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Department of Justice and Attorney-General

Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 22/08/200

..DAY 46

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THE COMMISSION RESUMED AT 10.10 A.M.

COMMISSIONER: Mr Applegarth?

MR APPLEGARTH: Mr Commissioner, I wasn't here on Thursday - that was the day I was briefed - but Dr Wakefield gave evidence that day, and you asked him at page 4509, line 40 of the transcript about an instruction that was given by my client to the investigative team looking into Bundaberg Hospital that they check the credentials of all of the doctors at Bundaberg Hospital. You describe this as Dr Buckland giving a hint to look for some dirt on a few individuals. Dr Wakefield went on to explain that the reason that Dr Buckland gave for instructing the team to check on the credentials of all of the doctors at Bundaberg Hospital was "so that it could be assured that there wasn't another Dr Patel lurking". That appears at page 4510 line 3.

COMMISSIONER: Yes, I noticed that. Interesting comment, given that Australian-trained doctors were searched, including Dr Miach who had actually been appointed by Dr Wakefield.

MR APPLEGARTH: Be that as it may, can I say this - and I will come back to that - to a fair and reasonable person, the instruction to check the credentials of all doctors, be they overseas-trained or Australian, seems, with respect, to be an entirely sound and sensible thing to do. But, despite Dr Wakefield's evidence, you asked him whether it occurred to him to say, "Look, Dr Buckland, if you want us to do your dirty work for you, then we want it in writing?"

COMMISSIONER: Yes.

MR APPLEGARTH: And that appears at page 4510 line 20. That statement was unfair, there was no evidence to support it, and it is offensive to my client. The request by my client as Director-General to have the investigative team check the credentials of all of the doctors at Bundaberg Hospital was not doing dirty work. Queensland Health would have been derelict in its duty to the public if, being on notice of irregularities in the credentials of one doctor at Bundaberg Hospital, it neglected to check the credentials of the others, yet you seem to regard this as doing dirty work.

COMMISSIONER: No, I don't. What I regard as dirty work-----

MR APPLEGARTH: Then if you don't regard it as doing dirty work, I would ask you to withdraw the comment.

COMMISSIONER: I will withdraw it with respect to overseas-trained doctors, but when Dr Buckland sends his team to Bundaberg to rifle through the personnel files of Australian-trained doctors without any reason for suspecting that there is any problems when a minor irregularity is found in respect of Dr Miach, and the first Dr Miach hears about that is reading it in the press, there has been dirty work

afoot. Now, if it wasn't Dr Buckland's dirty work, then I will apologise to him when I hear his explanation.

MR APPLEGARTH: If we could deal with one thing at a time, because you have-----

COMMISSIONER: I am dealing with your point.

MR APPLEGARTH: Because you have brought together the original instruction to check the credentials of all doctors at Bundaberg, what subsequently happened you described as rifling through, and then the report, and Dr Wakefield has dealt with those matters. I am here dealing with the first matter, which is your suggestion that the original instruction, given at a time when presumably no-one's on notice of any minor irregularity in Dr Miach's registration and it was an anomaly, but at a time when no-one is on notice of what types of irregularities there may be - there may have been none, there may have been a minor anomaly, as in Dr Miach's, or there may have been a serious anomaly - but being on notice there was a system failure, that Bundaberg might have not done all it could have to check on the registration status of someone, it was entirely sound and sensible for an instruction to be given to check the irregularities.

Now, the anomaly with Dr Miach was simply an anomaly. It arose because of the-----

COMMISSIONER: That's not how it was reported in the press after it was leaked from Queensland Health, and it can't have come from anyone else.

MR APPLEGARTH: Are we going to have an inquiry into the leaking of it? I am interested-----

COMMISSIONER: On what point?

MR APPLEGARTH: I am interested to find out on what possible basis you say it was leaked by Queensland Health.

COMMISSIONER: Because it could not possibly have come from any other source.

MR APPLEGARTH: In due course I would like to know the basis on which you say it could not have come from any other possible source and whether you are going to call the journalists to investigate that fact.

MR ANDREWS: I would like to be heard. I understood Mr Applegarth was making an application this morning. It is appropriate for any party that wishes to to make an application at an appropriate time. Addresses are normally, and, indeed, always left for the end of a hearing.

I understand Mr Applegarth to have moved from his application, which was to ask you to withdraw something, an application, I might say, that took less than 20 seconds, to an address which has taken something like five minutes. The privilege of

addressing-----

MR APPLEGARTH: I will move on, sir, I will. I don't want to take up the time because I know there are many witnesses, but I moved on because other issues were raised. Simply put, statements like last Thursday's leads to the perception by my client, and would lead any fair-minded observer, to think that you might not bring an impartial or unprejudiced mind to the resolution of issues that you are required to decide about Queensland Health and about my client in particular.

COMMISSIONER: Do you represent Queensland Health?

