept up with the real increases in costs.⁴⁹
- 6.33 These budgets were further eroded through an 'efficiency dividend'.⁵⁰ This was not a dividend but a reduction made each year on the assumption that increased

⁴² T4880 line 55 – T4881 line 5 (Ms Edmond)

⁴³ T5722 line 8 (Prof Stable) – sourcing Commonwealth Department of Health and Ageing data

⁴⁴ T5722 lines 15-35 (Prof Stable)

⁴⁵ For example – See T1830 line 40 (Dr Thiele)

⁴⁶ Exhibit 336, p 17 (Dr Buckland); T4978-99 (Ms Edmond); *Queensland Health Systems Review, Final Report*, p 102

⁴⁷ T4978 line 9 (Ms Edmond)

⁴⁸ T4978 line 19 (Ms Edmond)

⁴⁹ T4978 lines 15-25 (Ms Edmond)

⁵⁰ T4980 line 3 (Ms Edmond)

efficiencies would be made during the course of the year. This was invariably a reduction of one or two per cent each year.⁵¹ I shall say more about this when discussing the culture of economic rationalism.

- 6.34 In addition, budgets were affected by political promises. Dr Buckland accepted that government policy must play a significant role in determining the allocation of Queensland Health resources and that a key priority of any government was to honour election commitments, but he quite appropriately observed 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'. Dr Buckland cited as an example, that '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'.⁵² Although he did not say so, Dr Buckland may have been thinking of the establishment of Hervey Bay Hospital. It was opened, against the advice of Queensland Health because, according to Dr Stable, Mr Horan, then Minister for Health, directed that a hospital be opened at Hervey Bay before the 1998 election.⁵³

The problems with historical budgets

- 6.35 Historical budgets were not based on the needs of a community, linked to clinical services promised or demographic trends, but on an original budget, fixed many years ago, updated in a rather mechanical way. This gave rise to at least three problems. The first of these was that, if the original budget was not fixed fairly to provide an adequate service, it would be unlikely that this mechanical updating would change that. As Dr Nankivell put it:

Our funding was based on what I call an historical funding model ... which basically means you have been duded in the past, you are going to be duded next year.⁵⁴

- 6.36 The second problem was that, even if the original budget was based on the then needs of a community, subsequent budgets failed to take into account changes in those needs. Communities change size and demographics, sometimes quickly. Hervey Bay was an example of this. It had substantial population growth and a substantially increasing ageing population.
- 6.37 And the third problem was that, because some communities were perceived by medical practitioners to be more attractive than others, they ended up having a greater number of medical practitioners per head of population than others. No doubt that occurred also in the case of nurses. It was, therefore, and remains

⁵¹ T7180 lines 21-53 (Mr Leck)

⁵² Exhibit 336 para 89 (Dr Buckland)

⁵³ See Chapter 4.2 of this report

⁵⁴ T2943 lines 8-15 (Dr Nankivell)

necessary to provide incentives to attract doctors and nurses to those communities which are perceived to be less attractive. As I mention later, Area of Need Registration was premised on the assumption that incentives would be provided to general practitioners, both newly registered and established, to relocate to regional and rural areas of the State. But more generally, unless some incentives are provided, some areas of the State will be better served by medical practitioners than others. Historical budgets did not take into account the number of practitioners in an area who could provide support to a hospital on a part-time, or visiting sessional basis.

- 6.38 There was a further problem which, though not necessarily the result of historical budgets, was a consequence of the budget process. Public hospitals were required to carry forward any debt to the following year. The consequence was, of course, that the budget was effectively reduced in the following year. That practice was discontinued only in July 2004.

The allocation process; elective surgery targets

- 6.39 In addition to the historical budget, further funding was based on a target for elective surgery, weighted for complexity, aimed at increasing elective surgery throughput. If the target was not met, funds so allocated would not be paid or would be taken back by Queensland Health. More importantly, the elective surgery target and, consequently, the budget as a whole, would be reduced by that amount for the following year. This put pressure on hospitals to meet elective surgery targets at the expense of emergency surgery and medical services. Targets for elective surgery have now been abandoned.
- 6.40 This was in addition to the pressure placed on District Managers, like Mr Leck and Mr Allsopp, to maintain budget integrity.⁵⁵ A budget overrun was viewed very seriously, and little flexibility was permitted. District Managers had been dismissed for over-running budget. The Queensland Nurses Union summarised the practice accurately in the following submission:

