State Reporting Bureau

Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

TOWNSVILLE

..DATE 04/08/2005

..DAY 34

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 9.35 A.M.

COMMISSIONER: Mr Andrews, before we resume, there's one matter that I wanted to deal with. I see Ms McMillan is present. Newspaper reports this morning were critical of the Queensland Medical Board for failing to provide or volunteer files to the Commission of Inquiry. I'd like to make it very clear on the record that we had not sought nor had the Medical Board offered to provide wide-ranging files. We've made specific requests and every such request has been met immediately. It may be that that was our mistake in not making a more wide-ranging request and I would invite the Board to consider whether there would be any other files that could be brought to our attention but as matters currently stand, any criticism of the Medical Board on that matter is really quite unfounded.

MS McMILLAN: Thank you, Mr Commissioner, and in fact that was the matter that I wanted to raise. In fact, that the Board had, after requests on the 28th of July from the Commission staff, produced the file on the 29th of July in relation to Dr Berg. And, in fact, I have to tender this morning a statement by Mr Demy-Geroe, whom you've already heard from in Brisbane.

COMMISSIONER: Yes.

MS McMILLAN: In relation to matters pertaining to Dr Berg, and that really relates to the - responding to matters, as far as able to, in the statements of Dr Johnson and also Mr Whelan, and, again, when those statements became available, instructions were immediately sought from Mr Demy-Geroe, and I'm instructed to inform you that he's available to give evidence in Brisbane tomorrow if it's sought to amplify any matters, and he's available to assist the Commission in any of those matters.

COMMISSIONER: Mr Andrews, have you yet seen this statement?

MR ANDREWS: A copy has been provided to me. I haven't had the time to peruse all of it but I have indicated to Ms McMillan one area of ambiguity and suggest that a letter from Mr Demy-Geroe Would probably be able to clear that aspect up.

COMMISSIONER: I'm completely comfortable proceeding either way but it strikes me that we've heard evidence from Mr Demy-Geroe, all of the parties who are interested have had an opportunity to cross-examine him. Should anyone wish to do so relevant to the matters that have now arisen, they could indicate that to you, Mr Andrews, but subject to any such request, I'd be happy to accept the statement now and any clarification, whether by in the form of a further statement or simply a letter, to resolve the ambiguity that you've mentioned.

MS McMILLAN: Mr Andrews has indicated to me a letter will be sufficient and I will attend to that. So I only, I'm afraid, have two copies of that at the moment and it is not affixed in a way I would like, but could I hand that up? It was sworn yesterday.

COMMISSIONER: Why don't you keep it for the moment. We do have some copying and stapling and other facilities here, and perhaps at the mid-morning break you could liaise with Commission staff.

MS McMILLAN: Thank you. My friends have copies of it. The only other matter I'd like to place on record, Mr Commissioner, is that the Board emphatically rejects any allegation that it or any of its staff have engaged in covering up information pertaining to Dr Berg or any other matter relevant to the Commission.

COMMISSIONER: Look, I think it's a valid point that you make. I'll wait for the aircraft to pass overhead. Obviously the Board does have an important role in our community and part of that role is reviewing the credentials of applicants for medical practice, but that role of its very nature is one that has to be conducted under a high level of confidentiality and, as matters presently stand on the evidence, I would be inclined readily to accept that issues of cover-up really don't arise with the Board because it has statutory and other obligations to maintain that confidentiality.

MS McMILLAN: Yes.

COMMISSIONER: Which puts it in a very different position from Queensland Health in its position as the employer of a doctor who is certified by the Board. But they're matters about which we can have argument at a later stage. I think it's entirely valid for you to put the Board's position on record. We'll see where it goes from there.

MS McMILLAN: Yes, thank you.

COMMISSIONER: Thank you, Ms McMillan. Mr Andrews.

MR ANDREWS: Commissioner, I call the first witness, Kenneth Douglas Whelan. Mr Whelan has made two statements which are, as I recall it, Exhibits 236 and 237.

KENNETH DOUGLAS WHELAN, SWORN AND EXAMINED:

COMMISSIONER: Mr Whelan, please try and make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- Not at all, Commissioner.

Thank you.

MR FITZPATRICK: If the Commission pleases, I seek leave to appear for Mr Whelan.

COMMISSIONER: Such leave is granted. Which reminds me, Mr Fitzpatrick, have you made any progress in resolving the matter you mentioned yesterday?

MR FITZPATRICK: I'm sorry, Commissioner, it still hasn't resolved.

COMMISSIONER: I understand that and I again record my appreciation for your efforts and those of Mr Boddice and Mr Farr in attempting to resolve that difficult situation.

MR FITZPATRICK: Thank you, Commissioner.

MR ANDREWS: Mr Whelan, Exhibit 236, if my numbering is correct, is your statement sworn on the 29th of July 2005 and that is a statement of - I'll tell you the number of paragraphs.

COMMISSIONER: Seventy-five.

MR ANDREWS: Seventy-five.

COMMISSIONER: Yes.

MR ANDREWS: And Exhibit 237 is your statement of 14 July of 26 paragraphs. Are the facts recited in those statements true to the best of your knowledge?-- To the best of my knowledge, they are, yes.

Are the opinions you express in them, are they honestly held by you?-- Yes, they are.

Did you provide a third statement sworn on the 3rd of August of eight paragraphs as a result of things that you've learned since the sittings commenced in Townsville?-- Yes, I did.

And the facts within it are true to the best of your knowledge?-- Yes, they are.

And the opinion in it is honestly held by you?-- Yes.

I tender Mr Whelan's statement of the 3rd of August.

COMMISSIONER: That statement is received as an exhibit and will have the exhibit marking previously indicated.

MR ANDREWS: Thank you, Commissioner. Mr Whelan, you are the District Manager of the Townsville Health Service District which covers the hospitals and health centres of Townsville, Ingham, Palm Island and Magnetic Island?-- That's correct.

You've had significant experience in New Zealand before coming to Townsville. I see from your statement that you've been a chief executive of a hospital, a chief executive of a district health board, a general manager, a senior project manager and

a director. Can you explain simply what those different positions were within New Zealand?-- The New Zealand health system, one of the similarities with Australia is that it is as complex I will admit. I was a director of area mental health services a few years ago and that entailed for the area that where I was living, I had the responsibility to ensure that legislation as applied to the Mental Health Act was followed. The project manager role I moved into at that time in New Zealand, they had regional health authorities, funding authorities, and I moved into that role for a period of around 14 months. To be honest, I was moving out of the hospitals into bureaucracy to see how the enemy worked I guess to some extent and in that time I guess I learnt a lot about funding models, about how large bureaucracies tend to work and once I had the information that I felt I - that I needed, I then very quickly jumped back into the health system and I was in a general manager's role initially of mental health services but then moved on to medical services, clinical support services. And the chief executive of that hospital at that time left and I applied for the job and was fortunate enough to be appointed to that role. So I became chief executive of Northland Health, which was a hospital and associated community health service. And I'd like to come back to that because I think there are some experiences there that are probably worth sharing. But just to complete the history, New Zealand then went through a restructure, a change of government and we moved into a district health board and I think in New Zealand, from memory, there are 14 district health boards.

How long were you in New Zealand under that new structure with the health-----?-- The district health board structure?

Yes?-- Two or three years. Two years. And I was chief executive of that district health board. Going back to the chief executive of Northland Health, which was a hospital and community-based services, there were 21 of those hospital and health services. I was employed by a board, the board was actually appointed by government at that time. The chair of the board was directly accountable to the Minister of health. The ministry of health, which is - I guess we would call that, in Queensland, Charlotte Street, Queensland Health-----

COMMISSIONER: Corporate Office as it is sometimes called?-- Corporate Office, thank you, Commissioner. It went from - it was interesting because prior to that structure there were 1200 people in the ministry of health, I mean Corporate Office. We went to a more decentralised structure where the chairs were accountable to the Minister and I was employed by the board and accountable to that board and the Corporate Office actually dropped - I think the lowest it got was 400 people, which is quite remarkable. The advantage of that as I saw it is that we negotiated funding with the funding arms of the government, and they were the regional health authorities which also, although they were part of government, they were not part of the corporate office, not part of the ministry as such. And once that funding had been - had been negotiated, myself and the chair of the board negotiated that on behalf of that community, we then seek to provide health services to

that community. The thing that struck me I guess the most when I got over here was I found that I went from an environment where there was a huge amount of flexibility in relation to meeting community need as perceived by the community as opposed to as perceived by government authorities. I must admit, in the first two or three months I was here I did wonder whether I'd made a very large mistake indeed.

MR ANDREWS: So the huge amount of flexibility, was that in New Zealand or in Townsville?-- No, that was in New Zealand, sorry. Flexibility - no, yeah, sorry, that was definitely New Zealand, and I think when I got to Australia, one of the big frustrations I had was all of a sudden I found that, perhaps for good reasons, although I haven't been able to find them, it is a very inflexible structure in Townsville and it seems to me that services are provided and are based around decisions that are made out of Corporate Office based on the government of the day's health agenda, and although that's important, I think we should never ever lose the focus and the focus of a health service is to provide timely health intervention to a community and I can't for the life of me see how one can do that if that community is not involved. And I think the single biggest advantage to having - having a local board is that that community has a say.

However-----

COMMISSIONER: Mr Whelan, I'm sure you're aware that this matter has concerned us to a great extent and we actually put out a discussion paper canvassing some of the possibilities for a major restructuring. One of the things that we were at least of the tentative view has to be accepted is that there are some aspects of Queensland Health's operation that have to be centralised and can only operate efficiently from a central control. Some examples are things like the indigenous community programs, the breast screening programs, the health promotional advertising campaign, antismoking campaigns, those sort of community health initiatives which can only be run effectively and efficiently if they're done on a statewide basis. Would you accept that much?-- Absolutely, Commissioner.

All right. I also have, I'll readily admit, swung around to the way of thinking that there are significant economies of scale in having central control or at least central coordination over things like administrative systems, accounting packages, audit programs, and I mean financial audit programs rather than medical audit programs, the recruitment programs, those sort of things where conceivably under a new structure the local health authority, whatever it's called, would say, "This is what we need", and a central administration would say, "Here is our package for supplying those services", or those functions. I know I'm putting that to you in the very broadest and most general terms but do you accept again that there are administrative roles which are better handled on a statewide basis?-- Yes, I do. I think compromise perhaps is - they should be left at a state level

to ensure consistency across the state and economies of scale as you rightfully say but perhaps managed locally.

Yes?-- And I think sometimes there is confusion around leadership and management.

Yes?-- And again, if I can go back to my experience in New Zealand, certainly although we had the boards that were providing services, some of the things that you rightfully mentioned like the public health activities-----

Yes?-- -----they were managed at a country - at a New Zealand wide level, given how small our country is as compared to here. The policy advice to government, that was done at a ministry, at a corporate level, which also makes sense and out of that policy advice came strategies which were agreed between the government and the department and from that, that was turned into purchasing priorities and then it came out to the local districts, the district health boards, and we had an opportunity to put a local flavour to those national priorities. So I think I absolutely agree with you that there are some things that it makes a whole lot of sense for it to be run at a state level but I also think in that there has to be an opportunity for a local flavour.

Yes?-- I don't think, given the structure we've got at the moment where we have - sorry, I'm not a hundred per cent sure, I think it's over 50 - is it - districts that we've currently got, we seem to have districts all over the state.

The figure that sticks in my mind is 37?-- Okay, 37. I think under a rolled up structure, that would need to be significantly reduced and I think if that was to happen, some careful thought needs to go in, particularly in North Queensland where there are a lot of very small communities who I think rightfully in some cases feel if they lose control of their local services, they will have done to them what we feel is done to us by Brisbane.

Yes?-- That said, again I think by good representation at a board level, at a governance level, I feel some of those concerns can be laid to rest.

Doctor, I wonder if I can spend a little moment canvassing with you some of the structural pragmatics of that sort of proposal. One of the suggestions we raised in the discussion paper and I'd like to confirm it really only raised as a suggestion for discussion is that there is some merit in having the captain of the ship or the figurehead of such a community organisation being a person with a current or in a retired capacity but actual clinical experience so that he or she, whether as a nurse or as a doctor or perhaps even as an allied health practitioner, a pharmacist or an optometrist but someone who understands the confidential and the patient focused issues that are involved in health care. How do you relate to that suggestion?-- I must say I have a nursing background.

Yes?-- And I have found the learnings as I went in nursing have actually held me in good stead in terms of the understanding of the complex issues that arise in health. So I think I agree with you and the reason I say "I think" is, again, I think we need to look at the difference between day-to-day management-----

Yes?-- -----of the organisation and at a governance level.

Yes?-- And if at a governance level the chair of that board, the chair of that subcommittee that looked after the hospital was a doctor in the community who was held in very high regard or, indeed, a nurse in the community held in the same regard, I think that would be very advantageous.

Yes?-- Having a nurse or a doctor for that matter in the role that I currently have is also fine but in some ways I'm a bit of a realist in that there are a lot of doctors and nurses who are very good at doctoring and nursing and prefer to stay clinically hands-on and taking them out and putting them into some of the stuff that I deal with maybe not as easy as it seems.

Doctor, perhaps it's what you've said gives me the opportunity to make my thought processes very clear. I don't think there's anyone in this room, certainly not me, who disputes the need for professional administrators or professional managers in a day-to-day managerial capacity. My concern is really the risk that we're making the purser or captain of the ship or making the head of the commissariat the leader of the army and it seems to me that in a traditional medical structure where you have an old-fashioned medical superintendent and a nursing superintendent, there were grave problems because you had a person who wasn't trained in management running a managerial role and you had a person who'd been educated at great cost to himself or herself and great cost to the community to be a doctor not performing medical services. So I think that was a problem there. But one of the advantages of it was that there was someone in a mentoring capacity and a capacity to provide advice and encouragement and a guiding hand to medical staff, one who could speak to patients about patient issues as a clinician rather than as an administrator and the sort of compromise it strikes me as desirable is one where you have a chairman of the board however described who is a either current or retired clinician, but that doesn't for a moment derogate from the fact you will need a true professional administrator to conduct the very complex business of running a hospital?-- I agree, Commissioner.

D COMMISSIONER VIDER: I'd just like to canvass the notion Queensland is a large geographical area. Would you have a comment on the current carving up of that geographical area into roughly the three zones? I'm not asking you to comment on how the zonal system works but just on that geographical carve up, whether you think that's an appropriate way to carve up Queensland?-- No, I don't, and I can explain that. I think Western Australia, I believe, run a - what they call a

metropolitan and non-metropolitan system. I certainly think there needs to be a carve up and I think - but it is beyond me why you would have two zones basically based in Brisbane and one zone for the northern zone. It seems to me that a metropolitan/non-metropolitan structure sets up some economies of scale within the Brisbane - within the metropolitan division and, more importantly, it would be an opportunity for us to perhaps look at where the boundary currently sits because one of the disadvantages we have in North Queensland is particularly in relation to the tertiary services, which is the highly specialised ones, we haven't actually got the volumes to maintain a workforce and it's my belief that if the boundary was dropped down, I'm not sure where, perhaps Rockhampton, and we had more people within this zone, that would enable us to employ more tertiary specialists and therefore would make the whole system sustainable, and I think that is an opportunity that perhaps could be looked at.