MR APPLEGARTH: No, but any-----

COMMISSIONER: Counsel is here representing Queensland Health. If they have a problem, no doubt I will hear from them.

MR APPLEGARTH: Yes.

COMMISSIONER: Tell me what Dr Buckland's problem is.

MR APPLEGARTH: His problem is that last Thursday's "dirty work" remark was completely unjustified, unfair and should be withdrawn, not just with respect to overseas-trained doctors, but in its entirety.

COMMISSIONER: Well, I decline to withdraw it. When I hear Dr Buckland's evidence, if there is some intelligible explanation for directing his people to go through the personnel files of Australian-trained doctors, including those appointed by Dr Wakefield himself, and that intelligible explanation consistent with innocent motives, I will very happily, very gladly withdraw any reflection on Dr Buckland and I will keep an open mind on the matter until that time.

MR APPLEGARTH: In my submission - and I will just be one sentence in it - the intelligible explanation was given by Dr Wakefield last week and, with respect, you should act upon it, and the intelligible explanation was that there should be a check of all credentials. I can't take the matter any further.

COMMISSIONER: Let's explore that, Mr Applegarth. The intelligible explanation was as to whether there would be another Dr Patel. How on earth would going through the file of Peter Miach or any other Australian-trained doctor, particularly those appointed by Dr Wakefield, conceivably be relevant to ascertaining whether or not there was a Dr Patel?

MR APPLEGARTH: Well, I apprehend that the shorthand remark "another Dr Patel" relates to a doctor who has some irregularity, small or large, in relation to his or her registration. Now, that's what I apprehend the point is, that one would want to check that doctors, be they the finest doctors in the world, the worst doctors in the world, or somewhere in the middle, are properly registered, that if they are conducting specialist work, that they are registered as

specialists. Because, as I understand it, there is a dual registration and it would be unfortunate if it be the case that a doctor who is only registered, through no fault of his own, through an anomaly in the system, to be on the general register, isn't on the specialist register but is carrying on specialist work. So that was the point, as I understand it, of the instruction to check on the credentials.

Perhaps we're at cross-purposes, but in my submission the instruction to check on the credentials of all doctors was, on that basis, sound and sensible and Dr Wakefield explained it, and it shouldn't await my client's giving evidence for you to appreciate that an instruction to an investigative team to check on failures in the credentialing of doctors at Bundaberg Hospital was an entirely reasonable request and couldn't possibly be construed as an instruction to dig up dirt on anyone.

COMMISSIONER: Well, Mr Applegarth, that comment was made in the context, not just of the instruction, but three other factors: firstly, that there was the instruction given; secondly, that Dr Buckland did not put it in writing; thirdly, what happened when the information came out, which was that Dr Miach wasn't told, wasn't given a chance to make the phone call or to fill in the form, which would, I am told, take less than a day to get his registration in order; and, fourthly, that the first he or anyone else knew about it was when Mr Parnell published it in The Australian. Those factors together, in my view, warrant explanation.

If your client provides a satisfactory explanation, that will be the end of the matter, and I will very happily apologise to him for entertaining any suspicions to the contrary. But those suspicions exist. I am not going to pretend they don't. That's how these inquiries work, Mr Applegarth. The fact that I have got a suspicion doesn't mean that I have made up my mind; it simply means that there is something out there that needs to be investigated, and until it is investigated, I will continue to entertain those suspicions.

MR APPLEGARTH: With the greatest respect, I don't wish to take any more time of the Commission this morning.

COMMISSIONER: Take as long as you like.

MR APPLEGARTH: If it is only a level of suspicion and you don't have the evidence to support it, you shouldn't express yourself in terms like "dirty work".

COMMISSIONER: I have the evidence to support such a suspicion. Until that evidence is negated by your client, the suspicion will remain.

MR APPLEGARTH: I am happy for-----

MR ANDREWS: Commissioner, I submit-----

MR APPLEGARTH: I have said what I want to say. I have asked

for the statement about dirty work to be withdrawn, you haven't withdrawn it, and I don't propose to take the matter any further here today.

COMMISSIONER: What I do wish to make very clear is that it is no more than a suspicion at the moment. And the matter will ultimately be determined on the whole of the evidence. Once I have heard the whole of the evidence and the Deputy Commissioners have heard the whole of the evidence, we will arrive at our conclusions based on the whole of the evidence, and I am quite, quite open to being persuaded that a suspicion which presently exists in light of the full facts isn't justified.

MR APPLEGARTH: Very well. My final remark is the suspicion should not have remained beyond the completion of Dr Wakefield's evidence on Friday.

COMMISSIONER: Well-----

MR APPLEGARTH: That's all I wish to say.

COMMISSIONER: I will respond to that by saying that Dr Wakefield's explanation, in my view, firstly, offered no reason for going through the files of Australian trained doctors, and particularly those appointed by Dr Wakefield himself; secondly, offered no satisfactory explanation for the absence of any written instruction; thirdly, offered no satisfactory explanation for the fact that Dr Miach was not given a fair opportunity to deal with the matter himself rather than having it revealed for the first time in the media; and, fourthly, offered no satisfactory explanation for the way it got into the media. When those things are satisfactorily explained, then the suspicion will disappear.