Staying within budget (while at the same time having to meet unrealistic performance objectives) is the overriding imperative in Queensland Health: all else appears to take second place to this. The primacy of the budget bottom line is demonstrated again and again. In 1999 the whole District Executive at Toowoomba Health Service District (HSD) were removed for failing to come in on budget. Not long after that the District Manager in Cairns HSD was dismissed for reportedly failing to come in on budget. These dismissals were powerful symbols for the rest of the system and helped achieve better budget compliance by instilling fear of job loss on senior management across the agency, a fear that was in turn passed down to middle management and beyond.⁵⁶

As the evidence of Mr Leck and Mr Allsopp shows, this fear was ever

⁵⁵ T7179 line 30 (Mr Leck); T6048-6050 (Dr Bergin) and T7121 line 22 (Mr Leck)

⁵⁶ Queensland Nurses Union submission to the Queensland Health Systems Review, July 2005

present in their minds.⁵⁷

A culture of economic rationalism rather than patient care and safety

6.41 The plight of public hospitals funding was worsened by a philosophy of economic rationalism rather than of patient care and safety. The 'efficiency dividend' was one indication of this. Others were the concept that Queensland Health was 'purchasing' services from public hospitals, and that patients were 'consumers' of those services. Similarly, the system of elective surgery budgets focused on throughput and revenue rather than outcomes for the patient and the community.

6.42 Dr Buckland submitted:

In the mid late 1990s, 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. Dr Buckland's evidence was that it has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community.⁵⁸

6.43 The philosophy that budget, including throughput and reputation, were more important than patient care is epitomised by Queensland's Risk Management Policy which grades risks in categories of seriousness from 'low risk' to 'extreme risk'. It is not surprising that, in the category of 'extreme risk' we find 'multiple deaths'. But the other matters sharing that category are 'claims greater than \$1m or multiple claims resulting from multiple similar exposures', and 'sustained national adverse publicity, Queensland Health's reputation significantly damaged'. In the 'major risk' category we find 'loss of life'. But sharing equal seriousness with that we find 'claims greater than \$500,000 or multiple claims resulting from a single response', and 'significant and sustained adverse statewide publicity'. And in the 'moderate risk' category we find 'loss of function, major harm caused' sharing equal seriousness with 'significant adverse State wide publicity', and 'experience will result in a single claim'. This approach, it seems to me, is hardly conducive to the declared purpose of the policy 'to improve the health and well being of Queenslanders'. Rather, it seems as much concerned with adverse publicity and civil damages as with death and serious injury.

6.44 The results of this philosophy and pressure can be seen in the approaches of administrators at Hervey Bay and Bundaberg. Although Mr Allsopp at Hervey Bay Hospital was concerned about Dr Naidoo's absences, his concern seemed to be more about losing throughput than about the absence of supervision of Dr Krishna and Dr Sharma. Even more concerning, is the e-mail which Dr Keating

⁵⁷ T7129 line 37 (Mr Leck); T6051 line 10; T6051 line 40 (Dr Bergin). See also Final Submissions on behalf of Mr Leck

⁵⁸ Exhibit 336 para 48 (Dr Buckland); Final Submissions on behalf of Dr Buckland, para 159

at Bundaberg sent to a member of staff on 8 February 2005, after Dr FitzGerald had been called in to investigate complaints about Dr Patel. It read in part:

...At the present time BHSD is 92 WTD separations behind target. The target is achievable. [Bundaberg Health Service District] must achieve the target – for many reasons, including financial (over \$750,000 per year), ability to undertake range of operations, new equipment for OT, repair of equipment, education and training of staff.

....Therefore, it is imperative that everyone continue to pull together, and maximise elective throughput until June 30. All cancellations should be minimal with these cases pushed through as much as possible.

- 6.45 The e-mail goes on to say that all elective surgery cancellations were to be discussed by Dr Patel and others.⁵⁹ The e-mail becomes even more disturbing when it is seen in a context in which, without Dr Patel, that target could not realistically be achieved.
- 6.46 There will always be a tension in hospitals, private as well as public, between, on the one hand, patient care and safety, and, on the other, cost. And of course there is a difference, as to what is acceptable treatment in a rural or regional area, between an emergency procedure, and an elective one. In an emergency, it may not be possible to provide specialist care in a regional, or, especially, a remote area. But where a procedure is not urgent, and a patient is able to be transferred, the position is different. Then there is no excuse for providing inadequate and consequently unsafe surgery, as occurred in Bundaberg and Hervey Bay. In both cases the perceived need to meet the elective surgery target was paramount in the minds of administrators, blinding them to the evident danger.