COMMISSIONER: It's an interesting point you make because I think for well over a century, for most administrative purposes the state has been divided into southern, central and northern regions based on Brisbane, Rockhampton and Townsville, and over the last couple of decades there's been a tendency to expand those three segments into a fourth, which is Far North Queensland based on Cairns. Is that more traditional division of the state one that you'd find attractive?-- I'm sorry, I'm not-----

Well, you made the point that it does seem strange having two zones based in Brisbane, one on either side of the river, and then a third zone which encompasses the whole of North Queensland. Would the traditional division of Southern Queensland based on Brisbane, Central based on Rockhampton and North based on Townsville make more sense to you?-- Yes. Yes, it probably would.

And would you see scope within that for a Far North Queensland zone based on Cairns, or do you think the population and economies of scale and so on really mean that the whole of North Queensland, including Far North Queensland, has to be treated as one unit?-- One of the - the more zones that are added, potentially the more levels of bureaucracy that are introduced.

Yes?-- So perhaps the notion could be that we have the traditional zones, as you suggest, but given that there are some unique qualities up in the far north, to use the jargon, a hub and spoke model within the northern zone, for example - and I know Terry Meehan, the zonal manager, is very keen on this - whereby there is a hub, which down here is Townsville, which spreads out towards Mount Isa, Charters Towers, Bowen, that area, and that makes sure that the local needs, albeit two hours' flight time, I believe, to Mount Isa, but the local needs can be meet, and the same in the far north, have a hub run out of Cairns, but the whole thing is glued together by one zone. So from a tertiary point of view Townsville could have those services - I was fortunate, or unfortunate, depending on how you look at it, to be the zonal manager for three months at the beginning of this year, and it gave me a really good view of, I guess, the tyranny of distance in North Queensland, and it really opened my eyes. So I think it's really important that somebody continues to have that all of North Queensland view.

That really raises one of the other thoughts that we had canvassed, and that is that with the multiplicity of regions, of districts that we've got now, some of them quite small in terms of population and in terms of the health resources within that district, there are obvious advantages in combining in some instances two, in some instances perhaps even three or four districts into an area which can operate on that hub and spoke basis that you're talking about. I'm inclined to think, though, that if that were to happen, it would be vital for the communities involved to be both represented by, for example, at least one appointee on the administrative board, and perhaps for each of those local

communities to have their own subcommittee or subordinate board to oversee the day-to-day running of the local health service. So - and this may not be a valid example, but as I understand at the moment, Charters Towers constitutes its own district. If that were to be merged into the Townsville district, you would still want the people of Charters Towers to be represented at a governance level and also to have their own community organ to speak for them in relation to the running of their local hospital?-- Absolutely, Commissioner.

D COMMISSIONER EDWARDS: Could I ask you what flexibility could be applied to budget allocation, budget planning and so forth in such a system, or would it still be - would you see it still being centrally controlled?-- I think the total health allocation would remain - it's not practical to have every district speaking directly to government for money. So in terms of the total pie, that is likely to remain centrally controlled, but I think the flexibility comes in when we look at how that pie is split within the individual district. One of the things we tried to do - and this is an evolving structure, but one of the things we've tried to do in Townsville is create the institute, the service management structure, and those services are run by - in a partnership model, and each clinical service is run by a clinical director who is a practising doctor, and a nursing director - an operational director who is a nurse. We have internal budget negotiations, and it's interesting, we are at the moment - for example, we've already agreed our budgets with our institutes for this financial year. So we sit down with those - they put their cases based on volumes, based on what they know about acuity, and we agree an amount of dollars and give that to them. We have - when I say "we", it's the district management, Dr Johnson, myself, Shaun. We have no idea at this point how much money we're going to get out of Brisbane, but what we're saying - and we said this last year - is, "You are in the best position to make decisions about services that are offered to this community, doctors, nurses. You do it every day." We need to acknowledge that there is a fixed pot. The problem with health is you can spend every cent of taxpayers' money on health and you wouldn't have enough. That's the harsh reality I think we all know, but we also acknowledge that we can't continue to put as much pressure on the system. It then becomes our job, so we dump the deficit, as we say, and - end up with all this money that we've agreed to spend and not enough actual money, and we dump the deficit in a corporate cost centre, and then it becomes our role in the course of that year to have robust conversations with Corporate Office and try and recover that money. An example, I think at the end of this financial year just gone, we've ended up $2 million in deficit, and I guess we will hear about that town the track, but at the end of the day I think the point I'm making is we try to have clinical staff as involved as much as possible in the decisions of the spending of the resources, and I think that is quite unique for Queensland, and I think that is something that we could work on and evolve into a model that would get some buy-in.

COMMISSIONER: What attracts me is one of the other advantages of the sort of structure you are talking about is that I'm rapidly coming to the view that some very tough decisions have to be made in relation to the administration of health in Queensland, and some of them will be politically unattractive decisions. It may be, for example, that we have to abandon the idea of having small one doctor hospitals in country towns. I don't mean remote country towns, but country towns that are one hour's drive from an established hospital. That is, politically, a very awkward decision to make. It may be that in some of those towns it will prove necessary to have, for example, a nurse practitioner providing clinical services rather than a resident medical practitioner. It seems to me that those difficult decisions will be not easier to make, but perhaps at least easier to explain to the community if they're made at a local community level rather than simply dictated from either Charlotte Street or George Street?-- Absolutely agree.

Without putting you on the spot and asking you to give specifics, are there areas of rationalisation that you would like to see implemented in the northern zone that it would be awkward to achieve under the present structure? I'm not for a moment asking you to say we need to close Babinda or whatever it might be. I'm just asking in general terms, are there areas where you feel that economies and rationalisation could be achieved in a way which will ultimately benefit the patients, both in the major regional centres, and also in the more remote communities?-- Yes, Commissioner, I think there are. I think - and I think I'll answer it in two ways. Firstly from an administrative point of view, I believe the hub and spoke model would have some efficiencies in terms of oversight of those smaller hospitals, and that would then hopefully free up some resources which would be spent then in direct clinical care. So that's got to be a good thing.

Yes?-- I think, more importantly, it brings those hospitals into - or under the support of a larger institution where perhaps, because of our resources, our patient care models, our patient safety models are a little more evolved, and therefore in relation to ongoing support to those medical practitioners, and indeed nurses who work in those small areas, hopefully that would mean they would be better supported and therefore the risk of a disaster happening could be minimised. I know Dr Johnson, through the patient safety system that we have in Townsville, does a lot of work with some of the smaller hospitals around our area to get some of those principles in. I think the other big advantage that we have in Queensland, and one of the things in Queensland that I've seen that really impresses me, is the information network, the information system network. One of the downsides of the silo approach in New Zealand is that every little district got their own computer system, and I'm reminded of a small district down the south island that got this cheap computer system out of Germany and it's not supported in the southern hemisphere. That's, clearly, a very dumb thing to do. I think Queensland - the one thing they have got right, and are getting righter, is the infrastructure around

information systems. Within Queensland Health the systems talk to one another. The band within the bush seems to be being - and I don't understand all this technical stuff, but seems to becoming more available. I know again Dr Johnson - we've looked at - down in New South Wales they run what they call a virtual intensive care bed - assessment bed, and it's not beyond the realms of possibility that you could have a similar thing in Mount Isa, for example, whereby at a television clarity and realtime, a doctor out there would have a camera, there's document cameras, and the patient can be assessed whilst in the ED and be walked through that by a clinician in realtime at Townsville. I think the infrastructure is almost there to enable us to do that, and I think that would be a huge advancement in patient care in the smaller districts.

Doctor, I'm sorry for the conversational way in which I'm raising these matters, but I think it's hugely useful for us not only to be able to hear ideas, but share ideas and get feedback on them. From all the reading I've done, both medical and historical, Queensland undoubtedly had a world class, state of the art public health system in the 1930s, but it seems to me that so much that goes on in the public health system now is based on a - on concepts that are more than 50 years out of date. We know, for example, that whatever may have been appropriate in the 1930s, you can't now put a person through six years of education, make that person a doctor, send the doctor out to the country and he or she knows all the medical knowledge that he or she will ever need to know to treat whatever comes in from a difficult pregnancy to a broken leg to a heart attack or a stroke. Efficient medical services in a time of efficient rapid response communication, whether by road or by fixed wing aircraft or by helicopter, really needs having centres of concentrated medical specialisation rather than sort of outreach centres with what can only be, through the necessities of it, a very casual standard of medical specialist knowledge in a local environment, and that's why it's going to be increasingly important to have hubs of specialist care and clinics in the smaller communities which are more like reception centres for patients, deal with quite minor matters, but otherwise are principally involved in assessing and receiving patients for care in centres where the patients can get world class care. How do you feel about that?-- I agree. I agree. I think one of the other dangers that face, particularly places like rural Queensland, is within the medical profession, and to some extent nursing, we're becoming more and more specialised, and where that works in the big centres it becomes a real problem, even in hospitals the size of Townsville. It becomes a volume issue because you need so many people through in a year to maintain skill level, and if it's a very specialised area that becomes quite difficult. I think one of the opportunities that we have in North Queensland - I think people are realising that there is a place for a generalist, and I know the medical school at James Cook University is very, very keen on - and it is early days, but developing a post-graduate generalist stream, and I think if that was to happen down the track, that would be a bonus not only for North Queensland, but for

Australia.

Yes?-- We're certainly very supportive of that. I think the other area, if I may mention, that I find confusing and very challenging, particularly in small communities - if I can hark back to New Zealand, and one of the areas in small communities where we've been able to make it work is the relationship we have with the primary care centre, the general practitioners. General practitioners, in an age where we're all getting older and we're all living longer and therefore often we end up with more chronic type disease - and we're certainly seeing that through our hospital - the GPs, and the relationship with community providers, becomes absolutely paramount. We must work together to keep people out of hospital and then to better support them when they are out of hospital, and I think - actually, I read an article somebody sent me recently where at a hospital in South Auckland - and they concentrated on a group of people working with the general practitioners, and they've been doing this now for the last two or three years. They've just had a major flu epidemic go through, so what you would expect is the volumes of inpatient admissions to go up. The volumes have gone down, and the reason the volumes have gone down is because of the partnership and the investment in primary care. The difficulty of doing that here from where I sit is this federal/state thing where if you're primary care, it's the federal responsibility and the states say, "Well, that's not our problem", and if it's secondary, tertiary care it's a state responsibility and the feds say, "Well, it's not our problem", and in the meantime that cooperation becomes very stretched, and the patient - who really couldn't care less as they are in the community and all they want is access to a range of health services - tends to fall through the crack, and I think we have to do a lot of work within the community working with a GP partners, and I think that is an area that needs a lot of attention.

D COMMISSIONER EDWARDS: Are you restricted in doing that, relative to the general practitioners providing services, by the Medibank agreement? It's been put to us on a number of occasions that the Medicare agreement is now very restrictive on the kind of services that could be expanded by local initiatives?-- Yes, it does become a barrier, that's for sure. My understanding is that, for example, if you had a general practitioner - and I'm not 100 per cent sure of what I'm about to say, but if you had a general practitioner working in the Emergency Department, for example, and a patient came through the doors of the Emergency Department, was triaged Category 5, and we said, "You don't need to be seen by a hospital doctor. We agree you need to be seen. There's a GP there, go and see them", if that GP saw them, the GP then couldn't bill because it was within the state system, and to me that's ridiculous, in that if that GP was in a building across the street and that person turned up, well, they would legitimately be able to bill. So I'm not sure - and I don't think that's cost shifting. I think that's about access to the right needs, and whilst these people are being seen by general practitioners, it means our very busy emergency medicine specialists are able to get on and spend

more time with those people who are Cat 1 and 2.

COMMISSIONER: You make the point about the federal/state dichotomy, but it seems to me that the other inefficiency is the public/private dichotomy in that there are enormous areas of potential cost saving and rationalisation if there was more scope for local hospital management to enter into partnership with private medical practice, things like collocating radiology and pathology services in public hospitals. I don't mean in Townsville, where I imagine you already have state of the art pathology and radiology on site, but in smaller towns having the opportunity, rather than the public hospital's here and the pathology and radiology services are down the road, collocating those facilities so that they're there for the benefit of both private and public patients, allowing specialists with rooms in public hospitals to see private patients in their public hospital rooms so that they can generate extra income and provide a service to the community that's otherwise not being provided. Those sort of partnership arrangements that seem to be being largely restricted under the present structure?-- Absolutely. I think there is an example of that at Mount Isa where a private practitioner in fact bought a CAT scanner, from memory, and put that scanner in that hospital. So it's public and private people get to use that. I think that's quite innovative.

Yes?-- It's certainly something that should be encouraged. I think even in Townsville, the fact that we have a full cardiothoracic service in the Townsville Hospital, and at times struggles to get the volumes through in the course of the year, and we have a full cardiothoracic service in the Mater down the road, and while I can't speak for the Mater, I wonder at times whether maybe they struggle as well. Perhaps what makes more sense in a city this size, as we go forward, is that there is a conversation and an agreement one day that one of those facilities will provide cardiothoracic services for the twin cities, and whether you're private or public doesn't matter. I think that is something well worth investigating. I suspect we're a few years away from it happening, but nevertheless one should have the conversation.

But it has to happen, doctor - I'm sorry, it does have to happen eventually, doesn't it?-- I agree. Absolutely.

And similarly it has to happen that sooner or later you and your colleagues in the local private hospitals sit around a table and say, "We need another neurosurgeon in Townsville. Can we collaborate to advertise for someone to come to Townsville as a neurosurgeon, give that person three days a week at the hospital as a VMO on the understanding that he or she will also have private operating at the private hospitals", those sort of, to my mind, obvious forms of cooperation?-- Yes. Commissioner, one of the learnings for me, having followed this Bundaberg Inquiry, read many of the transcripts, read some of your discussion papers, and many conversations as a result of that - and I still haven't quite worked through in my own mind how I let this happen, but where I came from, private and public collaborations were quite

common. There were tensions, but collaboration was something that happened every day. One of my regrets, I guess, since being in Townsville, is that I feel that the conversations with the VMOs, the local private doctors, and the public have not been as useful as they could have been, have not perhaps taken the public interest into account, and I take some responsibility for that. I think there are some examples of some private VMOs who, for whatever reason, feel that they haven't been included in the public hospital, in the system as much as they should have been, and as a result of that I have seen we have lost the services of two or three very skilled, valuable clinicians. Why did that happen? I'd like to say because we all got real busy and we were focusing on our own worlds and it just happened, and I think that's probably part of it. I'm not 100 per cent sure. But I think the opportunity for us, and the only way we are going to have a sustainable health service in the north, is to put aside those differences and start working through some of those issues.

And Mr Whelan, when I spoke last week with Mr Forster, who has just put out his interim report, the impression he conveyed to me is that throughout the state most of the complaints from VMOs are about essentially little matters, sometimes trivial matters, but things that are important to them, having a carpark at the hospital so they don't have to park a block away and pay $10 and carry their equipment to the hospital, having a common room - I know it's an old-fashioned thought, but having a common room where they can sit with their colleagues and have a cup of coffee and talk about medical or non-medical issues as they think fit, being consulted, not put in charge of, but simply being consulted about recruitment of people in their area of specialisation. Those sort of things that cost no money or cost very little money but are very important to the individuals involved. Is that your experience in Townsville?-- Yes, it is. I think - they have their own carparks in Townsville. And-----

Pleased to hear it?-- I say that because it's actually - it demonstrates the balancing act that one has to be involved in because the VMOs have got car parks and there's good rationale for that. They come and they go. They're busy. They come and do their work and then they go again and they're not there all day, but some of our full-time specialists who are not necessarily oversees trained doctors, I might add-----

Yes?-- -----it's very easy for them to perceive they are being undervalued when some of these little things are given to VMOs and I guess we need to be careful that - I guess, it's a give and take relationship.