MR APPLEGARTH: Commissioner, as much as I would like to engage with you on those issues, I will do so at an appropriate time.

COMMISSIONER: I will look forward to that. Mr Andrews?

MR ANDREWS: Commissioner, I call-----

MR APPLEGARTH: Can I seek leave to-----

COMMISSIONER: Of course, Mr Applegarth.

MR ANDREWS: I call Dr Mark Francis Waters.

MR FARR: I seek leave to appear on behalf of Dr Waters.

COMMISSIONER: Yes, you have that leave.

MARK FRANCIS WATERS, SWORN AND EXAMINED:

MR ANDREWS: Dr Waters, your full name is Mark Francis Waters?-- Yes, it is.

You have provided a statement prepared with the assistance of lawyers engaged by Queensland Health?-- Yes.

Is that correct?-- Yes, I have, yeah.

It is a statement dated 15th of August 2005?-- I am sure it is, yes.

And all the facts recited in that statement are true to the best of your knowledge?-- Yes, they are.

And the opinions you express are honestly held by you?-- Yes, they are.

I tender that document.

COMMISSIONER: Yes, the statement of Dr Waters will be exhibit 295.

ADMITTED AND MARKED "EXHIBIT 295"

MR ANDREWS: Doctor, I see from your CV, which is exhibit 1 to your statement, that from - apart from your many other items of valuable experience, from the 2nd of August 1999 you spent about two and a half years as the District Manager of the Princess Alexandra Hospital Health Service District, from January 2003 you spent about six or seven months as the District Manager of the Royal Brisbane and Women's Hospital and Health Services District, from August 2003 you spent a year as the general manager of the Wesley Hospital?-- Yes.

And in August 2004 you became Senior Executive Director, Innovation Workforce Reform at Queensland Health?-- That's correct. I think I spent three and a half years at Princess Alexandra Hospital, but it is substantially correct.

The directorate of which you are the Senior Executive Director, that is the Innovation and Workforce Reform Directorate, was created in July 2004, but I understand you weren't involved in the restructure, you were appointed to be its first leader?-- That's correct.

The directorate is concerned with creating a climate for change to meet future challenges in the delivery of health care services?-- That's correct.

You, as a result of another recent appointment, have been forced to focus on the future, am I right?-- Yes, in May I was asked by Queensland Health to be seconded to the Administrative Review of Queensland Health as being led by Peter Forster.

And it goes without saying that the views you express are your own; you don't purport to speak for Mr Forster?-- That's absolutely correct, yes.

There are six centres and branches which comprise the directorate that you head?-- Yes.

The Commission has heard of the Patient Safety Centre from Dr Wakefield last week. The Commission's visited the Skills Development Centre on a tour conducted by Professor Diver. There are several other branches. One of them is the workforce reform branch, and the Inquiry has heard something of it. It is the branch that for a time was - contained delegates of the Health Minister for the purpose of certifying Area of Need and filling in forms that would be forwarded to the Medical Board?-- That's correct.

I understand from you this morning that the workforce reform branch no longer performs that function?-- The Chief Health Officer position now performs that function. I think that's pending transfer to the Medical Board in January, I understand, of next year.

Thank you.

COMMISSIONER: When did you first become aware that the Workforce Reform Branch was appointing or approving areas of need under repealed legislation?-- When I read the transcript of the Commission.

MR ANDREWS: When you took over those six branches, you'd have had briefings from people as to any current issues and, in particular, any issues that needed immediate solution?-- Sure. I mean, to be - we didn't - when I started there we didn't have six branches. I mean, there is just - there was a new directorate and we needed to work out exactly what we thought were the critical issues, but certainly I was absolutely aware that the Principal Medical Advisor was in my directorate, absolutely, and I had discussion with her on a number of occasions about a number of issues, yes.

And when you took over, you'd come directly from your position as general manager at the Wesley Hospital?-- That's correct.

Now, the Skills Development Centre-----

COMMISSIONER: Mr Andrews, before you move off the workforce reform directorate or branch, how long has that been in operation?-- The workforce reform branch?

Yes?-- Well, effectively it got formally established in January of this year.

I see?-- But it was sort of - it was being formed from September of last year and formally agreed to in January of this year - I think that's the best way of saying it - but it would be incorrect to say it wasn't running from about October of last year.