Some specific consequences to patient care and safety

- 6.47 There were many examples in the evidence of cost control being put ahead of patient care and safety, and of clinical decisions based on the latter being overruled by administrative decisions based on the former. Some of these examples follow.

Dr Thiele

- 6.48 Dr Thiele gave evidence, of his struggle to obtain a CT scan machine which Bundaberg did not have because it had been considered 'too expensive'.⁶⁰ This CT scanner was, according to Dr Thiele, a critical piece of equipment in modern trauma medicine used to identify the extent of patient injuries. Patients were, instead, transferred by ambulance to the Mater Hospital in Bundaberg, which had such a scanner and then brought back to Bundaberg Base Hospital. Quite understandably, Dr Thiele considered this was unacceptable. The Bundaberg

⁵⁹ Exhibit 72

⁶⁰ T1820 line 28 (Dr Theile)

Hospital did ultimately purchase a CT scanner but only in the course of a re-building project at the hospital.⁶¹

Dr Nankivell

6.49 Dr Nankivell gave evidence of an increasing demand for specialist outpatient clinics, endoscopy and colonoscopy services,⁶² and of the Bundaberg Hospital being unable to meet those demands. He attempted to have the problems he had identified in the course of his clinical practice brought to the attention of the hospital management and to Queensland Health's corporate office, but to no avail.⁶³ He became frustrated at what he saw as the serious failings in the budget allocation process. He also became disillusioned with the failure of Queensland Health to respond to what he had identified as serious failings that were affecting the health of the community that relied upon the Bundaberg Base Hospital.

Dr Jason Jenkins

6.50 Dr Jenkins is a vascular surgeon, and former Director of Vascular surgery at the Royal Brisbane Hospital.⁶⁴ He said that at the Royal Brisbane Hospital there has been a huge decrease in bed numbers;⁶⁵ that he had been directed not to use what he considered the best prosthesis due to its cost;⁶⁶ that he was required to put together a 'business case' in order to get changes made to the delivery of clinical services such as the type or prosthetics that could be used;⁶⁷ that on a daily basis he was given a message on his pager that he was not to admit any more patients as the hospital had no beds;⁶⁸ that the clinical demand for vascular surgery had increased dramatically in the previous 12 months;⁶⁹ that he had been given a direction that he was given a budget to perform 56 aortic aneurisms in a particular year and he was not to perform any more than 56 aortic aneurism procedures,⁷⁰ even though he had performed approximately 145 such procedures each year previously;⁷¹ that patients were discharged from hospital prematurely to make beds available for elective surgery,⁷² that he had to regularly cancel elective surgery due to there being an inadequate number of Intensive Care beds available to provide post operative care;⁷³ that clinicians were powerless as the system was run by administrators;⁷⁴ that the

⁶¹ T1820 lines 35-38 (Dr Thiele)

⁶² T2945 line 40; T2946 line 28; T2963 line 30 (Dr Nankivell)

⁶³ T2948 line 58 (Dr Nankivell)

⁶⁴ T3674 line 40, T3675 line 22 (Dr Jenkins)

⁶⁵ T3678 line 28 (Dr Jenkins)

⁶⁶ T3678 line 32 (Dr Jenkins)

⁶⁷ T3678 line 42 (Dr Jenkins)

⁶⁸ T3678 line 35 (Dr Jenkins)

⁶⁹ T3676 line 18 (Dr Jenkins)

⁷⁰ T3680 line 2 (Dr Jenkins)

⁷¹ T3680 line 5 (Dr Jenkins)

⁷² T3683 line 15 (Dr Jenkins)

⁷³ T3685 line 48 (Dr Jenkins)

⁷⁴ T3684 line 3 (Dr Jenkins)

funding for the Royal Brisbane Hospital was inadequate given the area that it had to cover, and the result was that the Hospital was 100 beds short of what it needed to cope with the demand placed on its services;⁷⁵ and that he, along with other vascular surgeons, had been directed to drive to the Nambour Hospital to provide vascular surgery services at that hospital rather than having patients travel to Brisbane for treatment.⁷⁶ He considered the extra travel involved a waste of the valuable time of clinicians and an inefficient use of resources. He and the other vascular surgeons were given \$400,000 in funding to provide a 'carotid artery stenting service' at the Royal Brisbane Hospital. However that funding would only be given on the condition that the vascular surgeons would travel to Nambour and provide vascular surgery services there.⁷⁷