Yes?-- And both parties need to realise that and there needs to be compromises on both sides and I think that is something that needs to be worked on.

D COMMISSIONER VIDER: I'd just like to come back and ask you how long has the New Zealand system been in operation?-- The current structure?

The one you were talking about?-- Six years.

How has that been evaluated by the stakeholders, and I'm interested in the community? I'm interested in the health care professionals and I'm interested in the Government's reaction and has it cost the Government more or less money?-- Working backwards, I think it's cost the Government more money because whether it is more money than they would have had to spend, I'm not sure, because every year health costs go through the roof and that's just the nature of the beast. I've been out of the system now for two and a half years, but my understanding is that, generally speaking, particularly in the smaller communities where there is a sense of community, which I think is more difficult in the bigger cities, communities feel that their health service is part of their community rather than the hospital on the hill. So, in other words, one of the big things is being, I guess, to use the jargon, the health service has been branded for that community. They feel part of that ownership and, therefore, they become part of the solution. My understanding is that a lot of people feel they have more say in the delivery of care and that is a good thing. Is it the silver bullet for health care? No. Are there still problems? Absolutely. Our waiting lists there are as bad as here. Do they have blitzes on waiting listings, particularly around election times? Yeah, they do. So a lot of that stuff is the same, but overall I think people feel more involved. I believe that the health professionals were still feeling fairly disenfranchised. I think - and this is just my opinion, but the pendulum perhaps swung a little too far towards the community, and the health service deliverers, the health professionals are saying, hang on, this is all very well, but I need to be more involved in this decision making too and I think there are more examples we health professionals are more involved in some areas than others, geographical areas. I think the smaller communities have more health practitioners involved than perhaps the bigger cities. The one thing that I

have just heard though that has made a huge difference - and I think this is something that Queensland's going to have to look at - is for whatever reason the Government has just spent a huge amount of additional money on health and they put it on what they call price, so it's not about attaching that money to additional activity, and my understanding is that nurses and doctors over there have recently received a significant pay rise. My understanding is that nursing got, I think, up to 20 per cent over the next two years. That's about market forces. Whether we like to admit it or not we are in a global market when it comes to recruiting. I think North Queensland I've been here two and a half years and I think it is one of the nicest places I've ever lived. I think you've only got to fly over and you see this place and you see the weather and it's just beautiful. I think that is - makes it very sellable, but that's not the only thing. We can't rely on just selling that, and what worries me is that we are losing a lot of very skilled health professionals, whether it be to places like New Zealand or down in New South Wales, simply because we are not in the market.

D COMMISSIONER EDWARDS: Financially?-- Financially.

COMMISSIONER: I am interested to know, Mr Whelan - I don't have the demographic figures at my fingertips, but my impression is that population wise it's not inappropriate to compare New Zealand as a nation with Queensland as a state. There would be a similar sized health market?-- Yes.

And a similar sized health budget?-- Yes, I think so. I think Queensland might - it's confusing because in New Zealand, of course, you've got the primary care side as well so it's not apples and apples.

Yes?-- So the cost of delivering health services in Queensland, particularly out of Brisbane, is a lot higher because of that - there are different economies of scale and the reason for that is the tyranny of distance and that will always be, but apart from that I agree with you, I think they are comparable.

Mr Andrews?

MR ANDREWS: Mr Whelan, quite some time ago in answer to a couple of the Commissioner's first questions to you it appeared to me that you agreed with two contradictory propositions. One was that there was some benefit to having a zone with Rockhampton as its hub, but your evidence, I thought, was that you saw some benefit to Rockhampton being included in your zone because there would be some benefits of scale for the Townsville Hospital. Can you-----?-- Clarify?

Yes?-- Perhaps I misunderstood. I certainly believe that if the northern zone included Rockhampton and the volume, therefore the people within there, that would help us have sustainable services.

For instance, you mean you would probably in your public

hospital be able to have ENT services, three neurologists because you'd be supporting-----?-- No, I think those particular services are more likely to continue to be run at Rockhampton, but when it comes to neurosurgery and cardiac arrest surgery and interventional cardiology, those high, big end services, you are absolutely correct. That would enable us to have three of each of those rather than two and that makes those services more sustainable because you're not putting people into rosters, on-call rosters in particular which are in this day and age intolerable.

COMMISSIONER: But I think the real point you are making, Mr Whelan, as I understood it anyway, is that if it's a matter of Rockhampton being put in the same zone as the Royal Brisbane Hospital or being put in the same zone as the Townsville Hospital it makes then a lot more sense to have it as part of the same zone as the Townsville Hospital because you've got so much in common and so much more capacity to share resources and achieve economies of scale?-- That's correct.

MR ANDREWS: Within your statement of paragraph 8 you speak of the clinical institutes, the risk of creating a silo approach and you mention the ambition that the Director of Nursing and the Executive Director Medical Services take a whole of workforce approach to ensure that professionals across institutes take a whole of patient approach. I see that you've expressed the ambition. How do they achieve that?-- How do they achieve that?

Yes?-- Just explain the silos. I think the services that we have got, the surgical services, medical services and such like, they spend their days concentrating on those services and obviously from a professional standards point of view there are major crossovers. Rightfully or wrongfully, one of the things I did when I got here is, with agreement, albeit reluctant initially, I believe, with the medical superintendents and the Director of Nursing we agreed that the line responsibility for those staff would go to within those services which would free up some to enable those positions to concentrate more on those whole of organisational issues, so using the medical superintendent as an example this has enabled him to meet with clinicians across the institutes and look at the services as a whole organisation and look at the things that are important in providing comprehensive patient care which ran across the services rather than within the services, so I guess that's what I mean by that. How they achieve that? They achieve it by being able to get out on the floor and meet with those clinicians across a range of services.

At paragraphs 11 and 12 you speak of some of your frustrations in having to deal with head office in Brisbane and do you explain that it creates problems for you as an administrator here in dealing with your clinical staff?-- Clinical staff are obviously very clinically focused. Most of them are very passionate about what they do and many of them can't be bothered, from where I see it, some of the bureaucracy that

goes on even within the Townsville health district, and when they need something they need it now and some of that's appropriate and I say some of it isn't. It's made a lot more difficult, however, where the budget that they need is over a certain amount of money and I would need to go to Brisbane to get permission, okay.

What sort of discretion do you have, for instance, with respect to purchasing things that have been requested by clinicians that seem to you to be useful or sensible requests?-- It's up to a couple of hundred thousand dollars, but some of the big equipment can be a lot more than that and some of it is not just equipment. Some of it is the round processes and - it seems to me - and goes to Brisbane, goes to head office to make sure that this complies with the overall state direction, I have not got a problem, you know, but what I have got a problem with is when it gets to some policy person within a division of Queensland Health who then has to talk to another policy person and before we know where we are we have a committee and the one thing I hate - and I am probably wrongfully because I'm sure there's - and I see committee staff often in this place where we have social gatherings and, quite frankly, I've got enough friends. The problem with all that is it goes round and round and round and by the time it comes back here we are three or four months down the track and what's happened within that three or four months time is I have a very frustrated clinician saying, "Where the hell is my - what's happening?" "It's in train. It's in train. It's in train." So what can happen is, I think, what is human nature, we take it out on the person we can see and I think at times as a result of that that adds to tension between local management.

Mr Whelan, when requests made by you to head office are declined are you usually given the reasons for it and the identity of the person who's refused your request?-- Yes, I am.

We have heard complaints at Bundaberg that quite often requests would be made and it was obvious that the requests had to be passed down the line to Brisbane and that months later requests might be refused and it could be very frustrating for the person initiating things because the reason for the refusal, the identity of the person who's made the decision aren't communicated. Is it your experience that generally they do reach the - the reasons are known to the executive at the hospital?-- I guess because of my personality - and I tend to be a little blunt at times - when I hear nothing back I tend to, regrettably at times, become fairly assertive, and some describe aggressive, I guess, so I think as a result of that people do tend to let me know where things are at and I have no problem picking up the phone and ringing the Director-General if I need to, and on occasion I have, and I think some of that, to be fair to Bundaberg, is the fact that we are a far bigger institution and maybe that means they take us more seriously. I'm not sure.

COMMISSIONER: I think that part of the problem as

communicated to us in Bundaberg is that if you have a clinician who thinks he's got a really good idea - and I'll take a specific example which was given to us by a renal specialist who wanted to participate in a local level in some sort of national kidney day or something - I don't recall the precise details - it did come across as a good community based idea and he puts his report to his Director of Medical Services who puts it to the District Manager and puts it to the zone manager and goes all the way up and some months later, I think, after the relevant date had passed, in any event, he is told that he can't do it and I think his biggest frustration, apart from not knowing who made the decision or why, is not having someone at the other end of the line so he can pick up the phone and say, look, you know, if there's a problem with that plan, you know, can we save it by a bit of adjustment or tweaking or fine tuning, or is there some fundamental flaw in it that means we should ban it altogether, and it's that sort of lack of input and feedback, the ability to find out what the thought processes were and, indeed, whether there were any thought processes involved in rejecting the proposal. Do you find that problem or do you find you can get answers when you're asked for them?-- I find on occasion I have that problem, but I tend to get the answers. Either that or the other thing that we have done here - and I give the example - I've created eight additional bays in our Emergency Department. It's overflowing and - it was sold to us by the clinicians. We added a lot to it and the nursing staff were certainly tearing their hair out in terms of the space and we knew winter coming on - actually, we have almost already missed the boat anyway - that had we gone downtown and we had gone through the proper process it would have taken months, so we actually just did it and I think there are examples which is why, I guess, we have been described by some as - I think recalcitrant was the word. There are times where we just, because, I guess, we blame ourselves - I've often used the phrase, "I'm sorry. I'm a dumb kiwi and I don't understand." It's a bit like - I know that sounds like a bit of a cowboy thing, but when asking is real important I think the best way of doing it is on getting agreement from the clinicians doing it and then trying to do a work around solution.

Mr Whelan, I'm afraid you are preaching to the converted. I heard your comments about committees and I don't mind sharing with you the situation that I was on the Queensland Barristers Board for about 14 years and that I made it clear to the chairman from the outset I was happy to be appointed if any committee wanted me on two conditions. First was that I was the chair of the committee and, second, that I was the only member of the committee. That's my idea of how committees work or don't work and one of the things we see again and again, particularly coming from Bundaberg with various committees, is that, on the one hand, people seem to be unable to go to a committee meeting without there being speeches so instead of a sharing of ideas and a discussion of concepts people want to put their views on the record and the person who's the most - got the loudest voice or the most persuasive manner tends to dominate, and the other thing is that a lot of

people are reluctant to raise things at a formal meeting which is minuted because they don't want it to come back and bite them. They'd be quite happy to sit down with a cup of coffee in the sun on a warm winter's afternoon and say these are my concerns, but then they're not interested in documenting or recording them at a committee meeting because that just creates more problems and gets referred to another committee and life becomes miserable. Is that the context against which you've had to operate?-- Yes, yes.

MR ANDREWS: You went ahead and did something in the Emergency Department without seeking prior approval?-- Mmm.

What do you then do? Do you seek retrospective approval in the hope that you'll get funding for it?-- I guess I - we need - you need to understand that, I guess, that the budget in the Townsville health district is $260 million a year.

And you were over budget by 2 million last year?-- Yes.

What happens to you if you're over budget?-- I'll tell you in a month or so's time. I don't-----

COMMISSIONER: It doesn't come out of your own pocket?-- No, I hope not. I'll have to sell the boat.

Yes?-- I think certainly that - it is important and - to come in on budget. I remember having this conversation with Dr John Scott a while ago and he said to me that obviously we - the budget is important in that this not affects - that's a fixed budget. We can't keep spending on it. Then said - and I think John certainly tried within the bureaucracy to be honest and look at clinical concerns. He said if you can put up a case which demonstrates that there is a good clinical argument, providing, of course, we are not talking all of a sudden Ken rings up, "I think I've just blown the budget by $20 million.", I suspect we would have a different conversation. So I think providing there are legitimate clinical reasons it would probably be okay, certainly for one year. The question becomes once you've put up that argument is that money then put into the system so you then start the year off from zero or do you carry that debt across, and if you carry that debt across you end up with a residual debt and once that starts happening it can be a slippery slope, particularly when the funding model that we seem to have - one of my colleagues described it as a hysterical model and not a historical one, and I think that sums it up quite nicely. It is very difficult to actually carry forward debt and then make financial plans to recoup that. So we're still working on the end of the financial year and I guess, as I say, time will tell what happens.

Mr Andrews, is that a convenient time to take the morning break?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 10.54 A.M.

THE COMMISSION RESUMED AT 11.21 A.M.

KENNETH DOUGLAS WHELAN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews?

MR ANDREWS: Mr Whelan, you give an example within your statement of an occasion when you didn't first consult head office before instituting an initiative of your own, and that was simply creating, apparently, T-shirts here that bore a special logo to show that the Townsville Hospital was part of North Queensland?-- Yes, we come back to what I talked about before, trying to brand the local health service with the community. Some nurses actually were going down to Brisbane on a recruitment drive, so had half a dozen nice shirts designed "Townsville Health District, outstanding people, genuine care", I think it said, with the Queensland logo. And I thought it looked really good. So we talked about it and just had some of these shirts reproduced and offered to sell them to the staff. And what I didn't realise - maybe I did, I have forgotten - was there were quite a few rules around when you had logos, what size they have to be and what can be on them, what can't be on them, and we had a veritable reprimand, I guess, from corporate office about not doing this sort of thing unless we ask prior permission. The interesting thing about it, I guess, was that we actually sold 2,000 of these, which suggests there was quite a bit of buy-in from the staff of 3,000.

D COMMISSIONER VIDER: That's what you call a collector's item?-- Sorry?

That's what you call a collector's item?-- That's right.

MR ANDREWS: I gather you are not doing it again, since the reprimand?-- I wouldn't say that.

Now, you speak of levels of frustration at the local level which can lead to high staff turnover at all levels because of the inflexibility of Brisbane. Have you just yesterday had a directive from Brisbane that compels you to cease oesophagectomies and pancreaticoduodenectomies.

COMMISSIONER: Otherwise known as Whipple's procedures?-- Yes, a memo was produced on the 27th of July which stated very clearly that only two hospitals in the State at this time will be able to do those procedures, and that is the Princess Alexandra Hospital and the Royal Brisbane. That creates a problem for Townsville, in that as a large tertiary facility, we actually do these - we have a surgeon competent in these procedures.

MR ANDREWS: In fact, does your surgeon speak at medical conferences on the topic of these procedures and is this

surgeon - is it one of his areas of expertise?-- That's my understanding.

And is your concern that you weren't consulted first with respect to this policy?-- I have got two concerns. My first concern is definitely that, but I believe that that - it may or may not be appropriate, but the reality is that we should have been asked. We should have been asked. Because the result of this is this particular surgeon has taken some leave without pay to enable him to look at his position, and that will mean for that period, unless we can find a locum - well, in fact, based on this memo, it won't matter because we won't be able to do them anyway - that these patients will now need to travel to Brisbane. And I think that is a massive inconvenience for the population of North Queensland and an insult to this surgeon who has extraordinary skills in this area.