All right. And what would you say are its major achievements in the eight months that it has been formally in operation?-- Well, many of the things that it has achieved had been running on from before the structure was formed anew, if you know what I mean. I mean, all the people hadn't been appointed since October of last year, some of them had been in different areas and reamalgamated, if you like. Some of the big things that have been achieved are in the areas of the nurse practitioner legislation and the move towards nurse practitioners. That's required a fair bit of work. I guess the other thing that's been achieved more recently is the understanding around the issues around intern training and the fact that James Cook is going to graduate another 60 interns next year, and certainly they brought it to the attention of Queensland Health we really needed to fund these positions. And they have also highlighted we're going to run into a bit of a problem in the future because Queensland has been graduating about 250 interns - interns are first year doctors - 250 interns-----

MR ANDREWS: Could you slow down so that the shorthand writers can get it down?-- 250 interns for many years-----

Doctor, you are still speaking very quickly?-- I am pleased to be stopped at any time. We have been - Queensland has been graduating 250 interns for many years, and next year it goes up by 60 as James Cook comes on line, and then, of course, over the next couple of years it will go up to about 500. The way we train first year doctors and, indeed, junior doctors is going to need a major rethink. We think we are likely to need to train them outside of hospitals because the idea of having 500 first year doctors hitting our hospitals in 2009 we think is probably unsustainable in their current structure. So that's one of the issues that has been raised and is being worked on. The other work that has started is the - now that we've pulled people together, we have come to realise that our relationships with the universities are many and varied, and we have pulled together a working group with the universities to try and establish some standards around our engagement with the universities. In particular, this is now an issue because for many years there was only one university in Queensland, the University of Queensland, that trained medical students. So whilst it was possible for many years to run, if you like, ad hoc arrangements, now that Griffith University is starting and, of course, Bond University is starting, might I put it to you that all the universities look with some interest on the particular arrangements with Queensland Health and are keen to ensure that their rights are preserved. So some of the ad hoc arrangements now need to be reviewed so that we can bring some standardisation to it.

COMMISSIONER: Doctor, I was really asking about what has been achieved, rather than initiatives or projects or ideas that are in formation?-- Okay.

What has this branch actually done in the last eight months?-- It has established - it has established an integrated intern recruiting process for next year. It was meant to be for this year but it was not possible to do it in that time. It has established funding and relationships for the interns from James Cook University. So, I mean, that's what it has done. I mean, there may be other things of which I am unaware. The reality is that workforce reform I think is by far the most difficult area in the directorate in which I deal. I think that the issues around workforce reform will be difficult and in many ways very prolonged in their resolution. We have many special interest groups. We have a long history of professional silos. We have a long history of very rigid boundaries in how we do our work. We have in many ways a very guild or craft-based way of doing our work and whilst that has served the population well, we have a demographic crunch coming, both in terms of the population of this country ageing rapidly, and, indeed, the population of our medical workforce which is actually ageing rapidly, and we are required, I think, to fundamentally look at how we deliver our services, who delivers them, and where they are delivered. My personal view is that there is a huge work ahead of us to marry the skill of people required with the complexity of the task required rather than what we do now, which is marry the profession of the person with the task required. This leads, in my view, to significant waste and I don't believe we can continue it in the future. I can go on. I mean, I am in contact with other States - this is not a Queensland issue, I should say, this is an Australian issue and probably, indeed, a first world issue.

MR ANDREWS: Doctor, so-----

COMMISSIONER: Doctor, do you recall what my question was?-- I am happy to have it repeated?

I simply asked what has been achieved in eight months?-- Okay.

MR ANDREWS: I think you began, doctor, by mentioning the integrated intern-----?-- Recruitment process.

-----recruitment process?-- Yes.

Could you, for instance, tell us what that is, because it sounds as if it is a concrete achievement?-- Yeah, well, essentially what we want to do is actually get all our medical students applying to a single database so we know where the medical students are going and have it much more overt and open. At the moment it is done through universities. Now, it has been okay with the universities in the past because we have only had one university.

Now, do I understand you anticipate that by 2006, the

graduates will be able to have themselves listed on a database that's no longer at the University of Queensland, but a database for graduates from wherever in the State?-- That's right, what the intention is, absolutely.

COMMISSIONER: Doctor, Queensland Health's had that for about 30 years, hasn't it?-- I am not-----

30 or 40 years?-- I am not aware of any database such as that.

Well-----?-- Commissioner, I can tell you when I graduated in 1980, which was 25 years ago, unfortunately, we met in the University of Queensland lecture room and it was a show of hands about where you wanted to go, and if more than the number of intern medical students wanted to go to a particular hospital, we would put names in a hat and pick the names out of who didn't go.

I am told that when, for example, Sir Abraham Fryberg was the Director-General, and before him Sir Raphael Cilento, and so on, the Director-General personally interviewed every medical graduate and indicated where he or she was going to go?-- Well, Commissioner, I can tell - that may have - well, I know that in the early 80s that didn't happen because I was there. I don't know what period of time you are talking about.

Yes?-- I just don't know, but in the 80s-----

I am sure Sir Llew went through it.

D COMMISSIONER EDWARDS: Up to about 1970, I think it was.