- 6.51 Dr Jenkins, as a doctor treating patients on an almost daily basis, had a clear understanding of the increasing demands being placed on a hospital such as the Royal Brisbane Hospital. Notwithstanding this wealth of knowledge he had little or no power to influence the distribution of funds in such a way as to meet that demand. There was no consultation with him on these issues:

They need to speak to clinicians and ask them what needs to be done, not have administrators telling us what clinicians should be doing.⁷⁸

Dr Sam Baker

- 6.52 Dr Baker, the former Director of Surgery at the Bundaberg Base Hospital, gave evidence of the difficulties he experienced with the inadequate funding and lack of consultation at the Bundaberg Base Hospital when he was the Director of Surgery, including an inability to purchase replacement surgical equipment;⁷⁹ decisions made by administrators of the Hospital about increasing the efficiency of the operating theatre without consulting him,⁸⁰ and an unaddressed lack of experienced doctors working in the Emergency Department at the Bundaberg Hospital.⁸¹

Dr Sean Mullen

- 6.53 Dr Mullen was an orthopaedic surgeon and a Visiting Medical Officer at Hervey Bay Hospital. When on call on a Saturday morning he saw an elderly woman who had been admitted with a fractured hip the previous night. In his opinion it required surgery as soon as possible, a better outcome being achieved if surgery is performed within 48 hours. He booked her in for surgery that day

⁷⁵ T3689 line 21 (Dr Jenkins)

⁷⁶ T3691 line 31 (Dr Jenkins)

⁷⁷ T3691 line 50 (Dr Jenkins)

⁷⁸ T3683 line 1 (Dr Jenkins)

⁷⁹ Exhibit 410 para 14 (Dr Baker)

⁸⁰ Exhibit 410 para 20 (Dr Baker)

⁸¹ T6349 line 58 (Dr Baker)

notwithstanding a general policy that emergency surgery only be performed on the weekend. Nurse Erwin-Jones, who was at home at the time, mistakenly thinking that the fracture was two weeks old, contacted Mr Allsopp, the District Manager, who cancelled the surgery without reference to Dr Mullen. It was only after Dr Mullen and a senior anaesthetist both spoke to Mr Allsopp that the surgery was rescheduled for the following day. This was clearly a case of putting economic matters ahead of patient care.⁸²

Dr Con Aroney

6.54 Dr Aroney, a cardiologist, gave evidence of the difficulties that he faced in providing cardiology services at the Prince Charles Hospital. The cardiology unit of that hospital experienced a reduction in funding without any, or any sufficient consultation with cardiologists about the funding cuts or the reasons for them. He also spoke of a prohibition by administrators on the use of certain prosthetic devices⁸³ and administrative interference in clinical decision making to save costs.⁸⁴ He gave an example of Dr Pohlner, the most experienced paediatric cardiac surgeon in the State, being twice refused a ventricular assist device, which he considered necessary for surgery in each of the two cases. Dr Aroney believed that the refusal was based on the cost of the device, and of the consumables. The refusal was ultimately reversed but surgery was delayed.⁸⁵

Mr Whelan

6.55 Mr Whelan is the District Manager of the Townsville Health Service District. As discussed below, he, with the assistance of others, has introduced a different model of funding and administration into the Townsville Hospital. However, he also experienced overbearing central control when it came to the allocation of funding. He gave evidence of the failure of Queensland Health to consult with the community adequately or appropriately in a number of cases including a lack of consultation with the community regarding the redevelopment of the Ingham Hospital, the redevelopment being pushed along for political reasons without considering the health care needs of the community in sufficient detail;⁸⁶ a lack of consultation with the Hospital over the nature of procedures to be performed;⁸⁷ and a funding model based on funding positions rather than outcomes. One example of this was Queensland Health agreeing to fund an additional physician to provide renal services, but not providing funding for nursing and allied health staff to support that physician.⁸⁸

⁸² See Chapter 4 - paras 4.179 - 4.187

⁸³ Exhibit 263 para 10 (Dr Aroney)

⁸⁴ Exhibit 263 para 11 (Dr Aroney)

⁸⁵ Exhibit 263 para 9; T4804, line 51 – T4805 line 3 and T6282 lines 32-50 (Dr Aroney)

⁸⁶ Exhibit 236 para 7; T3531 line 15 (Dr Whelan)

⁸⁷ See Chapter 5 of this report

⁸⁸ T3338 lines 24-35 (Dr Johnson)