You speak of-----

COMMISSIONER: I am sorry, Mr Andrews, who issued that directive?-- It was actually signed by Dr John Scott, who was the Senior Executive Director of Health Services at the time.

MR ANDREWS: Mr Whelan, are you in a position to comment upon whether there may have been good intent behind that directive? For instance, are you aware of some authority for the proposition that despite the competence of the surgeon and the facilities at a hospital, there is research which suggests that the probabilities of a good patient outcome are increased if at least certain number of procedures are done annually at that hospital?-- Yes, I am. And I would agree with that. I guess one of the things that I am more upset about, as I say, isn't necessarily the result but is the fact that prior to the memo coming out we were not asked.

COMMISSIONER: You said you had two concerns. One was not being consulted?-- And the other was I now find myself in a position because of that that I have not got a surgeon to perform these procedures and the likelihood of finding one is distant.

And the risk of losing that surgeon for good-----?-- Is high.

MR ANDREWS: I gather that surgeon performed procedures other than those two very complicated ones?-- Yes. He is a VMO and he, on my understanding, provides around 40 per cent, I think, commitment to the public system. So if he does choose to go, he will be a huge loss to this community.

COMMISSIONER: And presumably the bizarre impact of that is that people who can afford to have private health insurance will be able to get those procedures done in other local hospitals by that surgeon but because of this unilateral directive from Brisbane, public patients just won't have that option?-- That's correct.

D COMMISSIONER VIDER: The memo never referred to tertiary

hospitals, it named two - it named the institution by name?-- Yes, it did.

MR ANDREWS: At paragraph 16 you speak about a poor industrial relation policy which sees disputes lasting sometimes up to 12 months with resultant friction in the workplace. Dr Berg, as we heard yesterday, was a person who was - who initiated a dispute about five months before his contract ended and, as I understand it, that dispute hadn't been resolved by the time his contract ended. Is that a typical example of how long it takes to deal with these matters?-- I think so. I think bullying is a word that's used a lot. Are there examples of real bullying within Queensland Health and within the Townsville Health District? Probably. But I also think that sometimes we are confused around performance management and that's not helped when we have delays such as this. And it is not just with doctors. Like, it can be very frustrating within our administration stream, for example, where two receptionists perhaps have a fallout and there is an accusation of bullying. If it takes six, eight, 12 months to work through the whole process, you can imagine the impact that then has on that small department over the course of that time.

COMMISSIONER: Mr Whelan, just as a working definition I would think of bullying in this context: as meaning a situation where an administrative functionary attacks a person over one issue, or alleged issue, or pretext as retribution for something the person has done which is quite unrelated. So a person puts in a complaint or report or makes an allegation and then suddenly finds themselves the subject of a disciplinary investigation on something quite unrelated. The allegation that we've repeatedly heard is that at least at some echelons and within some parts of Queensland Health there is what's referred to as the shoot-the-messenger culture; that if you have the temerity to speak out against the system as it exists, whilst you may not be directly challenged for doing that, you will find life uncomfortable in some other way. Using that sort of definition, have you any experience or knowledge of that form of bullying going on within the system?-- I would have to say, using that definition, personally I can't give you any examples.

Yes.

MR ANDREWS: Do you have any suggestions for improving the process, that is the industrial relations process, so that things can be determined in less than 12 months so that they can be determined quickly? Or are you bound by legislation to do it in a way that takes so long?-- I think we're bound by legislation, we're bound by industrial agreements, and I think perhaps it is something that should be flagged that requires minds to come together to look at. But I have got no short term solutions.

At paragraph 18 of your statement you seem to single out policy section personnel of Queensland Health as a particular species with whom you have strained relations. Can you give

us examples, not of the people but of the episodes which lead to this relationship?-- I guess in some ways it goes back to what I was saying before about committees, and often these sorts of policy analysts tend to be people that make up these committees because that's when policy analysts gets together and do what policy analysts do. The frustration for me is that - I am just trying to think of a real example, but if there is an innovative idea, maybe even an idea, perhaps we don't need a policy on every idea in the place. And there have been times where I - I am not a very rules-based person, and at times, because of that, I break the rule. And I just get sick of people quoting policy XYZ. In fact, I had somebody say to me recently from down there, down in Brisbane, was I not aware of policy XYZ, and I said no, I wasn't, and one of the reasons for that is that I haven't read the policy manual because it stifles innovation and I guess that sums up my very biased view on it.

COMMISSIONER: Talking policy stifling innovation, that sort of bleeds into the area of media management and media spin. Are you regulated by corporate office as to the way in which you can respond to media inquiries and deal with issues of concern to the local community?-- Yes. All media releases prior to being released to the media are signed off in Brisbane. Depending on, I guess, the sensitivity of the release, it is either signed off I guess within the public relations team or, indeed, may go to the - to the next level up, or, indeed, to the DG, and perhaps sometimes even to the Minister. But certainly we get clearance before we go to the media.

D COMMISSIONER EDWARDS: So if you needed to make a press statement about something that was almost routine, would that still go to the head office?-- Yes.

COMMISSIONER: And what about if it was something of urgent relevance to the local community; if there was an outbreak of Ross River Fever, or meningitis, or something like that, that needed a fairly urgent response for clinical reasons, not for publicity reasons?-- To be fair.

Under that regime?-- Yes, Commissioner, but to be fair, in my experience where there has been an urgent clinical matter and we've gone to Brisbane, the response is usually very quick and we're able to get on with it, so it is more of an information sharing with Brisbane rather than an asking of permission, if you like.

The area of greater concern to us at least is the management by Queensland Health of bad news which involves, amongst other things, withholding from patients knowledge of problems within the system. Are you in a position to comment on the level of control exercised by corporate office when there is a problem? You acknowledge that there is a problem, you would like to explain to the people of the community why there is a problem and what you are doing to sort it out where you want to go public on an issue like that?-- There is - we - it is not uncommon for news releases - for us to be directed on

releasing a media release in a certain way.

Yes?-- That's for sure. It is sometimes we are told of what we can say and what we can't say, yes.

You see, we've seen instances - and they're only instances - where it is anticipated that a bad news story is going to break in a locality, there is going to be criticism of waiting lists or bed shortages, or some problem at a hospital in a particular locality, that the local newspaper is on to it, and we know that health stories sell newspapers, and so the directive comes from Charlotte Street that you should sort of generate a good news story to grab the headlines so that the bad news doesn't get coverage. Is that the sort of thing you are talking about?-- It would be certainly fair to say that quite often there are good stories ready to go.

Yes?-- In my experience, and my brief experience over here, seems particularly with the print media, letting good stories go becomes irrelevant because they are not printed anyway.

I have been told - and I am not sure whether it is something that's in formal evidence at the moment, but I have been told that in one hospital - I am not speaking about Bundaberg - but one hospital that has attracted a lot of bad press in the local media, that the district manager had a direction, a standing instruction from Charlotte Street that he had to produce one good news story a week and have that ready to go with the local press?-- I have not had that experience, and to be honest, Commissioner, I think it would be a gutsy person that gave me that directive.

It is another rule that you would regard yourself-----?-- I would ignore.

-----at liberty to break, yes.

MR ANDREWS: Mr Whelan, you say there is not the flexibility in the system to acknowledge outstanding performance. How do you see high performers being rewarded in some practical way?-- I put that in - I think I can understand why, perhaps, we don't have such a thing because everybody works really hard. That said, in my thinking it was that if we had, I don't know, 20, $30,000 available at the end of year - at the end of the year and a group of people's peers sat down, and based on a whole range of quality - so not financial management, but clinical quality indicators - those peers decided that these nurses or this doctor, or, indeed, this gardener, had actually met this criteria in the course of the year, that there would be an opportunity at Christmas time to acknowledge that, not only with best employee of the year, or whatever you want to call them, but with some hard cash.

Have you ever seen that done anywhere else?-- Yes, in the last hospital that I worked in we did that, we had the flexibility within our budget to do that. And the important part, I guess, is not that people like me make the decision on who gets it, but the person's peers make that decision, and I

think it is a small contribution and a recognition of people's - of outstanding performance and I think it is good for morale, and a little bit of extra cash at Christmas time always helps.

COMMISSIONER: Mr Whelan, one of the recurrent rumours that keeps surfacing - and I would like to resolve it if we can - is the allegation that some managers within the hospital system - and I am not saying it is district managers or zonal managers, I don't know - but the rumour keeps surfacing that there are performance bonuses for coming in under budget. Do you know of any such system?-- No, I don't. No, I don't. I have never - and I came - the first year - second year I was here we came in on budget and I certainly didn't get a performance bonus. The opposite applies, Mr Commissioner.

In what sense? You get punished?-- It goes the other way.

Yes.

MR ANDREWS: As a practical matter, what sort of punishment do you endure if you are over budget? You certainly no doubt would have received telephone calls, but is there any other kind of disincentive for those who go over budget?-- As I said before, I will tell you in a month or so. So I haven't had any direct experience. I think Queensland Health does run - and this is common in a lot of places, and a no surprises rule. So I think, to be fair, if on a monthly basis you have a budget and it is blowing out and there is a good reason for that, a good clinical reason for that, we have conversations with Brisbane about that, and it is likely at the end of the year, by the time your budget blows out totally, everybody is aware it is going to happen, and it may be that there is a conversation about, "Well, you need to manage that differently." I think where it gets a little more serious is where you're forecasting a surplus and then at year end - or you're forecasting balance budget and at year end you end up over speed, and people then say, "Well, how come you didn't forecast that?" And that's been, potentially, I am told, a little more serious.

D COMMISSIONER VIDER: You have the opportunity to do your budget review halfway through a year?-- Yes, we do.

And can the budget be altered?-- Internally we can move bits of the pie around, but there is - certainly it would be unusual, I think, for additional money to be put in to a core budget. What I mean by that, Deputy Commissioner, is quite often throughout the year we find more money coming in to the system but more often than not there is additional activity attached to that.

Yes?-- So it is unusual in the course of the year to get an injection of funding into core activity.

MR ANDREWS: As a teaching hospital, have you concerns that at Townsville you need more funds because you wish to remain a teaching hospital?-- Mmm.

What's the Victorian survey of which you write? Victorian study?-- There was - I'm unsure exactly when it was - Bendigo - there was a study put out in Victoria which demonstrated that where there is a teaching hospital and clinicians happen to take an active role in that teaching, there is up to 20 per cent increase in costs. If a clinician has to provide a consistent level of care - well, I will put it another way: if care is not to be compromised, the person has to be able - can only fit so much in in a day. So if you are a teaching hospital and there is not additional resources put in, ie more doctors in this case, it is my belief that you can't provide core services and provide good teaching. You either provide good teaching and, therefore, core services would suffer, or you provide good clinical services and teaching suffers. And I believe - and I have looked back through and I cannot find anywhere where Townsville has been resourced at all for the fact that we're a teaching facility.

Okay. Does that mean, Mr Whelan, that in, for argument's sake, a regional hospital that has some teaching, that a hospital manager concerned about meeting budgets would have an incentive to let the teaching go from the hospital as a way of reducing costs?-- I'm not sure about releasing - I'm not sure about reducing it because of budgets but I can say that - and we have had strained relationships at times with JCU Medical School where the volume of patients coming through the hospital stretches our current clinical staff, doctors and nurses anyway, and we have been involved in talking to our clinicians about providing care to the patients which may then impact negatively on their teaching. So I think what's more likely is rather than the budget side of it, it's more around pressure to provide clinical services over teaching. And it is our view, we believe, that we are a teaching facility, we believe the way forward for North Queensland is partnerships with JCU but there needs to be an acknowledgment that there is an added cost of that.

COMMISSIONER: Mr Whelan, we've heard some evidence in relation to the situation at Bundaberg that there were actual funds provided by the University of Queensland for teaching services at the hospital. Apart from your budget from Queensland Health, do you receive any funding from JCU or from the education department, state or federal, for providing teaching services?-- Not to my knowledge, no.

Is there a distinction for present purposes between teaching services provided by the hospital for the benefit of the medical school and training positions which will be provided to graduates from the medical school as trainee doctors, registrars and so on as the first cohort comes through from JCU?-- Yes, there is a difference. Sorry, when I'm talking about teaching, I'm not actually talking about delivering lectures to students-----

No, I know. Teaching medical students within the hospital by taking them around ward rounds-----?-- Yes.

-----and so on and so forth. But at the moment, as I understand it, the first graduates from Townsville, from the JCU, haven't yet graduated. Those students would be in your hospital as medical students but, presumably, within the next couple of years they'll be in your hospital as trainee doctors?-- That's exactly right.

Is the funding fully tied up to provide those traineeship positions?-- No, it's not, and that is of concern.

I would have thought great concern. What's needed there?-- I'm struggling a little bit with this. Dr Johnson is probably in a position to answer this better than I but I think, and I know, he and with the university are certainly lobbying around getting those positions funded.

Yes?-- And I guess, sense will hopefully prevail and then those dollars will come through.

Right.

MR ANDREWS: The local board system in New Zealand-----?-- Mmm-hmm.

-----will no doubt have its own special features. I have heard and I wonder whether you're aware of what system there has recently been in New South Wales that apparently has recently been abandoned? I'm told that there was some kind of community system in that state that was in place for more than a decade but has only recently been abandoned. Are you able to enlighten me?-- No, I'm sorry, I'm not.

I turn now to your second statement, Exhibit 236. You use the example of the Ingham Hospital development as an instance of the dysfunctional relationship between you and head office. Can you explain it, please?-- Ingham Hospital is about to embark on a redevelopment of the hospital. It is my view and my experience that the important thing in delivering services to a community is that, services; not necessarily the bricks and mortar. We have struck up a very positive relationship with Hinchinbrook Shire Council, members of the community and some consumer groups, and the GPs, and have been working hard to try and focus on what services in the Ingham district might look like as we go forward. The fear in redeveloping a hospital is everybody gets fixated on beds. You can see them, you can count them and, often, there are views from end of the continuum to the other in terms of how many beds one needs and it's my view that if we get into that debate too early without actually looking at the clinical needs of that community, decisions are made around the beds without taking into account the need. So that's the context. So one of the things that I said very clearly was that when the health planners and project services and people rolled into Ingham, "Don't mention beds. And when beds are talked about, it's certainly okay to acknowledge that beds are important", because to communities they are, and it is not about downsizing them, it's about making decisions that are based on the clinical need. People in the community had a fear, because they heard rumours, that Ayr Hospital, which had been redeveloped and had 28 beds, that we were going to pick up Ayr Hospital, that model, and drop it in Ingham. So the number that was not to be mentioned was 28 and that was the number that was mentioned and, I'll be honest, I had to take the blue pill the next day. I was very, very angry.

Do you mean you actually advised somebody who was coming up not to mention 28 beds?-- To be fair, I had certainly advised capital works project services in other meetings that they were not to mention 28 beds and somebody, and I wasn't at the meeting, did mention 28 beds and I think the fact that it was fairly well known, it just surprised me. And I believe that that - we've got it back on track but that did take us on a backward step with the community and this is a community that are fairly distrustful anyway, and for good reason I might add. It is my belief - and it is my belief that we will end up in the right place but I guess that was just another example of making sure that when we agree on a strategy and we

agree to consult, that we do it in a consistent manner and therefore don't give communities mixed messages.

D COMMISSIONER VIDER: Mr Whelan, in some of the areas that are in your district that may have support facilities, do they have adequate means of meeting the clinical needs of their aged care population?-- No. I think-----

So often you do get people that really ought to be in a nursing home in the acute care facility?-- Absolutely. Indeed, Commissioner.