COMMISSIONER: Yes, all right. So we're turning the clock back to having it all done from headquarters, are we?-- No, not at all. The reality, of course, is that going from one medical school to three medical schools - in fact, I have got that wrong, of course, we're going from one to four medical schools, dramatically increases the complexity of these arrangements, a complexity which wasn't previously there.

You see, when I go through this attachment to your statement, MFW8 relating to the Innovation Workforce Reform Directorate?-- Yes.

I see on the second page there are key priorities and objectives which are listed?-- Sure.

The first is "Recruiting, developing and retaining an appropriately skilled workforce"?-- Uh-huh.

Is it still the case that recruitment is done at hospital level?-- Recruitment?

Yes?-- I will take some time - is it okay if I just answer-----

Yes?-- Recruitment is done for virtually all positions at

hospital level with the exception of interns, as I understand it.

All right. So apart from the situation with interns, there has been no progress towards the first objective, which is recruiting developing and obtaining an appropriately skilled workforce?-- I think the issue there, Commissioner, is around having processes in place so that we can recruit. I think there is a very fairly widespread understanding that we have a major workforce shortage at the moment and unless we can deal with a whole range of issues, all of which are quite difficult, it would be difficult to imagine that we can recruit appropriate staff. So that's really in that context rather than about specific recruiting of a specific doctor-----

But-----?-- -----or nurse.

-----how does a hospital at Mt Isa or Longreach or Rockhampton expected to compete in the international workplace for medical practitioners without some central assistance?-- I think there should be some central assistance.

Well, what progress have you made towards providing that central assistance?-- There is a project which has been - report now written, Commissioner, called the RAPS project. It is called the Recruitment Assessment Support Placement Training of Overseas International Medical Graduates that's been handed to Queensland Health, as I understand it a week or two ago, and it has been - I have got a copy as well. I would have a view - for some time there was actually such a system about - from about 1990 to about 2000 - those dates may be a little inaccurate - we actually did have a centralised recruiting system which did take into account the conditions of all hospitals and we had an international recruiting process. For a range of reasons, which I am not fully aware of, that recruiting process has fallen by the wayside and it would be my personal view that that process has to be reintroduced and as a matter of some urgency.

Right. The second objective is "Delivering integrated workforce design planning and policy". I am not even sure I understand what that means. But what progress has been made towards achieving it?-- Well, I guess what we're really trying to do is again look at the way we do our business and seeing if there are better ways of doing our business. There is overlap between the innovation group and the Clinical Practice Improvement Centre and, indeed, the Patient Safety Centre. So what we are trying to do is align tasks with skills, examining exactly what's going on in various work situations and seeing if we can actually redesign those workplaces to enable them to be a much more, if you like, efficient but also sensible environment in which to work. And I could give you an example, if you like, Commissioner?

Is this one that's actually been achieved?-- In the eight months since I have started, no, this is not one that's been achieved. It is one that we've started.

Can you give me an example of one that's been achieved?-- Well, Commissioner, I would have to give you examples of patient outcomes from the clinical practice improvement centre.

I am simply talking about this-----?-- Innovation branch.

-----Innovation and Workforce Reform directorate?-- Yes.

Something that's been achieved in respect of the second objective of delivering integrated workforce design planning and policy?-- I can't give you an example of that, Commissioner.

And the third objective is "Optimising external partnerships"?-- Yes.

Is that the discussions with the universities you have talked about?-- There are discussions with universities going on, there are discussions with Colleges of Surgeons going on. There are a range of discussions there.

What's been achieved in that - under that heading?-- Well, we have - well, the simple answer is that we have achieved, I think, for the first time in Australia private surgical training going on - or training going on in private hospitals using surgical trainees. That's more complex than that but that's been achieved, it has been agreed to by the Queensland branch of the College of Surgeons and that's been actioned. I think it won't probably start because of the time issues until January of next year with the new rotations.

How many people work in this directorate?-- The total in the directorate-----

Yes?-- -----would be about - currently about 230 but when it is fully operational we would expect 300.

300 people in this Directorate of Innovation Workforce Reform?-- Yes.

How many are there at the moment?-- About 200.

200?-- Many of the - because it has only just been formed in January, because of recruitment process, there is - very many of the positions are vacant.

What does it cost to run this directorate?-- The new initiatives for the directorate are all funded out of Queensland Quality & Safety money. It would be difficult to know this year because we are so - so many positions unfilled, but I would expect the new initiatives to cost about $20 million per year, that includes a Patient Safety Centre Skills Development Centre, Innovation Workforce Reform branches, and, of course, Statewide Services Planning. Some of the initiatives that have been there for many years such as - I mean, when the group was formed, there were a whole lot of

work going on, has continued to go on, and I guess we haven't changed that. So there is additional money associated with that.

And what's it expected that these 300 people will actually do?-- We can start, if you like, with the clinical - I think you have heard a bit about the Skills Development Centre.

No, I am sorry, I am still asking you about the Workforce Innovation and Workforce Reform directorate?

MR FARR: Can I just interrupt? I think there might be some cross-purposes going on here.