Some more general consequences

- 6.56 Because budgets were fixed on an historical basis, with little consultation with clinicians, the Australian Medical Association, specialist colleges, specialist associations or nursing bodies, there was no point in involving local doctors and nurses in determining changing needs. Take the example of Hervey Bay Hospital. When it opened its orthopaedic unit, it did so with one specialist orthopaedic surgeon. Had there been any consultation with the Royal Australian College of Surgeons or the Australian Orthopaedic Association, it would have become clear to Queensland Health that that was a grossly inadequate number of orthopaedic surgeons to provide an adequate and safe orthopaedic service to include elective surgery. Similarly at Bundaberg, the general surgery unit was understaffed by qualified surgeons, anaesthetists and nurses for at least three years before Dr Patel was employed and Dr Patel might never have been permitted to operate as he did, notwithstanding complaints, if it had been adequately staffed; that is, if he had had peer review.
- 6.57 Nor was there any flexibility in sharing services between districts. Dr Thiele gave the example of there being, at one time, a long surgery waiting list at Bundaberg, and almost none at Hervey Bay. Yet the system did not permit transfer of patients from Bundaberg to Hervey Bay for this purpose. Bundaberg, Maryborough and Hervey Bay seem obvious places where specialist elective services could be rationalised.

A cost-efficient system?

- 6.58 It is said that Queensland Health has, for some time been recognised as the most cost-efficient jurisdiction in Australia in delivering hospital services. The latest data records that Queensland's total recurrent cost per case-mix weighted separation⁸⁹ is \$2885 compared to the national average of \$3184,⁹⁰ more than 10 per cent lower than the national average. This lower cost at which Queensland delivers health services reflects a lower expenditure on nursing, allied health and medical services (staff numbers and average salaries) and lower relative stays in hospital than other states.⁹¹ More specifically, Queensland has a lower than average number of medical practitioners; has the lowest number of nurses per capita of any state in Australia (except Tasmania) and has a critical shortage of nurses. It employs 11 per cent fewer public hospital staff per 1000 people; and pays 5.6 per cent less in average salaries for

⁸⁹ This data is 'case-mix adjusted' to take into account the complexity of the admission

⁹⁰ Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, Table 9A.4

⁹¹ *Queensland Health Systems Review*, Final Report, p 12

public hospital staff.⁹² Yet Queensland Health spends 82 per cent more on health administration than other states.⁹³

- 6.59 The last figure is concerning. It might be explained, in part, by the much greater decentralisation in Queensland than in other states. But whilst the limitations on my terms of reference prevent me from examining it further, it is necessary to remark that whilst it is undoubtedly the case that Queensland has too few qualified doctors and nurses, it may well be that it has too many administrators.
- 6.60 Even more concerning is that the lower cost in Queensland, in delivering health services, has come at the cost of lowering the standard of healthcare to one which is grossly inadequate and dangerous. It has been thought better to employ poorly trained foreign doctors under the area of need scheme than, for example, to make greater use of Visiting Medical Officers or to provide incentives to Australian trained doctors to relocate. And it was thought better to provide a system which was so grossly inadequately staffed as to be dangerous (as in Hervey Bay) than to provide none at all. This last appeared to be the stated views of Mr Leck and Mr Allsopp, and also of Dr FitzGerald to Ms Hoffman.

Possible solutions: The overall public hospitals budget

- 6.61 What is needed and what must be done in this respect are beyond my terms of reference. But it would be remiss of me not to point out difficulties in solutions already proposed as these difficulties have emerged from the evidence before this Commission.
- 6.62 The *Queensland Health Systems Review*, Final Report, argues that to bring the Health budget up to the national average would require an extra \$1.2 billion a year, increasing to \$1.9 billion a year by 2009 – 2010.⁹⁴ It suggests or implies that \$1.2 billion a year may not be required because, for many services, Queensland Health provides a similar level of activity but with a lower level of expenditure.⁹⁵
- 6.63 Significantly, one of the 'efficiencies' relied upon in that Report is that Queensland performs weighted separations at a lower cost than other states; that is, more efficiently.⁹⁶ But the evidence given in this Commission has shown that weighted surgical separations in public hospitals in Queensland were often provided unsafely, primarily because there were too few, too poorly qualified or supervised doctors, and too few nurses. But that lowered their cost.

⁹² *Queensland Health Systems Review*, Final Report, p 14

⁹³ *Queensland Health Systems Review*, Final Report - quoting data from *Australian Institute of Health and Welfare, Health Expenditure Australia 2002-03* (2004). See also *Australian Institute of Health and Welfare, Health Expenditure Australia 2003-04* (2005).