Is that the same situation here?-- Yes. And in Townsville?

In this district?-- Yes. And, in fact, currently we have, certainly as at the beginning of the week and within Townsville, we had 30 patients, that's 3-0, out in respite facilities waiting nursing home placement who in fact could end up being returned to hospital, and that is a major issue for us. In fact, as the - as the population as we know gets older, there is going to definitely need to be more nursing homes and I guess that comes back to what we were discussing before around that relationship between Commonwealth and state, that that is certainly an issue that is of great concern to us.

It's been going through my mind since we talked about nominating a local area as a community because you can't really talk about provision of services unless you actually put that bit into the equation as well?-- Yes.

Mmm?-- Yes.

MR ANDREWS: Mr Whelan, when in your statement you discussed how you resolved a problem for general practitioners wanting space in a public hospital, you mentioned that it resulted in you having to be investigated by the Audit and Operational Review Branch of Queensland Health which caused you particular stress. But is that not a necessary evil to ensure that you're accountable for your decisions?-- Perhaps, but I guess there are ways in which that can be done and-----

You were, of course, acquitted of any wrongdoing at all?-- I was. I was. But I guess it comes down to simple communication. Like, the reality was, as you say, I was audited and found that it was all above board and that's a good thing but given the media attention I guess and the stress that we went through at the time in terms of those conversations with those Ingham GPs, it would have been nice to get a phone call.

From the Ingham GPs or from the audit branch?-- No, no, from Corporate Office.

Yes. I see. You simply learned that no misconduct had been found; file closed?-- Mmm-hmm, that's right. Well, I was involved in the investigation, obviously they came up and interviewed me. I guess my concern was, and maybe I'm being a

bit precious, but my concern was that I thought I had actually in this case done good and we were feeling pretty chuffed about the fact that we had brokered a solution for that community, with the GPs remaining and they were happy, and we saw some opportunities to go forward and then a sort of audit came along, a bit out of left field and I guess I was a bit put out. So perhaps in writing my statement, that I was a little bit precious about that.

COMMISSIONER: Mr Whelan, I have to say, my concern with that whole incident is, and all I've really seen is the audit report, but on the face of it, no allegation was made against you that even justified an investigation. This was a disgruntled person who wrote in and said according to the quotation set out in the report, that there was a lack of clarity in handling the issue. Well, I think there's a lack of clarity in that allegation; I don't know what it means. And then demanded an investigation of possible collusion between a member or members of QH and Dr Jackson. That's not a basis for putting anyone under a disciplinary audit investigation and it's just a nothing. And I guess going back to the example I earlier gave of bullying, I'm not suggesting the decision to investigate this was payback for something else but it does look rather like a trumped up investigation when the allegation, even taken at face value, simply doesn't amount to anything that you would investigate someone for?-- I guess all I can say to that is, thank you, Commissioner. By clarifying that certainly from your view, I guess in some ways that makes me feel that just by putting it in the statement, I was justified in doing so. I haven't really got an answer.

But you have got no reason to suppose it was payback for something else?-- No.

MR ANDREWS: In your position in the hospital, are you aware that the threshhold for an allegation to trigger a need to investigate misconduct or an allegation of misconduct is quite low in Queensland?-- It certainly seems to be.

The patient safety program at the Townsville Hospital seems to have been instituted under the watch of you and Dr Johnson and well before there was a call for it from Corporate Office?-- I'm a very much a bit player. Dr Johnson is the leader of the process which I support and most certainly - and, in fact, I remember at the time when we were looking at it and Andrew, who is very passionate about patient safety as you've heard, was looking at this, one of the people involved in America in setting some of this stuff up is actually is an astronaut and he's been out here a couple of times, and there was quite a few jokes floating around about, oh, yeah, the Townsville Hospital sort of astronaut policy. And I'm not - and this is just an opinion, but I'm not sure that we were actually taken that seriously when in fact the program is innovative and it would appear that as a result of this, that the patient safety group down in Brisbane are now looking at rolling this process out. And I think that's not only a credit to Townsville Hospital and the clinicians that agreed to be part of it but also to Andrew, who was the person who continues to lead this.

COMMISSIONER: Mr Andrews, I think we've heard enough about the details of that from Mr Gallagher and Dr Johnson. Unless there was something particular you wanted to cover, I think we can probably safely move on.

MR ANDREWS: Thank you, Commissioner. You speak of the Patient Safety Centre at Queensland Health being an example of Queensland Health listening to the concerns of community and clinicians. Are you aware that there have been overtures made to Corporate Office to roll out this patient safety process?-- Yes.

You have some criticisms to make of the measured quality report system in Queensland. Can you explain?-- The important thing about quality, particularly in a clinical sense, is that we deal with the issues in real time. That the data that we collect is real-time data, that it's analysed by clinicians and staff alike in real time. Decisions are then made and we move on. There is a group in Brisbane who deal in and are very passionate, I must say, about what's called measured quality and, don't get me wrong, I think quality is very, very important. I just find it really hard and maybe it's because of my style, but I find it really hard to get clinicians excited about measured quality when a lot of the data that's being dealt with is up to two years old. The world has moved on. So one of the things - I'm very critical about that and we've talked to the doctors and we've got them involved in ongoing quality programs and have basically told the measured quality people in Corporate Office that, "We're not actually interested in dealing with two-year-old data anymore."

You prefer your root cause analysis process and your mortality and morbidity meetings?-- Yes, yes.

At paragraph 34 of your statement you paraphrase what you wrote to the Medical Board by saying you've sought clarification about whether the board intended to prosecute Mr Berg. I see, when looking at your exhibit KDW2, that you don't actually ask, "Are you intending to prosecute Mr Berg?" You do seem to ask in the last sentence of the letter whether they'll be reporting the matter to police for investigation as a criminal offence.

COMMISSIONER: The correspondence speaks for itself. It is just a matter then of interpretation.

MR ANDREWS: Indeed, Commissioner. Did you have any other communications with the board in which you've discussed prosecution of Mr Berg?-- I did not.

I noticed looking at KDW8, which is the e-mail from Dr Buckland to Terry Meehan, a suggestion that in discussions with the Medical Board, the Board refused to acknowledge - or it's alleged that the Board refused to acknowledge that Mr Berg was not registrable. Do you see that e-mail?-- No, I'm sorry, I've-----

COMMISSIONER: If you find your KDW8, it's actually two pages. There's a covering e-mail and then where Terry Meehan sent this on to you and then Dr Buckland's e-mail is the second page?-- Got it. Thank you, Commissioner.

MR ANDREWS: You will see in the second paragraph of that e-mail that Dr Buckland is asserting to Terry Meehan that in discussions with the Board, they refuse to acknowledge that he was not registrable. That's an e-mail of the 24th of January 2003. Now, bearing that in mind, you've received a letter which is KDW3, a letter of 28 January, four days later, from the Board to you and in its final paragraph there's a suggestion that, "As a result of your concerns, a process has been put in place to ensure that employing authorities are notified if it is subsequently found that a person who has been registered in fact did not hold recognised qualifications."

COMMISSIONER: And, Mr Andrews, it's even more specific in the middle paragraph where it says, "The Board became aware that Mr Berg did not hold recognised qualifications to enable him to be registered."

MR ANDREWS: Yes, Commissioner. Have you determined what the Board's attitude would be in circumstances where they were investigating whether a person had recognised qualifications but had not yet made a determination about such matters? You as an employer, no doubt, would be interested to be alerted to the risk that you were employing someone who was not qualified while the process of investigation continued. You might, for instance, determine to stand them down with pay during the process?-- It certainly would be important to us as an employer to be notified as soon as possible to enable us to make a decision around what we would do with that employee, absolutely.

And have you determined yet what the Board's attitude is to informing you during their investigative phase?-- No, I haven't.

COMMISSIONER: Mr Whelan, might I take you back to that e-mail from Dr Buckland, which is part of KDW8, and refer particularly to the sentence commencing, "There seems to be some inability for Dr Johnson et al to brief properly". I think the material we have seen includes the entire brief prepared by Dr Johnson. In your opinion, are there any flaws in that brief? Was there any justification for that really quite offensive attack against Dr Johnson?-- No, I think the brief was comprehensive and there was no need to make those comments.

Has Dr Buckland ever explained to you the basis for that attack on your immediate subordinate?-- No, he has not.

Would you expect if Dr Buckland did have grounds for concern as to the competence of your immediate subordinate, that he would have taken the trouble to explain to you what his

concerns were?-- Yes, I would. In this case the e-mail was actually to my direct boss, Terry Meehan, but, yes, Commissioner, if - I would expect that if Dr Buckland had a concern about Dr Johnson's competence, he would certainly talk to me I would hope.

I mentioned earlier the expression "shoot the messenger". This may or may not be an example of that but on the face of it, it certainly would seem to be. Do you have any view about that?-- I think - I must say the whole - I came in at the end of it, I started at the end of it. It was very tense times and I was aware that Dr Johnson and, indeed, Dr Allan were very passionate about pushing the point around, the patients, the need to actually get the patients involved. And I am aware there were several, I guess, attempts at getting permission. So I think perhaps that caused some of the frustration and maybe this e-mail is a result of that frustration but I'm surmising.

Thank you.

MR ANDREWS: You contacted the local police because Doctors Johnson and Allan were concerned about their personal safety and at KDW4 there are three pages of e-mails exchanged between you and Christopher Reeves of the Queensland police. Let me put two of those pages on the monitor. You see the highlighted section at the top. Is that where an e-mail from Christopher Reeves to you begins, "Ken, my appraisal and advice on the situation is as follows. Because he continued to work and dishonestly represent himself to be a psychiatric registrar within a unit of public administration, his actions would fall within the ambit of misconduct as defined in the Crime and Misconduct Act. Among other things, sections 38 and 39 Crime and Misconduct Act, a public official must report any matter to the Crime and Misconduct Commission if there are reasons to suspect that a complaint or matter involves or may involve official misconduct." May I see the next page. Thank you. And did he then earnestly recommend that the matter immediately be reported to the Crime and Misconduct Commission, or that a formal complaint be made to the Queensland Police Service? You didn't do either, did you?-- I didn't.

Is that because of your interpretation of Dr Buckland's e-mail which is part of KDW8?-- Possibly. To be honest, at that time I started in Queensland Health - I arrived in the country early October, started, I think mid-October. At the time that all this broke in November/December I was settling my family into Australia and felt quite unwell, which I put down to stress. All this was going on at the same time, and I was getting a whole lot of advice from a whole range of different sources about what was right and what was wrong and what I should do. That's not to make excuses, that's just, I guess, to complete the context. And as a result of my unwellness, which I put down to, as I say, stress and moving to a new country and a new job, I ended up, in early January, having one of my main coronary arteries stented. It was 98 per cent blocked. When I look back on - and I guess this is why I struggle with this Berg - and I struggled with the statement at the time. Because of that, I guess for that three month period November through December/January, even early February, my secretary now tells me that I may as well not have been there. I may as well just have been home. My mind was a blob, and I just do not remember a lot of this stuff. So to, I guess, put it in that context, I do remember going to my zonal manager eventually saying, "I've had all these, what do I do?" I think in fact one e-mail said - "help" was the actual e-mail. As a result of that he went downtown - down to Brisbane and got that response from Dr Buckland, and I think that response was fairly clear about what we as a health service should do, which was basically it wasn't our problem. But in terms of some of the detail and some of the timing, I just have not got memory of some of that.

COMMISSIONER: Mr Andrews, if it assists, I see that the next segment of the statement deals with Dr Myers and the resignation of Dr Guazzo, and for the reasons I mentioned yesterday afternoon, I see no merit in revisiting those issues. I think they're very satisfactorily addressed by the evidence to date.

MR ANDREWS: That does assist, Commissioner, thank you. Your hospital encourages VMOs to work at it. You will be concerned at the loss of valued VMOs, and there must always be, I suppose, a great temptation for VMOs to leave your system to go to what you, I think, concede is a less frustrating and more remunerative private system. We have heard evidence within the last couple of days of the loss of a staff ENT surgeon and the near loss of a VMO neurosurgeon as a result of their concerns about the process of recruiting overseas trained doctors to their specialties, and it seems that in each case there was at least some basis for their concerns. Are you aware of whether there is any process at your hospital to prevent alarm to your VMOs and staff about recruitment of overseas trained doctors?-- I think there are two levels of answer to that, and I think the first is in relation to bringing overseas trained doctors into this country. I think Dr Johnson and his team, they recruit with credential checks and we minimise the risk of a Patel. So I think that's important to say up front. I think I said earlier today that one of the learnings that I've had as we've gone through some

of this process and I've watched the Inquiry and thought about the relationship we have with VMOs, is that perhaps at times we've made decisions around appointments and not been as inclusive as perhaps we should be, and it seems to me that a couple of the examples that you've just given, the answer is had we been more inclusive in those interactions, the result may have been the same, but all parties would have felt they had an opportunity to be involved, and I think that is a learning that we will take from this Commission.

You have a concern that the response of the Medical Board of Queensland to the Patel crisis has - let me find your words.

COMMISSIONER: Perhaps the last sentence of paragraph 75 is the critical one.

MR ANDREWS: Thank you, Commissioner. At paragraph 75 you say you fear "the process may become too complicated and bureaucratic and will deter quality overseas trained doctors from coming to Queensland to practise medicine." Can you explain that?-- Yes. Making sure we have the important checks and balances in place to ensure that the overseas trained doctors are as qualified as they say there are is absolutely important, and I totally support that. Going back to what I said this morning - earlier, the fact that we are in a market in relation to doctors, given that the pay conditions for doctors in Queensland are not outstanding when it comes to comparisons with other states, that puts us at a disadvantage to start with. If we then put a whole lot of hoops in the system - hurdles in the system which are a lot more bureaucratic, perhaps, and complex than other states, does this mean that recruiting agencies are more likely to go to those states rather than waste precious time coming to Queensland? I think Dr Johnson talked about some of these challenges earlier in the week. So I guess - I absolutely understand the Medical Board have got a very important job to do, and I can understand why they may be tightening up, and I guess what I base this on is the experience we seem to be having at the moment, which may again be nothing more than a reaction from the recruiting firm, I'm not sure, but it would seem at this point in time we are finding it incredibly difficult to actually get what we think are well qualified, overseas trained doctors out of the UK into the country - into Queensland.

The Inquiry's had the benefit of receiving a statement from a David Symmons, a Fellow of the Australian College of Emergency Medicine and currently employed as staff specialist in the Emergency Department at your hospital. The Inquiry hasn't heard evidence from Dr Symmons yet, and is unlikely to, but do you understand that the doctors in the Emergency Department - overseas trained doctors work under the supervision of staff specialists there, and that as a result of the response of the Medical Board to the Bundaberg Hospital Commission of Inquiry, the processing of applications for overseas trained doctors to work in that department has been significantly slowed, and that as a result there's likely to be a severe medical staff shortage, and that there will have been since about the 18th

of July this year?-- Yes, I am aware of that, and can I also say that that's not unique just to the Emergency Department. We're experiencing that across a range of services.

COMMISSIONER: Mr Andrews, since you've gone into it, although we're not asking for that gentleman to come and give evidence, it does strike me that it would make more sense on the record if that statement became an exhibit. Does anyone have any objection to the statement of Dr Symmons being made an exhibit without his being called to give evidence? In the absence of any objection that statement will become Exhibit 249.