COMMISSIONER: There may be.

MR FARR: You have referred Dr Waters to Exhibit 8 to his statement.

COMMISSIONER: Yes.

MR FARR: Which as I read it refers to the workforce reform branch being one of the six branches.

COMMISSIONER: Yes.

MR FARR: But during the course of your questioning you have on a couple of occasions-----

COMMISSIONER: I am mixing up directorates and branches, am I.

MR FARR: The witness has been referring only to that branch.

COMMISSIONER: Yes, and I have been intending to refer only to that branch.

MR FARR: I think there has been some confusion.

COMMISSIONER: Is that the branch that's going to have 300 people?-- Oh, no, no.

All right. How many people were in that branch?-- I'll just look through that. I think there's - in the workforce reform?

Yes?-- I think there's about 30, 32, something like that.

What do those people do?-- Well, some of the things they are doing is looking at things like at the moment we have had - we have a major issue for clinical patients for our allied health staff, so physiotherapists and other people who came into hospital, there was a major change how universities dealt with them a few years ago. Now universities are training more physiotherapists than they used to do yet they need to get their clinical time in hospitals. Our clinicians are saying, "We're not structured to deal with that", so what we've been engaged with in that particular area this year is working with our physiotherapists, with our clinical trainers and with our universities to see if we can work out different models for training them: for example, can we do some of that training in the Skills Development Centre; for example, can we do some of that training in private physiotherapy areas.

And what progress has been made in that?-- I haven't had an update - I haven't got an update at the moment, Commissioner.

Yes, Mr Andrews.

D COMMISSIONER VIDER: Mr Andrews, I have a question for the doctor. Doctor, in the workforce planning area, Doctor, I think we're certainly aware that there's a problem. Could you tell me what input into the discussions on workforce planning areas like the zonings might have?-- Thank you. I think the - with your permission I would like to answer it by first saying I think what has been lacking and what continues to be lacking is a serious look at our services planning. So that I think - I mean, I'd answer your question by saying a workforce to do what? What is it that we wish to achieve? I think the first thing we have to do is very rigorously look at what services we think Queensland Health should be providing and where they should be provided. I think clinicians should be doing that. Out of that I think we'll develop a workforce plan - sorry, a health services plan and dropping out of that will be a workforce plan. That would be my view. I would think that that will increasingly happen at a zonal level.

COMMISSIONER: Well, I would have thought-----?-- It doesn't happen at the moment but I think it should.

I-----

D COMMISSIONER VIDER: One of the things that when this Commission of Inquiry started, certainly we were aware that there were problems with workforce shortages?-- Mmm-hmm.

And medical staff problems was one of those and hence we heard about areas of need and those sorts of things. As this

committee started to get - take evidence in its early days, it became very apparent that there are a significant number of medical officers in Bundaberg, for example, but they were not being utilised. We have had a lot of evidence to say that many of those doctors currently not working in the public system would happily have worked in the public system but for a variety of reasons their services are not being utilised there. You've mentioned in your submission that you are looking to optimise external partnerships?-- Yes.

To me, one of the things that would - you'd have to sit down and say, "We've got a workforce shortage problem here"?-- Mmm.

"What are the available resources we've got in this category, this category, this category? How can we form partnerships to get better efficiencies in the service delivery mode so that we can care for the sick?" It seems to me, Doctor, over and over again, we sit here and listen to evidence and we have lost sight of the fact we're supposed to be caring for the sick?-- Well, I'd agree with all of that. I think we do need to do that. In fact, we have been recently discussing - I personally have been recently discussing with my other job how we can re-engage clinicians, particularly in rural areas, to work in the public hospitals. I think that's an urgent need. It is more complex than I thought, I must say. In some of the discussions I have had with general practitioners in country towns, there are a number of issues. Firstly, many of our most skilled GPs are actually ageing themselves. We have got this scenario, rather unfortunately, that many of our GPs in country towns are in their early 50s and they're actually looking to wind down rather than increase-----

But, Doctor, you'll get some outcomes and I'm sure some recommendations and resolutions out of discussions?-- Yes, yes.

You don't need to go investigating it for a long period of time?-- I'd agree with that.

Yes?-- I think we need to seriously look at providing service payments like they do in New South Wales. I think there's a range of things we can do.

I think we need to stop looking at what we can do and we need to be doing it?-- I agree.

Mmm.

COMMISSIONER: Doctor, we've received evidence that as of 30th of June 2004, so something over 12 months ago, there are over 100,000 Queenslanders waiting to see a specialist?-- Mmm.

Something like two or three per cent of the state's population are in queues somewhere?-- Mmm-hmm.

What has been done to address that?-- I'm - you mean since June 2004 or before then?

Yes, since then?-- Commissioner, I have been working with Mr Forster since May.

Right?-- So I haven't actually been in Queensland Health since that time.

But-----?-- But could I put it to you that there might be things that my directorate should be doing and suggest some of those things?