⁹⁴ *Queensland Health Systems Review*, Final Report, p 39

⁹⁵ *Queensland Health Systems Review*, Final Report, p 40

⁹⁶ *Queensland Health Systems Review*, Final Report, p 40

That was also true of a number of other services including psychiatry in Townsville, emergency care in Rockhampton and anaesthetics in Charters Towers. By using unqualified doctors to perform complex orthopaedic surgery (Hervey Bay), by permitting doctors to perform surgery beyond their competence or the competence of the hospital (Bundaberg and Hervey Bay), by requiring too few doctors to work unsafe hours (Bundaberg and Hervey Bay) and by 'dumping' inadequately trained doctors employed under the 'area of need' scheme, in an emergency department (Rockhampton), substantial costs were saved, but at huge cost to patient safety.

- 6.64 If, as seems to be the case from the evidence before the Commission, weighted surgical separations have been carried out more cheaply in Queensland than in other states, at least in part because they have been provided inadequately and unsafely, it would be wrong to assume that, if they are provided at a reasonable level of competence and safety, they will still be provided more cheaply than in other states. For that reason, it may be wrong, as that Report posits, that, because of a greater level of efficiency in Queensland Hospitals, less than \$1.2 billion will be required to bring Queensland Health budget up to the national average.
- 6.65 It is also wrong, in my opinion, to assume that, to bring health funding in Queensland up to national average per head, is sufficient to provide the same level of services as the other states. There are several reasons why Queensland needs to spend more than the other states. I have mentioned these earlier. Queensland is the most decentralised state in mainland Australia; Queensland's age-weighted population is growing faster than other jurisdictions; and Queensland provides a free specialist outpatients service, much greater in its scope and cost than that provided by other states.
- 6.66 And it is also wrong, in my opinion, to assume that the other states are providing an adequate and safe system. Concerns similar to those investigated by me have been investigated in other jurisdictions; at the King Edward Memorial Hospital in Western Australia (1999),⁹⁷ the Canberra Hospital in the Australian Capital Territory (2000),⁹⁸ and Campbelltown and Camden Hospitals in New South Wales (2002).⁹⁹ The most recent example in New South Wales concerned allegations made by nurse whistleblowers of unsafe or inadequate patient care or treatment, disregard for quality and safety, and an indifferent hospital administration, following a number of patient deaths at the

⁹⁷ Douglas N, Robinson J, Fahy K, *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital*, 2001

⁹⁸ The report was not made public. See the ACT Community and Health Services Complaints Commissioner, *Annual Report 2002-03*, Canberra, 2003 – which outlines a summary of the major findings of the Inquiry

⁹⁹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003

Campbelltown and Camden hospitals.¹⁰⁰ The New South Wales Health Care Complaints Commission investigated some 47 clinical incidents, including 19 deaths,¹⁰¹ at those hospitals. The Health Care Commission's investigation supported the allegations made by nurse whistleblowers, finding that there were inadequate standards of patient care and safety¹⁰² at both hospitals.

- 6.67 An associated patient care systems review of the relevant hospitals in October 2003¹⁰³ concluded, amongst other things, that the relevant health service had many fewer resident, registrar, and consultant medical staff for each occupied bed than at other facilities;¹⁰⁴ that there was a shortfall in appropriately qualified and skilled nursing and allied health workforce and extremely limited numbers of academic clinicians;¹⁰⁵ that the lack of adequate numbers in the medical workforce with adequate skill and experience levels was perceived to be the greatest weakness in the delivery of health services, most notably in the Intensive Care Unit and the Emergency Department;¹⁰⁶ that additional resources were required in the area of clinical nurse consultants in intensive care, Emergency Department and medical ward;¹⁰⁷ that the Camden Hospital had a number of limitations, including a lack of adequate numbers of skilled staff and high level facilities resulting in the need to transfer acutely ill patients;¹⁰⁸ and that the development of a supported safe reporting culture needed to be a priority.¹⁰⁹ These bear a striking similarity to inadequacies found in Queensland public hospitals by this Commission.
- 6.68 Therefore it may well be that, in order to provide safely all of the health services in Queensland, now promised at the locations at which they have been offered, a sum greater than the \$1.2 billion a year would be required. And it seems to me from what I have said so far, that the required amount can never be ascertained merely by comparing Queensland's expenditure with that of other states.
- 6.69 In October 2005, the Premier and Treasurer, in delivering a 'Special Fiscal and Economic Statement', announced net new funding for Queensland Health. It is beyond my terms of reference and, as I have already indicated, in any event impossible for me to say whether that will be adequate, or if not the extent of the inadequacy, to provide an adequate safe public hospital system. What I have

¹⁰⁰ These hospitals service the sprawling working class suburbs on Sydney's southwestern outskirts.