ADMITTED AND MARKED "EXHIBIT 249"

COMMISSIONER: That's the statement of David Andrew Dyke Symmons. Exhibit 248 was, of course, the third statement of Mr Whelan.

MR ANDREWS: In New Zealand, staff specialists are paid more than in Queensland. Is that simply because all medical practitioners are paid more there, or is there more recognition given to staff specialists?-- No, I think generally speaking - again, it's about two and a half years, but generally speaking I'm pretty sure that most doctors, not just senior specialists, are paid more. The pay rates are higher.

I have no further questions, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Mr Fitzpatrick? Any additional evidence-in-chief?

MR FITZPATRICK: No, thank you, Commissioner.

COMMISSIONER: Ms McMillan?

MS McMILLAN: No, thank you.

COMMISSIONER: Mr Rebetzke?

MR REBETZKE: Thank you. I should announce my appearance in lieu of Mr Allen.

COMMISSIONER: We know who you are.

CROSS-EXAMINATION:

MR REBETZKE: Mr Whelan, just a couple of matters. Earlier this morning you gave some evidence responsive to questions put to you from Mr Morris regarding the role of Brisbane, I

guess, in terms of administrative systems, and as I understand your evidence, you favoured that there be a leadership shown by the central control rather than control as such so that local - that there was the opportunity for local flavour, I think was the way you put it. Apart from administrative systems such as accounting packages and so forth, is there also scope for that leadership to be taken in respect of what might be called clinical systems as well? And I might give an example. For example, in terms that you might be familiar with, in psychiatric nursing, for example, there are sometimes patients placed on a level of observations commensurate to their degree of suicide risk or - to put it bluntly, and in different hospitals there might be different ways of allocating the observations to nurses. There might be a team approach in some hospitals, or specifically - a nurse specifically allocated to do those observations, and there may be different ways of documenting that. When adverse incidents occur, and there are learnings that can come out of those incidents, surely there would be a role for a central administration to play a part in sharing that learning. So what I'm putting to you is that rather than - that there's certainly a role for a central point in Brisbane to be a leader and to share not just matters of administrative systems, but also what might also be - may go into the clinical sort of demand. Do you have any views on that?-- Yeah, I agree with you. I think certainly those things that would be decided - clinical documentation is a good example, where there are some benefits to having statewide consistency. It makes sense that it's led from Brisbane, but I would say that it is really important if that's to happen that - I nearly said "committee" - that a group of people is put together made up of clinical staff in some of the districts with expertise in these matters to actually guide the centre rather than the centre saying, "This will be the standard of clinical documentation."

Okay. Obviously that would require some degree of coordination from a central point to ensure that that happens?-- Yes.

But obviously it's desirable that learnings in one area can be transmitted throughout the state so everyone can learn from those matters?-- Absolutely agree.

And on a different topic, you gave some evidence about - I think you mentioned in New Zealand there had been some substantial pay increases for health workers. The market forces that you talk about and the global market that we're operating in, they're real impacts, and the shortage of nursing staff in particular and medical staff, they're matters that are real and impact upon you as a manager of health services right now, aren't they?-- Absolutely.

And of course there would be no point in putting one's head in the sand about those matters, and really they need to be confronted?-- Yes.

I understand you only came into Queensland in relatively recent times, so it would be unfair of me to put any questions to you about what may have occurred in terms of enterprise bargaining or so forth before you came to Queensland. Certainly in terms of those real matters that you talk about, it certainly doesn't help, for example, that in two months' time - I only say that because the figures that I have are comparative figures as at 1 October 2005, but what I'm suggesting to you is that it certainly doesn't help that, for example, a registered nurse, pay point 8, which I understand would be the vast bulk of the nurses employed in your district - you'd agree with me there?-- Mmm hmm.

That their pay on the 1st of October will be paid 15.53 per cent less than their colleagues across the border in New South Wales, and you're nodding, so you're agreeing with me there?-- Why would you come to Queensland?

Yes. I have no further questions.

COMMISSIONER: Thank you, Mr Rebetzke. Mr Whelan, just one other thing I wanted to canvas with you. You refer in your statement to the confidence you have in your immediate subordinates, Dr Johnson as Director of Medical Services, and Val Tuckett as Director of Nursing. Is it your observation that they operate within their respective roles in a hands-on way, moving throughout the hospitals, participating where possible in - not necessarily perhaps formal walk-arounds, but at least visiting the wards and the other coalface areas of the hospital, or are they more administrative based?-- It is my belief that they use - they certainly use their best endeavours to get around the hospital, and certainly not be involved in hands-on patient care-----

No?-- -----but interact, again certainly, with those people who report to them. In Val's case, for example, as Director of Nursing, her direct colleagues who are working out in the coalface speak very highly of her in terms of her supportive role, and Val is often not to be found in her office and she will be out talking to and supporting those colleagues, and I know Dr Johnson spends a huge amount of time with his colleagues. So I believe - although there may be some that disagree, but I believe that they spend a lot of time out in the workplace so they make sure when we're involved in administrative meetings they can relay what's actually happening on the ground rather than just their perception.

And from the way you've answered my question, am I right in thinking that you feel that that is, if not the only way to do it, certainly the best?-- That's the only way to do it. We can't make decisions sitting in - one of my biggest faults, I guess, is that I do spend more time in my office than perhaps I should, and I think I need to get out there more, which is why I guess I'm such a strong believer in the institute model, devolved management. The people that make the decisions in these hospitals on a day-to-day basis have to be the people that are involved on the ground, otherwise it won't work.

Sir Llew?

D COMMISSIONER EDWARDS: No, I have nothing.

D COMMISSIONER VIDER: No, thank you.

COMMISSIONER: Any re-examination?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Thank you. Mr Whelan, I'd like to take this opportunity, since you are here - I meant to say something at the end of our Townsville sittings, but I think it's appropriate to do so since you're, as it were, the head of the local hospital organisation. I'll be very candid, Mr Whelan. When we first sent investigative staff from the Commission of Inquiry to Townsville it was because we had received certain information that we considered was worth investigating from the viewpoint of flaws within the Queensland Health system. Those matters were very thoroughly and very competently investigated, and apart from the issue concerning Dr Berg - or Mr Berg, those concerns were largely addressed to the satisfaction of the investigative staff and haven't been taken any further. The reason we decided to come to Townsville, though, was quite different. Apart from the Berg issue, it became very clear in the course of those investigations that your hospital, and the staff of your hospital, and in particular yourself and Dr Johnson, were being extraordinarily co-operative in a way that we've encountered nowhere else, and there was an impression that you had a genuine desire not only to assist us, but to demonstrate how things are done differently in Townsville from the rest of the state and how the rest of the state can learn from what's happened in Townsville. I will certainly be going away from Townsville with the impression that the future of Queensland Health is actually being made in this city at the moment, not only in your hospital with the patient safety program and other initiatives, but also taking into account the fact that probably the largest problem of all for health in Queensland is the shortage of medical practitioners, and within the next couple of years we're going to have the first cohort of graduates from the local university. Those two things in themselves are probably the most positive things that we've heard about in the course of almost three months of evidence. So I am very delighted that even if our interest in Townsville was initially raised for the wrong reasons, that at least we had an interest in coming to Townsville and we have had the opportunity to hear what goes on in the city and the way in which you and your hospital and the local medical school are leading the way forward for the rest of the state. If I can say something anecdotally, it intrigues me - it's always intrigued me that in Australia we have universities named after sailors like James Cook and Matthew Flinders, we have universities named after soldiers like Macquarie and Monash, we have universities named after lawyers like Griffith and Deakin, but we don't seem to have any universities named after medical practitioners. Perhaps that will come one day. It has been terrific to receive the support which we have from

your hospital, and can I say at the same time terrific to receive the support of the local community. Everywhere we've gone in Townsville, even going into town for lunch or dinner in the evening or mixing within the local community here in this building, the support we've had from the people of Townsville has been overwhelming and extremely gratifying, and I just hope that we have the opportunity to finish our project and come up with a report which will assist the people in the rest of the state to get some of the benefits that you and your colleagues in Townsville have already conferred on the people of this city. Thank you for coming and you are excused from further attendance?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews, I see it's 20 to one. What I had in mind to do - I can almost hear your stomach grumbling from here, but what I had in mind to do is to just have a short 15 minute break, go on with the next witness so that there's no risk that we'll run over time-wise, and then if there is time left to have a late lunch, we can do that afterwards. Does that suit you?

MR ANDREWS: Yes.

COMMISSIONER: Everyone else at the Bar table? Why don't we adjourn now for 20 minutes until 1 p.m. and we'll resume then.

MR ANDREWS: Thank you.

THE COMMISSION ADJOURNED AT 12.42 P.M.

THE COMMISSION RESUMED AT 1.15 P.M.

COMMISSIONER: Ms McMillan, the affidavit of Mr Demy-Geroe has now been copied.

MS McMILLAN: Yes, and I have given a copy to Mr Groth.

COMMISSIONER: All right. The affidavit of Mr Demy-Geroe will be Exhibit 250.

ADMITTED AND MARKED "EXHIBIT 250"

COMMISSIONER: Thank you.

MS McMILLAN: Could I just raise one matter, please? Dr Symmons' affidavit which was admitted just before lunch - well, before the break, which has been made clear won't be the subject of cross-examination, could I just say there's only one paragraph and that's 17 which relates to my client. Could I just - I am content for that course still to be taken, but, naturally, of course, the weight that will be accorded that paragraph will be such as would usually follow given that's not going to be the subject of cross-examination.

COMMISSIONER: Look, in any event, I would read that paragraph as merely speaking to Dr Symmons' perception from his viewpoint.

MS McMILLAN: Yes, thank you. It's a personal opinion.

COMMISSIONER: Yes.

MS McMILLAN: Yes, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: I call Shaun Drummond.

MR FITZPATRICK: Commissioners, I seek leave to appear for Mr Drummond.

COMMISSIONER: Thank you, Mr Fitzpatrick, such leave is granted.

SHAUN PATRICK COLIN DRUMMOND, ON AFFIRMATION, EXAMINED:

MR ANDREWS: Mr Drummond, is your full name Shaun Patrick Colin Drummond?-- Yes, it is.

You're from New Zealand?-- Yes. I won't say fish and chips.

Mr Drummond, you swore a statement on the 2nd of August of 2005?-- Yes.

Are all the facts contained within that statement true to the best of your knowledge?-- Yes, they are.

And the opinions expressed in it, are they honestly held by you?-- Yes.

COMMISSIONER: Mr Andrews, we don't actually have copies of that statement.

MR ANDREWS: I regret that. They're being obtained for you, Commissioner. Mr Drummond, you are the Executive Director Operations of the Townsville Health District?-- Yes.

And have been since 2003?-- Yes.

You've in previous occupations been in New Zealand as a consultant to unions and employer groups?-- Yes, I have.

Predominantly in health, manufacturing and construction industries?-- Yes.

You've worked in Human Resource and Corporate Services in hospitals in New Zealand since 1996?-- Yes.

At Townsville Hospital you are responsible for monitoring performance, activity, finances and coordinating the resources of the hospital?-- Yes.

You have no direct responsibility for supervision of clinicians on clinical issues?-- Yes, that's right.

The Townsville Health Services District is divided into seven institutes, but when you arrived six of them had already been established?-- Yes, that's correct.

When you arrived each institute had a chair and that person had a full clinical workload?-- Yes, that's correct.

And, for example, in the Institute of Surgery Dr Rossato, who at the time was a VMO, had the responsibility to administer and plan for that institute with a $40 million budget and staff of 700?-- Yes, that's correct.

And a full clinical workload?-- Yes.

Do you have - I assume it's your opinion that that was too

much work to put upon Dr Rossato?-- I think it's unreasonable to expect somebody to operate two days a week full days, have a full clinical load as far as follow-up and attend at clinics and then ask them, with no time spare, to actually manage a service of that size and nature.

Since that time the duties of the institute are shared between two people, are they not?-- Yes, that's correct. They are shared between the clinical director and the operations director who may also be a nursing director.

When you arrived at the hospital in 2003 it had exceeded its budget for the previous year?-- Yes, on all the previous five years, I believe.

That-----?-- It had certainly exceeded its budget the year before, but also the four years before that as well.

And in the 2003/2004 year what was your primary goal?-- I suppose to bring the - the budget back into balance with what was our clinical activity, what were the clinical resources we actually needed for the activity that was actually occurring and to try and balance that with the funding we received.

And for this financial year what's your goal?-- It's to-----

That is the one that's just passed?-- The year that's just passed we actually looked at a lot of areas where we could clearly identify that there was community demand that wasn't being met by our clinical service and what were the areas that we could actually expand those services.

Well, let me simplify that so that I as a lawyer can understand it?-- Right.

In 2003/2004 your goal was to balance the budget?-- Yes.

In 2004/2005 you started to examine community needs with a view to expanding your services within your budget to meet community needs?-- That's correct.

And is it the case that over the past two years your hospital has managed to employ an additional 100 medical and nursing staff within its existing budget?-- Yes, that's correct.

And was that done because there was perceived to be a community need for those additional staff?-- For example, the surgical areas we would be examining what were the waiting lists, whether we were actually meeting reasonable time frames for operations that those people needed and - and nursing, that's primarily based off what actual inpatient activity was occurring inside the hospital that we needed to meet.

You, for instance, observed that in the Institute of Women's and Children's Health it had been about $2 million over budget for the previous few years?-- Yes, that's correct.

To address that the executive took a decision to take $2

million from the executive services budget, transfer it to the Institute of Women's and Children's Health?-- Yes, that's correct.

That meant the executive had to find efficiencies to make up for the shortfall of $2 million in its own budget?-- Yes. That wasn't the only institute that we actually had to do that. That particular year we carried about $8 million into the executive area which was actually more than our entire budget for the executive area by a considerable margin and we as services had been historically underfunded. Every year there was a budget negotiation with them and they were never offered the money to actually cover the costs that they had already been incurring.

The fact that you have managed to employ an extra 100 staff within budget suggests that there's been a recent efficient management?-- I think the key to it is the fact that where staff are so frustrated - and this is the clinical staff that have actually got to manage the resource issues and deal with the clinical activity and have a patient focus where they believe they are actually given the focuses that are so woefully inadequate that they're never going to meet their target they never try because it is counterproductive. They know that they can't hit that so putting the image into it they concentrate on the patient and that is their central focus. So I suppose giving them a chance where it was realistic for them where they thought it was achievable they actually far exceeded our expectations and they performed better than their costs that they historically had actually been incurring and that was through a lot of motivation - because they felt motivated to actually work with it they felt supported with the systems that we put in place to assist them and a lot of the planning work that we actually did with them for service delivery.

COMMISSIONER: Mr Andrews, if I could interrupt for a moment. We now each have copies of the statement and the statement of Shaun Patrick Colin Drummond will be Exhibit 251.

ADMITTED AND MARKED "EXHIBIT 251"

MR ANDREWS: Mr Drummond, the directors at your hospital, that is, the directors of each of the seven clinical institutes, have responsibility for purchasing equipment, hiring staff and the general operation of their own institutes?-- Yes, that's correct.

They become involved when issues of inadequate resources to provide the services arise?-- Yes.

Now, the hospital's recently applied to Queensland Health to increase the financial delegation of the clinical directors from $20,000 to $50,000?-- Sorry, there is a slight

correction. Some of them are 10 and some of them are actually 20,000.

Does that mean that you've applied to allow the clinical directors of each institute the discretion without referring to anybody else-----?-- Exactly.