I'm, frankly, not interested in that. I'm interested in finding out - we have had this situation for now 14, 15 months. Your directorate includes a specific body designed - said to have the priority of, if I can remind myself of the language, recruiting, developing and retaining appropriately skilled workforce?-- Mmm.

That would seem to me to be the part of Charlotte Street most specifically relevant to dealing with these extraordinary waiting lists. What progress has been made in dealing with them?-- Well, I can't answer that question because I haven't been there since June but I think you're asking me how can we deal with more patients-----

I'm not asking how can you deal in the future?-- Uh-huh.

You have known about these figures, not you personally - I don't know whether you knew about them or not - but Queensland Health has known about them for 14 months?-- Mmm-hmm.

What's happened over that 14 months to do something about it?-- Well, I mean, my view would be that people would have been working hard on recruiting the appropriate surgeons and the appropriate physicians and looking at how we provide care. That would be my opinion. I've not specifically been involved but there are good people working hard in Queensland Health, I would think at all levels to try and produce or achieve the best service that we can.

Mightn't the best possible workforce reform to be to have 30 or 32 less people involved in workforce reform and 30 or 32 more wages to be spent on clinicians?-- Yes, look, Commissioner, I - that question is of course a very reasonable one. When we started - I spent all my life providing health care services directly. This is a very recent foray into corporate life for me. And one of the guiding principles we have is that we will evaluate our work to determine value for money. I mean, I have made it very clear to everyone who is working in the directorate that every dollar we spend in our directorate is not a dollar spent providing direct care. I would argue that we must provide greater than one to one value because there is a lower risk. If you provide it directly, you have to be seen to be providing better than that to continue to sustain it. So our process was going to be - and I clearly am sorry that we can't give you more evidence but we are only just starting, our process was that we would review all of our actions every six and 12 months both internally and with

district managers and clinicians because I think we need a bit of fire in our bellies. It is very easy to get disconnected from the front line if you like and if we weren't providing that value, then we would change what we would do.

Doctor, I'm sorry, I have a lot of trouble accepting that. You can't say you're just starting. These figures have been there since June of last year?-- Now, I don't know how many people have died on waiting lists since June of last year but just to say you're just starting doesn't seem to me to be an explanation for why nothing - why you're unable to identify anything that is actually being done in a concrete sense to address these waiting lists?-- There would be specific initiatives that would have been carried out in health services and provide - I mean, I'm assuming this.

Yes?-- In the health services directorate looking at particular clinical specialities and particular areas of waiting list. There has been a wasting list strategy that has been going on now, as I understand it, for some years and new services have commenced at various sites. That's my understanding.

Over the last fortnight we seem to have lost another - what is it, another 50 VMOs, or something, from the system at the Royal Brisbane and Nambour. Are you aware of that?-- I am aware of it, yes.

You talked about the difficulties in country towns getting the local GPs involved and I'd suggest also local specialists?-- Mmm-hmm.

Isn't the solution to that instead of having an office run out of Brisbane-----?-- Mmm.

-----to give local administrators, whether it's under the system of having a Director of Medical Services and District Manager or local board, or whatever, the opportunity to engage with their own local community?-- Look, I think - I think, absolutely, I think that that would - that is a way forward. I think you need to be a little bit careful for the same reasons you raised before. It would be quite, I think, retrograde to say to Mount Isa, "There you go. See you later. You do all your own recruiting." I think there has to be a degradation so that local areas engage with their local communities about local services, but those things you -really need to work in, like, hubs. You could easily imagine Townsville, Royal Brisbane and Princess Alexandra providing support and oversight which need oversight but that local decision making can happen at a more local level, yes.

You see, what we keep hearing is that the reason VMOs are reluctant to work in the public system isn't merely a matter of pay. In many cases it's much more things like having a car park at the hospital, having a doctors' common room-----?-- Yes.

-----or sitting room where they can talk with their

colleagues?-- Yes.

Having sessions scheduled at a time which fits in with their private practice, having flexible arrangements so that they can organise their holidays, organise their weekend or whatever-----?-- Mmm, mmm.

-----with the hospital. Having flexible pay packages. I'm not suggesting for a moment that we should have a bidding war between different hospitals for the services of either VMOs or staff doctors but having sufficient flexibility to allow normal sort of salary sacrificing arrangements to a doctor who chooses to have a vehicle supplied rather than a direct salary payment or a doctor who chooses to have boarding school fees paid for rather than a direct salary payment, that sort of flexibility. For the moment, I don't see how having 30 people in Charlotte Street working on workplace reform is going to help any of that. I think the way it's going to is to give District Managers and Medical Superintendents and local administrators the power and the authority to make those sort of arrangements themselves?-- Well, Commissioner, I would - there are some of the things you said that I would agree with; there are some, I think, are more problematic. And I think that it would be easy to underplay the system changes that have to happen, which won't happen at a local level. But to go back to some of the things you said, there are other issues - there is one thing you didn't mention which I would mention is because we are a big public service, there is much more paperwork involved with our VMOs than they would encounter in their own rooms. When they're in their own rooms, they have their own secretaries that they employ because they're effectively a smaller business. So I think the other thing we could do would be to actually employ or to provide some sort of, if you like, personal assistants for visiting medical officers when they attend the hospital because they actually are only there for short periods of time and the interface is a difficult one for them. So I think there are a range of things we can do to make it better for them to work in our system.