¹⁰¹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 3

¹⁰² NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 4

¹⁰³ Conducted by a review team led by Professor Bruce Barraclough

¹⁰⁴ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁵ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁶ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

¹⁰⁷ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁸ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁹ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

endeavoured to do in this Part is merely to point to evidence before my Commission which casts doubt on the assumption, apparently made in the Final Report of the Queensland Health Systems Review that the amount referred to there would be adequate to provide, safely and adequately, all of the services now promised to all of the people to whom it is promised, at no cost to them.

- 6.70 In order to determine what that amount would be, it would be necessary, in each public hospital in Queensland, to estimate the cost of providing, at an adequate, safe level, the services which it offers. In order to determine what would be needed to provide any health service at any specified location, Queensland Health would need the advice of the Australian Medical Council and the specialist colleges. To take the example of the provision of an orthopaedic service at Hervey Bay, it is primarily only orthopaedic surgeons who can say what are the requirements, in terms of surgeons and supporting doctors and nurses, to provide such a service. And it is now plain that, if their advice had been sought before such a service commenced at Hervey Bay, it would never have been commenced. Without such an exercise first being carried out, it seems to me that Queensland Health cannot even begin to know what it would cost to provide a reasonably safe, adequate health service.

Can the promise ever be fulfilled?

- 6.71 Dr Waters is a hospital administrator of considerable experience. He had been District Manager of the Princess Alexandra Health Service District and the Royal Brisbane and Womens Hospitals Health Service District. He had also been the General Manager of the Wesley Hospital. He put the question this way:

The primary question is an issue of scope ... Queensland Health promises to the Queensland community to do all things to all people at all times and yet, clearly, it has a defined budget.¹¹⁰

This statement gives rise to a fundamental question which requires an answer. Can Queensland, or for that matter Australia, ever provide, at no cost and at an adequate and safe level, all of the services promised to all people, at least without a substantial increase in taxation or a substantial increase in income from other sources? The evidence before this Commission shows that it is not being provided in Queensland public hospitals. And from the indications from inquiries in other states it may be that it is not being provided there either.

- 6.72 Yet, if recent reported events are any guide, this seems to be a question which national leaders, on both sides of politics, seem reluctant to face or even admit exists. When the Queensland Government raised the possibility of co-payment for some services, both the Australian Health Minister and the Leader of the Opposition stated that all Australians were entitled to a free health system -

¹¹⁰ T4662 lines 45-51 (Dr Waters)

whatever that may mean. But neither questioned what it would really cost to provide all of the free health services, now promised to all Australians, at a level which is reasonably adequate and safe; or whether indeed that is realistically possible. That is a question which is beyond the scope of this Commission.

- 6.73 If it is not possible, then it may be necessary to consider whether either the number or extent of free services should be limited, or the classes of people to whom such services are provided should be limited, or both of these. It may not be possible for Queensland alone to do this consistently with its obligations under the Australian Health Care Agreement, but that question is outside the terms of reference of this Inquiry. The question whether free hospital services may be limited in any significant way may be one which can be, and should be addressed only on a whole of Australia basis. The reality is that Australia's national real health care spending¹¹¹ has been growing faster than the Australian economy in every year since 1990.¹¹² Sooner or later this imbalance must be addressed, as must the reality that, in Australia generally, free public hospitals do not appear to be providing those services adequately.

Possible solutions: abandonment of the culture of economic rationalism

Greater involvement by clinicians

- 6.74 There are two points to be made here. The first of these is, I think, now accepted by Queensland Health. A system which included an historical budget with an efficiency dividend was wrong and should be abandoned. And elective surgery targets diminished the quality of surgery and gave priority to elective surgery over emergency surgery. It is now accepted, I think, that individual hospital budgets must be based on the changing needs of each community.
- 6.75 The second point may not yet be accepted by Queensland Health. It is that there must be much greater involvement by doctors and also nurses, and less by administrators, in the allocation of individual hospital budgets, both among and within individual hospitals. I discussed earlier how administrators have triumphed over clinicians, at the expense of patient care and safety. This is likely to continue unless clinicians are given greater control in this respect.
- 6.76 I note that the *Queensland Health Systems Review*, Final Report, recommends that administrative staff be transferred from central office to the districts.¹¹³ This