-----to spend up to $50,000 at a time?-- Yes. We are just going through that process again. It was just about to start. Certainly my statement refers to last year's process.

And you'd like to see them given authority to decide to spend amounts between 50 and 100,000?-- Yes, that's correct.

Without that authority is the situation that decisions have to be referred to Corporate Office in Brisbane?-- No, they have to be reported through the executive office which is to sit in threshold, then myself and, I think, another executive director - it's up to a certain amount that we refer to the office of the District Manager of the Townsville Health District and one of the executive directors is able to sign off on that or, in particular, myself or Mr Ken Whelan because our financial delegation's considerably higher.

So it's the ambition of the executive at Townsville to allow more financial decision-making to be made by the clinicians themselves?-- Yes, that's correct. Unfortunately, in our first application to have this delegation changed when we tried to explain our structure to the corporate person who was actually administering this process, they couldn't even understand what we were asking for or why and - because historically only the Director of Corporate Services and the District Manager had any significant financial delegation, couldn't understand why we were asking what we wanted.

This person who couldn't understand, I gather, was in head office?-- Yes, that's correct.

COMMISSIONER: Has that application been formally rejected or refused?-- Yes, it was.

And were you given any grounds or reasons or explanation?-- It didn't fit in the framework of how the financial delegations worked and so on and so forth and that is a problem for us because our structure isn't atypical of Queensland Health.

MR ANDREWS: And so at paragraph 14 in the last sentence where you observed that the recent application to increase the financial delegation was not supported by the officers coordinating this for Queensland Health and subsequently rejected by Corporate Office you're referring to an application to allow the clinical directors to make decisions to spend between $20 and $50,000?-- Yes, that's correct. We actually sought it for all of the directors, but the - we sought that for both the operations directors and the clinical directors, but the people managing the actual services themselves we wanted the delegation sitting with them rather

than - a silly circumstance would be renal fluids. Because they're fairly expensive we might do an order for $12,000 of renal fluids at one time and somebody from the Institute of Medicine has to come up to me to actually get me to sign whether that is actually okay for us to purchase that or not. It is an absolutely necessary clinical supply. I wouldn't know whether that was the right quantity or not. I'm not the clinician actually involved in the delivery of that service and they have needed my okay. Now, they can't sign that, and then we will so it can be purchased, but it is a ridiculous exercise in bureaucracy.

D COMMISSIONER VIDER: Are you saying that somebody from the renal service has to come and get you to sign an order for renal fluid?-- Yes, and mainly that's because of the size of our actual renal service because when we're ordering we have approximately 130 patients going through our renal service at any one time-----

COMMISSIONER: But that service is continuous so that would be?-- Exactly-----

-----predictable?-- Yes. I think that was our point in actually asking for the financial delegations to actually be increased. It doesn't recognise the difference between a hospital that has 100 staff and a budget of 2 or $3 million and a tertiary service of our size where clinical supplies orders alone can far exceed-----

D COMMISSIONER VIDER: That would nearly be on increase?-- That's not practical.

Oh.

MR ANDREWS: The management structure at Townsville, is it similar to structures that you were aware of within New Zealand?-- Yes. It's - that structure exists at a large number of hospitals. Our District Health Boards inside New Zealand, there they have been in existence for about six or seven years across a number of organisations.

And so far as you're aware it's unique in Queensland?-- Certainly inside Queensland Health it is unique as far as I'm aware.

Now, you address it from paragraph 19, Corporate Office. What sort of contact do you have with Corporate Office?-- Very frustrating contact, I would say. The majority of our contact is through Mr Whelan, the District Manager, or on the professional side through Val Tuckett or Andrew Johnson, and I would tend to deal with them on some of the reporting issues about activity and we get a lot of requests for information on very short notice that sits with our clinical institutes because they are running the services and we could be ringing up and asking Dr Messon to suddenly have to supply information on patient flows by 4 o'clock that afternoon and we could be asking him in the morning. It doesn't account for actual clinical environment that people actually live and work in.

And is that an example of your complaint at paragraph 21 that the constant requests for data are a burden on the clinical directors?-- Yes, it is. I think if they were seeing the outcomes of what was actually occurring with these requests and actually seeing some change - many times we have supplied information and we actually see no outcome out of it and we're hoping for one so that when we do ask for these urgent requests for them they feel very frustrated in actually doing it because they often don't see any benefit or any response from that information request.

D COMMISSIONER VIDER: Do you have any opportunity to say to Corporate Office, "We have a difficulty because you ask for information at short notice. We don't know why it has to be given at such short notice, but we don't get any feedback."?-- I think that's what has resulted in our reputation as being a very recalcitrant district in the fact that we do challenge the unreasonable time requests that they actually put in and the usefulness of the information that they are requesting.

Thank you.

MR ANDREWS: You say that the Townsville Hospital has a five day coding time and most other hospitals have an average of 30 to 40 days?-- Yes, that's correct.

How is that achieved?-- I think it's actually a bit of logic. If you are always sitting the 35 days for your coding time it must be possible for you to always sit the five. You just actually have to bite the bullet and put the resource and actually bring yourself to - back to coding at five days which is what we did and then actually make sure that we maintain it at that otherwise you would expect their coding times to continue to grow and they don't. They just happen to sit somewhere between the 30 to 40 day range.

And that means at your hospital you can provide a snapshot of your patient data in five days?-- Yes, that's correct, and that's quite important for us because at the end of each month we would actually be looking at clinical activity, financial activity, clinical standards, we'd be looking at clinical indicators and it's not useful for us to actually not be looking at the same periods at the same time.

D COMMISSIONER VIDER: That turn around time for coding, has that always been like that in Townsville or is that something that's recently happened?-- No, we had a major exercise at the beginning of last year to actually - as I said earlier, we bit the bullet. We put the resource in and worked exceptionally hard coding staff to bring that timeframe back and since then they've been able to maintain that.

And you maintained the increased staffing level as well?-- No. Actually, once we actually - because it was - the whole issue we were actually fixed at about 32 days. We went from growing month to month - it may vary - but we were always there with that coding delay. So that said we had the right

amount of staff, but we had a historical backlog at some stage we had to actually catch up so we said let's deal with that historical backlog, so the first stage in that process was we turned the live coding round to five days and then over a four month period started dealing with the backlog.

Did that have a flow-on effect through the culture because if you're going to have the coding done within five days you've got a discharge summary done as the patients are discharged?-- It certainly made a significant change in the practice and culture because of the coding delays files could actually sit somewhere for a while because they weren't urgently needed so we have had a lot of work with our clinical areas to make sure the turnaround back to health and information is very prompt.

MR ANDREWS: The funding model used by Queensland Health, you criticise it for taking no account of activity and being based on historical funding?-- It says - Mr Whelan said earlier, I suppose, we often comment about that historical or hysterical funding which seems to be a model of you get budgeted on what you had previously, and whatever somebody outside the organisation is screaming about there's an urgent need for without actually consulting with us about what are our pressure points.

I assume that you can by elective surgery have your budgets to some extent reflect the activity?-- Yes. The elective surgery program allows us to actually program for activity in the surgery and it's the only method on top of the annual allocation for us to control how much funding we get.

Well, if you're not speaking of the activity of elective surgery what other activity do you think should be taken into account when setting the budgets for your hospital?-- Certainly for our hospital our health district medical volumes would have to be taken into account. As appears in my statement, at the end of last financial year, the financial year that's just finished, we were about 200 case weights under on our elective surgery program so we had to hand the funding back for that. At the same time we're probably in excess of 1,200 case weights over in our medical activity and so we have got nothing that actually allows us a balancing exercise between the pressure we're having between acute admissions into medicine and the need - and it's a real need - for elective surgery for people.

COMMISSIONER: Mr Drummond, we have heard a lot of comment about the funding model for elective surgery and one of the additional concerns I have, you make the contrast that it doesn't take into account the amount of work done or the results achieved in the medical ward or, for that matter, in the obstetric ward or the - any other ward apart from surgery, but even within surgery itself some of the most beneficial preventative procedures like colonoscopies and endoscopies aren't treated as surgical procedures; that is, no extra funding for those?-- Yes, that's correct.

Does that create some frustration in your experience amongst

the surgical staff as well as other departments of the hospital?-- It actually creates a great deal of frustration inside our organisation and because there's certainly areas of the organisation where we can do something for people where there's a health demand in the community, because we can access the funding upon submission and there's a program to get that and - for example, if it's a colonoscopy we historically have a very large waiting list for a number of gastro procedures and this year for the first time we actually managed to convince Queensland Health to take some elective surgery funding and actually put that into doing some gastro procedures.

I mean, I'm not an economist, but it just strikes me as so perfectly obvious that if you can detect a cancer early and prevent it you are not only doing a wonderful thing for the patient, but you are also saving the system money. It's a lot cheaper to prevent than to cure?-- Certainly. Not that I want to keep using New Zealand as an example, but the funding model that is there actually allows trade off between medical and surgical activity so, for example, if you are actually under surgical activity, but you're over delivering the medical, they bring the logical conclusion to that and say, well, they actually aren't prevented from having their surgical activity if your hospital is already performing on this medical activity so we will allow them to balance, yet it doesn't occur in this system.

It also strikes me that in the most cynical way that there is almost an encouragement to mismanage patients, and I'm not suggesting for a moment that that's happened in Townsville or anywhere else in the state, but if one imagines, for example, a cancer patient who could be treated either surgically or by chemotherapy or by some other form of care the system is saying there's an incentive to treat that surgically rather than medically, whereas the clinical advice may be that the preferred course for the patient is to treat medically?-- I would agree. It is a perverse incentive. I don't think it actually changes behaviour because that would have to change the behaviour of the clinicians and I don't believe that they would ever have a bar of that, or certainly in our model, because it is controlled by the institutes and there are actually active clinicians. Our structure would prevent that actually occurring.

That's the other thing that strikes me as unhelpful about the system. It seems to be based on a bureaucratic notion that if you wave a wad of dollars under a clinician's nose that he or she is going to decide to do more surgery than would otherwise take place, and apart from the situation in Bundaberg on which we have to consider at a later stage I can't imagine any clinician being influenced by the opportunity to make a bit more money for the hospital rather than what's best for the patient?-- I would certainly agree, Commissioner. I think one of the advantages that we have actually used out of elective surgery program though is to actually build medical services.

Yes?-- There is a decision we've actually taken as a district rather than potentially elective surgery funding is actually for. Then if we take neurosurgery as an example, the complementary service on the medical side is neurology, so one of the things we've actually now been doing, by having a higher elective target, is to say, "We're prepared to create an additional position in neurology to actually support the neurosurgical services so we have a better neurosciences service."

So that in itself sort of demonstrates the utter stupidity of the funding system-----?-- Oh-----

-----that you're, in a sense - I am sure no-one will misunderstand me, but in a sense you are distorting the system, and you have to distort the system to achieve the right outcome for the patients because it is such a silly system to start with?-- I wouldn't necessarily say distorting. The change that we actually do is there is a marginal cost to service if we're already providing it.

Yes?-- For example, if we do have two neurosurgeons and we say we would like to do 100 more case weights, because we have the existing cost already, we may only have to do one more theatre session a fortnight for a year to actually do that work.

So in a sense it is profitable for the hospital?-- Yes.

The hospital will use?-- There is only a marginal cost at that time which we're then able to put into medicine and in certain circumstances we're establishing an entirely new position to actually do that. Then actually all the funding is inadequate.

I mean, one of the witnesses we heard some little while ago said that it would be better to reward hospitals for outcomes rather than procedures. In a strange sort of way, I think that's almost offensive to suggest clinicians need a financial incentive to try and get the best outcome they can. But in another sense I guess the present system, pushing for quantity rather than quality, is a disincentive to quality?-- I think the point and the argument is outcome versus other alternatives is the issue, of if you input fund, you say that you need one FTE of this to deliver the service and it is actually not judging the clinical outcome - which is the quality of it, not just the quantity, but you need to actually have the clinically appropriate outcome, and the activity that you should be funding rather than saying already, "This is the configuration you need for that." So it doesn't allow for flexibility for the system. The majority of our funding is actually received on the basis of specifically designated FTE.

Surely, Mr Drummond - no doubt I am going to get myself in trouble for saying that because people will think I have reached final views - but surely the only logical funding system is one based on demographic statistics one that says

this is the population catchment area that we're dealing with, this is the age spread, this is the disease history, these are the racial and cultural circumstances of the community that contribute to the need for health care, and, therefore, on an equitable basis the people of Townsville get dollar for dollar what the people everywhere else, subject to adjustment for the special needs of the local community?-- I would agree, Commissioner.

Does that happen in New Zealand?-- There is a population base funding formula in New Zealand. It exists in other health jurisdictions in the world as well. New Zealand's constantly refining theirs because you actually get changes in the demographic over time. But primarily they are population-based funding formula adjusted for growth in population relative to the population of New Zealand as a whole, it considers ethnicity because of the much poorer health status in Maori in New Zealand, age as being a very significant act, and socioeconomic status of the community, what proportion of the community is in D-cell 9 or 10, and therefore they have a lower health status than a wealthier community who may have access to private insurance or is much more likely to have the ability to actually go and see a GP when they need to.

Yes?-- Compared to people who struggle.

And simply better diet and those sort of things?-- Exactly.

And no doubt there would be complexities involved in all of this because, for example, if the PA or the RBH is providing a specialist service for the entire State, neuropsychiatry or something like that, it is really very, very specialist, then the funding that goes into that in a Brisbane hospital would have to be apportioned on the basis that it is a service for the entire State but all of those adjustments can be made?-- What they actually have implemented in New Zealand is a mechanism called cross boundary flows and for tertiary services that were being performed for the population from another health district, there is actually a transfer of funding. But there are many ways of doing it. The way you are talking about, having a tertiary adjustor-----

Yes?-- -----for that hospital, is also a Commonwealth as well.

The idea of cross boundary flows has some disattractions to it. We've heard about the situation in the old days in Queensland, the older District Hospital Boards where the local superintendent was reluctant to send a patient to a tertiary hospital, or even to a larger secondary hospital because that was more money out of his budget. That's why I prefer the other structure?-- It is interesting. The experience of New Zealand, with 20 district health boards, is that 19 of them are actually in surplus now after introduction of this model, and that while the cross boundary flow for tertiary services continues to be a challenge for them - I don't know, because I am no longer in the setting myself - they somehow are

grappling with it on an equitable basis.

I won't ask which the 20th is.

D COMMISSIONER EDWARDS: Would it be fair to say there is a potential for a hospital or a hospital district to be penalised by central office if you really need financial supply for the following year if they are aware of savings that you had made?-- Yes, that's certainly the case.

In other words, the more efficient you become in dispensing medical service, the potential is that your overall budget could be reduced?-- It is a very perverse system because the better we do, the less likely we are to actually get the funding we need, and I think for the Townsville Health District we have got to the point where our clinical services are being managed and administered by clinicians, they are exceptionally efficient, clinical quality is excellent, whether we benchmark against such groups as the health roundtable or the ACHS clinical indicators, we have excellent clinical care, but there is nothing to help us on the issue about the volumes that come through the hospital now we can no longer cope with within the changes we've made.

COMMISSIONER: And the worst part of that is that if you do what in fact has been done at Townsville, you scrimp and save, and reduce administrative and overhead costs to put more clinicians into practice - I think you mentioned the figure of 100 extra clinicians you managed to achieve - then when you go cap in hand to Queensland Health they say, "Well, you have got all the clinicians you need, we're not going to give you any money even though you are demonstrably underfunded."?-- Yes, up until recently we haven't been public on what we'd actually done with the increases in our actual number of clinical staff. We still have demand that's meant for the community, we still need additional clinicians, and some of our challenges actually include, particularly in the medical and nursing workforce and some areas of allied health, we have actually made the funding available to the institutes but we can't get the people.

Yes.

D COMMISSIONER VIDER: It highlights the need to accept the challenge that we have got to come to a point where we develop a better system of costing diseases. Because we have got them in competition now. We have got surgery against medicine. And in an economically rationalist world, you can understand how that's happened, because you can itemise as an economic unit second by second times of operating in the equipment, and prosthetic devices that might be used in the operating theatre, but you can't do the same exercise for an 86 year old patient with pneumonia, nor do you elect to have pneumonia when you are 86 on a given day. So we probably need to come back and put that right at the centre of a care model and cost it from that perspective rather than come at it purely from the economics as the driver because we put them in competition?-- Yes, I would agree.

MR ANDREWS: So current funding model is historical based with incentives for elective surgery?-- Yes, that's correct.

We have heard you express a preference for an activity based model which might take into account, for instance, that you're providing such an efficient renal service that it is costing your hospital an extra million a year, while you're doing less elective surgery and having your budgets cut by half a million dollars a year?-- That's correct.

And the third model referred to by the Commissioner and in your paragraph 33 is a population-based funding model. Which is your preferred model?-- I think population-based funding model would be my preferred method for actually addressing funding for a community or population. Activity is a weak substitute for that.

D COMMISSIONER EDWARDS: Could I ask if the population base is the base for ongoing activities reviewed on a continuing basis though?-- Yes, that's correct.

Relative to other needs within the hospital?-- Yes.

COMMISSIONER: Tell me, I know this is a little bit out of the blue, but with your funding, does that include funding for capital works or do they come as a separate grant? So if you are rebuilding the Ingham Hospital, is that part of the recurrent budget or is it-----?-- There is three ways we access capital funding. There is the whole of site or campus redesign, which is essentially funded through capital works. For example, the Ingham redevelopment is being funded through capital works. We get some health technology through the health technology capital planning process, which has actually been reducing each year. Rather than recognising that medical equipment is getting more expensive, it is actually going down each year, and then it is out of our operating budget we have the ability to put a certain proportion of that against capital. For example, in this year the Townsville Health District had about a $1.7 million capital budget from our internal resources. Unfortunately, we spent about 4.1 million on capital, but that was really designated need areas that we couldn't not do something on.

I guess that's the other thing that would require some equalisation. You have got a wonderful new hospital here in Townsville, and presumably that adds to efficiencies in economies and cleaning billings are less?-- Unfortunately, the opposite has proven true, and I will use the most ridiculous example for us. We were meant to be able to pull multimillion dollars out of our costs by actually going to the new facility, but one of the first things that they actually did when they found there were insufficient funds to build the hospital was put things like disposable air conditioning filters in the hospital.

Yes?-- The recurrent cost to us to actually maintain the disposable air conditioning filters is in the hundreds of

thousands of dollars. On one hand we have been told, "You are going to get a facility that will actually save you lots of money", but instead of spending some capital money that would allow us to reduce the current costs, they saved on that and now we spend lots of money on throwing away air conditioning filters.

The point I was going to make - and perhaps you have already answered it, though, is that a lot of particularly more remote and country hospitals are getting a bit long in the tooth. Beautiful buildings - you can go out to places like Barcaldine, Blackall, and Longreach and Winton and so on, wonderful old hospitals, often with big verandahs, deck chairs out there where the TB patients used to live out their lives, and so on, but they would be tremendously expensive hospitals to maintain, just in a recurrent costs sense, on a per bed or per capita basis?-- It is a bit of a catch 22 because while you will have higher costs because of the nature of those buildings - and they were built in the 1930s, 40s or 50s for a very different health system - by the time you get to a large metropolitan hospital or tertiary hospital like ours, the cost for subspecialisation is extreme.

Yes?-- The capital costs in the actual medical technology is disproportionate. You couldn't compare the costs for an imaging service even on a pro rata basis between Charters Towers and the Townsville Hospital.

Yes?-- Because even when you scaled up their budget, the cost of the clinical equipment that we're actually using is so substantive to be able to provide the degree of tertiary services we do, that then doesn't help. Probably your argument works when you are looking at secondary services but by the time you get to a tertiary service, it goes the other way.

And I guess the reality, too, is that buildings hopefully last for many decades, whereas imaging equipment and other technology has to be replaced at fairly regular intervals?-- Some of our medical equipment, we would be ecstatic if it could last 10 years, and these are items that might cost half a million dollars.

D COMMISSIONER EDWARDS: The models that you are developing your financial communities, are they being looked at by Queensland Health?-- No.

Why not?-- I can't answer that question. As I say, I think we are considered a recalcitrant health district.

Odd but efficient?-- Yes.

COMMISSIONER: And you are subject, of course, to financial audit from head office?-- Yes, that's correct.

D COMMISSIONER EDWARDS: And nobody has reported that your systems are not in accordance with recognised audit procedures?-- I think that the largest thing they struggle to

come to terms with is actually how we set budgets with our clinical institutes when they haven't given us a budget, and today they still - whenever we tell people that, they don't understand how we have done that. If we didn't do that, we are now in the second month of this financial year and we wouldn't have had resources allocated for the delivery of those clinical services.

MR ANDREWS: Another oddity that you would recommend is more flexibility in remuneration of staff specialists. You give an example of a wish to be able to tailor salary packages to individual doctors. Is there no discretion allowed to you?-- No, we have very strict guidelines on exactly what we're able to offer people. Now, some of them are ludicrous, and the example I use in my statement is that if, for example, a specialist wished to cash in their motor vehicle and take a cash benefit rather than the vehicle that we're supplying them, we'll only give them $6,000 even though it is costing us $22,000 per annum to actually provide that. And even if you split the difference with them, they would probably be very, very happy and would actually benefit all of us. But it actually makes no difference to the actual health district, so it is an artificial rule. So they won't cash their vehicle in because they don't get equivalent benefit and then they are dissatisfied about it. In fact, one of the other issues on that, which is a great example of bureaucracy not recognising the clinicians, is when they changed the accomodation assistance. A lot of rural and regional health services offer accommodation assistance to medical staff upon engagement. This used to be paid by having a gross payment beside their salary or in their fortnightly pay, and they would actually get a net benefit equivalent to approximately $200. An accountant at corporate office decided it would be really clever for us to pay them the $200 net and then we'll pay FBT on the amount. So that's what we actually do, and it costs us the same, but we now prevent our doctors from salary sacrificing because if they salary sacrifice they have to pay the FBT on the accommodation assistance that we've paid them. Now, what that means is that the clinicians don't salary sacrifice because it would be a negative thing for them to do so. We don't make any saving out of this bizarre decision to do this, yet the only people we penalised are the people we're seeking to employ and we don't have enough of.

Have you considered the relative costs of VMOs and staff specialists for Townsville?-- Yes.

What degree of analysis have you done to come to your conclusion that they're very comparable as far as total cost?-- They're very comparable as part of, actually, our planning and our budget process. We actually have to look at what expectation we could receive from the particular clinical area as far as Commonwealth funds, through the Medicare or through private clinics that they may actually run private services they provide. Then we have a look at their total cost to that employee. We provide all the benefits that they are entitled to, and then when you compare that to effectively what is a very raw dollar cost for a VMO, they are very

comparable. They are not exactly the same but they are very close.

COMMISSIONER: We've heard the suggestion that whilst the direct and indirect costs of employing VMOs and staff surgeons are comparable in the sense that if you add up the package, and divide it by the number of hours, you come to a similar cost per hour, but that in some situations a VMO can be more expensive for the hospital because in some situations a VMO can be more demanding in the standards of facilities and equipment and services that he or she insists upon, the VMO can be a more difficult person to deal with in an administrative sense, and in some instances - and I don't want to be misunderstood - I accept without reservation that there are staff specialists who are every bit as competent and as people in private practice, but in some instances a VMO will prove to be more efficient, will get through more operations in a particular session than the staff specialist, and that's more beds that have to be filled, and more post-operative care that needs to be provided and so on. So the suggestion is put forward that even if the direct and indirect costs of employment are comparable, the actual cost to the hospital of the VMO is more?-- I have certainly not done any analysis on that basis. I couldn't really comment on that, sorry.

I suppose part of the answer to that argument about efficiency, assuming it is true, which I don't necessarily assume, but if it were true, then that would produce its rewards in terms of current funding model for elective surgery in any event. So it might cut both ways?-- That's correct. For us as a health service, we can't survive without either or of those parties. We need the VMOs and we need staff specialists, and the beginning of that model is what will allow us to deliver a successful health service.

Being very frank about it, what attracts me to the VMO model is that whilst the costs are comparable, in many instances employment as a VMO will be more attractive to the medical practitioner, particularly because he or she would have the opportunity to make more income in the private sector when not working as a VMO, and that's why I see some advantage, given the shortage of medical practitioners, particularly medical specialists, in attempting to attract more VMOs to regional areas, even if that involves, for example, partnerships with local private hospitals or innovative arrangements, allowing VMOs to have their own consulting rooms within the hospital precinct so that they can see private patients in their public consulting room?-- I would agree. A number of the positions we have been, where we have been trying to recruit people to, are staff specialists. In talking to those clinicians we've said we will actually try and make contact with the private hospitals and see what opportunities exist for you to actually expand into private practice. Because often when we're trying to recruit people we can't offer publicly sort of financial compensation that we would elsewhere. So us having a model whereby there may be fractional staff specialists with us and in private practice is desirable. And we have had a number of discussions with both the local private hospitals in those

circumstances in attempts to try and attract people.

Can I ask - you speak in your statement about the recruitment of an additional neurosurgeon for Townsville and the decision was made - and I certainly don't cavil with the decision that you needed an additional neurosurgeon as a full-time staff specialist and there was advertising in Australia and overseas and eventually Dr Myers was given the position. Would it have been permissible for you to advertise elsewhere in Australia a situation that you want a neurosurgeon to come to Townsville to be a VMO and work two or three days a week at the hospital and to be remunerated accordingly?-- It certainly has always been our plan to actually bring somebody who is a staff specialist and actually assist them into private practice.

Yes?-- I think at the moment our planning from the model would be two VMOs and staff specialist would suit us the best.

Yes?-- But we need to get somebody to here and then give them the time to actually establish private practice, and if that's the case, then by recruiting them as a staff specialist with intent to say, "Look, we're happy, if in the future you can develop a private practice, for you to become a VMO with us and we will do what we can to assist that."

Well, let me take a reasonably practical example. I'm sure Dr Rossato is going to be practising neurosurgery for many years to come but let's assume for a moment he was a much older man and he was thinking of retiring, giving up his practice and so on, the same with the other neurosurgeon, Dr Guazzo, and you're in a position to say to potential applicants, "With a neurosurgeon retiring from practice, he or she will be giving up their rooms and their visiting rights at private hospitals. Come to Townsville, work for us as a VMO and we can offer you these benefits." You're not really allowed to use that innovative form of packaging a position, are you? You've really got to-----?-- No, we're not and that's why we have discussions with them, "Come to us as a staff specialist and then we will try and facilitate you being able to move into private practice."

Yes?-- So that we get our need met and the private community need is met as well.

Because it's been pointed out to me that hospitals, for example in Victoria, public hospitals in Victoria, actually advertise that way. They will say, you know, come to whatever the town is, Ballarat for example, "There's a need for an ophthalmologist. We will give you two days a week at the hospital and for that you will earn 80,000 a year. The other three days, there's rooms available and you can work in private practice and you should be able to earn up to another 300,000 a year", which is a lot more attractive than going there as a staff specialist on 200,000?-- It certainly works very well where there's a shared campus between a public and private facility as well. Organisations that actually have that whereby people can actually move easily between the public and the private practice, it is a very good model.

It is not immediately apparent to me why you need to have a physically shared campus in that sense to achieve that level of cooperation?-- It's a matter if both are acute facilities, they can be being rung to say, "This person is your patient", and while somebody else may be on-call, "Would you like to attend the fact that there is an event happening with them?"

Yes, of course?-- And most clinicians, given the opportunity, will say, "Yes, I'd like to."

Yes. Mr Andrews.

MR ANDREWS: I have no further questions, Commissioner.

COMMISSIONER: Sir Llew? Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. I have no

questions.

COMMISSIONER: Ms McMillan.

MS McMILLAN: No, thank you, Commissioner.

COMMISSIONER: Mr Rebetzke.

MR REBETZKE: No, thank you.

COMMISSIONER: Thank you very much for coming in and giving your evidence. I won't repeat the remarks I made earlier. I'm not sure you were present in the room at the time but we have appreciated the cooperation and assistance we have received from everyone who has given evidence here in Townsville and I extend the same thanks to you that I have to the other witnesses and you're formally excused from further attendance?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Well, Mr Andrews, we've obviously finished. We should, however, resolve the situation with tomorrow's sittings. Can you inform us what time it's planned to start and finish?

MR ANDREWS: As I understand it, tomorrow starts at 10 and we'll run until I think it's 12.30, resuming again at 2.30 in the afternoon.

COMMISSIONER: Yes.

MR ANDREWS: And Dr De Lacey is the only witness planned for tomorrow.

COMMISSIONER: And his evidence may or may not take the entire day.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Yes.

MR ANDREWS: I think that sums up the alternatives.

COMMISSIONER: Is there anything else that anyone wishes to raise at this point? Ms McMillan?

MS McMILLAN: Mr Commissioner, just in relation to Dr De Lacey, we have written a letter to the Commission staff indicating that I understand it's hoped that by lunchtime there would be a small statement with the annexures of Dr De Lacey going over today. I don't know whether that's occurred or not. Hopefully that has. And also, the CD with all the patient records, I understand that was made available

yesterday subject to the undertakings-----

COMMISSIONER: Yes.

MS McMILLAN: -----being offered. Now, I understand there's between 40 and 100 patient records on those CDs. The effect of our position is we probably won't be in a position to be able to cross-examine Dr De Lacey tomorrow in terms of any matters of substance if I can put it that way.

COMMISSIONER: I don't see that as a difficulty. My understanding is Dr De Lacey will not say anything that is adverse to the Medical Board so I can't see how you're prejudiced.

MS McMILLAN: I was thinking more of the clinical issues that might be raised in relation to some of the patients. In terms of his draft, there doesn't seem to be anything in it relating to the Board.

COMMISSIONER: Yes. I'm not ungrateful for the assistance I have received from both you and Mr Devlin in raising clinical issues that aren't of direct relevance to your client, the Medical Board, but we are operating under a pretty tight time schedule.

MS McMILLAN: I understand that.

COMMISSIONER: And I wouldn't want to plan to bring Dr De Lacey back on another occasion to raise issues in cross-examination that aren't of direct importance to your client. But we will see what happens tomorrow.

MS McMILLAN: Yes. I can only indicate in effect in a vacuum to a large extent, because of the position I'm just outlining - I don't know some of the other parties, their position at the moment in relation to Dr De Lacey.

COMMISSIONER: Yes. All right. Well, the Commission of Inquiry will now adjourn to reconvene in Brisbane at 10 a.m. tomorrow morning.

THE COMMISSION ADJOURNED AT 2.20 P.M. TILL 10.00 A.M. THE FOLLOWING DAY AT BRISBANE