¹¹¹ Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$72.2 billion in 2002-03 (Australian Institute of Health and Welfare 2004; table EA.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2002-03, up from 9.3 per cent in 2001-02 and 8.2 per cent in 1992-93 (Australian Institute of Health and Welfare 2004)

¹¹² Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Health and Welfare Expenditure Series - Number 25, September 2005, Canberra, p 7. See also Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, E.5

¹¹³ *Queensland Health Systems Review*, Final Report, p xiv and pp 71-72.

may be a good thing if its purpose is to provide administrative support to doctors and nurses to ease their administrative burdens; for example, in the implementation of clinical governance policies, and those with respect to recording of complaints. But if it is, as I perceive it might be, so that they can determine budgets at a local level at the expense of clinician involvement, then I think that is a matter of some concern.

Townsville model

- 6.77 While the Townsville Hospital has little control over how much funding it receives from Queensland Health, the process by which that budget is allocated within that hospital has included greater clinician involvement. That process is described in Chapter Five, and while it may not be appropriate to every hospital in Queensland, the model may be capable of adaption to smaller hospitals.
- 6.78 The key features of the model are that the hospital is divided into clinical institutes. Each institute is headed by a medical director who is a doctor with both administrative and clinical responsibilities, and an operations director, who is a member of the nursing staff. The annual budget for each institute is negotiated between the executive and the directors of the Institute each year. This allows the director of each institute, who has a clinical role, to have input into the funding allocation each year. Each director is given financial delegation to enable him or her to purchase equipment and consumables; he is, to an extent, given the authority to hire nursing staff and junior medical staff; and he is accountable to the executive in the sense that he is required to meet the service standards agreed and ensure that budget integrity is maintained. The role of the executive is one of supporting the Hospital as a whole and balancing competing priorities across the Hospital.

Flexibility in the provision of services within a District and across Districts

- 6.79 Some flexibility is required in the provision of services within a District, especially in respect of specialist services. The *Queensland Health Systems Review*, Final Report, recommended a number of options to provide greater flexibility, which are worth repeating, including; greater use of Visiting Medical Officers,¹¹⁴ including on a per operation basis; and possible contracting out of surgical services to private hospitals and private specialists based on a fee for performance agreement.¹¹⁵ I mention in Chapter Six - Part C, the need to consider these matters when determining 'area of need' under s135 of the *Medical Practitioners Registration Act*. But they should be considered in all cases.

¹¹⁴ See the earlier discussion about Visiting Medical Officers in Chapter 2

¹¹⁵ *Queensland Health Systems Review*, Final Report, p129.

- 6.80 There should also be greater flexibility of services, especially specialist services, between neighbouring hospitals and districts. It may be necessary, for this purpose, to give greater discretion to those in charge of the respective Health Zones after consultation with specialists concerned and possibly also specialist colleges, to alter these priorities from time to time on a needs basis.

Financial incentives to experienced doctors and nurses

- 6.81 Queensland Health should also provide financial incentives to experienced doctors, especially specialists and nurses, to take positions, full time or on a part time, including sessional basis, in and to remain in, regional hospitals. I mention this also in Chapter Six - Part C when discussing the application of s135. The area of need scheme was premised on the assumption that such incentives would first be offered, but that has never occurred. It should be done, not just to comply with the spirit of the 'area of need' scheme, but to ensure better patient care in provincial areas.

Part C – A defective system of Area of Need Registration and its consequences; remedies

The defective system

- 6.82 This defective system has been discussed earlier in this report.¹¹⁶ It is proposed here to summarise the principal defects, to explain how they contributed to inadequate and even dangerous medical treatment and to make some consequent findings against the Minister, by her or his delegate, and against the Medical Board of Queensland.
- 6.83 There were two aspects of such registration and it is plain from the evidence before this Commission that there were defects in the administration of each. The first involved the making of decisions by the Minister's delegate, pursuant to s135(3) of the *Medical Practitioners Registration Act 2001*, that an area was an area of need; that is, that there were insufficient medical practitioners practicing in that part of the State to provide the service required at a level that met the needs of people living in that part of the State¹¹⁷. The second involved the process of registration under s135.¹¹⁸

¹¹⁶ See Chapter 3

¹¹⁷ especially in Chapter 3 – Defects in deciding that there is an area of need

¹¹⁸ especially in Chapter 3 – Defects in deciding that there is an area of need