Doctor, my point is that for those things to happen, we can't wait for years for people in Charlotte Street to come up with new policies and new documents and new studies. The way for it to happen is to give local administrations the authority to negotiate arrangements with their local medical communities?-- Yes, that is certainly the path that Victoria's got. Victoria has gone down that path.

Yes?-- It does provide - the issue of how you avoid the bidding war becomes a major issue. Do we actually increase the total pool or do we just shift the pool around, and I think that's a vexed question in a time of workforce shortage. I think there are many, many things we could do without necessarily - I mean, there are some things we could do which are just obvious. Like, at the moment there - well, we're proposing anyway that we just cash out things like study leave and conference leave, so they just get a cash amount. All they have to do is tell us once a year where they've been and

all the sort of rigmarole, if you like, goes away. They're sorts of obvious things we can do and do quickly and my understanding is that's currently - I do understand there's a bit of imbroglio at the moment with the VMOs but that's one of the items that's on the agenda in that process, that we just cash those things out. Things like salary sacrifice, I think it is unfortunate in that in this state we have chosen - this is not a Queensland Health issue. It is a state issue. That we have chosen to quarantine salary sacrifice. For example, I would think, having worked in the country, that it would be a great advantage to salary sacrifice school fees. I think it's a no-brainer frankly. However, that's not within Queensland Health to change. That's a government - that's a whole of government policy.

Has Queensland Health made representation to the government?-- Yes. I personally have.

Who have you dealt with, the Treasurer?-- Minister Nuttall.

I see. And what's the present status with that?-- I haven't had an opportunity - Mr Nuttall - I had conversations with him and then I think he's moved to a different portfolio, so I don't know what's happening with that. But these are all very reasonable things. I think the problem will be that if we go down - there are some things which I have a view that should be standardised and systematised because there are some issues which we think - I think that the government and the community has a right, if you like, not to leave up to individual areas and I think things like patient safety and clinical governance are some of those things. When you look at the current number of districts, we have 37 districts. The reality then is do we have the capability at 37 different sites and the skill level to manage some fairly complex issues like credentialing and privileging. Now, I'm not sure what Dr Wakefield spoke about on Friday and whether this has all been discussed and, if so, I'm happy to stop now, but I would say to you, Commissioner, that the better system that we have now is one which has a Corporate Office which deals with those things that around the nation are believed to be corporate things like legislation and regulation. Some issues around policy I think it is the - is the realm of government to decide, if you like, policy issues around health. But I think we also need - and New South Wales has just moved to a situation where we also need, if you like, the volume of numbers, of around a million people to actually do the workforce planning that one of the Commissioners mentioned before, to do the things like clinical governance, to do the credentialing. Those things should have been dealt with the - things like credentialing and clinical privileging, where you can get your major centres like Princess Alexandra Hospital, Royal Brisbane and Women's and Townsville to help the smaller districts. So I think there's all of those roles. But then I think at the local level it would be far better if there was local decision-making and local input and, if you like, local review of things like quality and safety mechanisms, clinical outputs, service issues, those sorts of issues, and I would have thought that Victoria has a very good model where it's local boards, and

they've got I think 100, produce an annual report once a year which touches on a range of topics including governance, including service level. There are a range of issues they talk about. They talk about safety issues. I guess I would say whilst it is very important to have a local input, going back to your original point about Mount Isa, it is also important not to let the weak sink if you like and the strong swim. We have to have systems in place to actually support those areas that don't have the local capability to do it.

Well, that sounds great in theory. It is just that in three months of evidence we've heard nothing yet as to any central assistance that was provided to the management in Bundaberg to recruit a competent surgeon?-- Yes.

Let alone to utilise the services of the competent surgeons or any existing in the community?-- Yes.

Nothing at all?-- That's right. That's why I would argue and that's why I think our group argued when it was first formed in September/October, we had our first meeting in February, that we need to have a much more robust recruiting process. I think we need a recruiting process which does personal interviews with international medical graduates. I think we can - I think we should centralise it into at least hubs or maybe just one database for the entire state, because if you flip it on the other side, when we get these international medical graduates, we should have an obligation to look after them. We should support their families, provide what training they require, integrate them into the community because it is a huge leap for some of these families to come to our country, but at the moment we don't do that. So we would argue there has to be a major focus on that and given the workforce shortages we think will happen before Christmas, we think it's got to start pretty much straightaway.

Doctor, I'll cut to the chase and put it to you as simply as I can. From everything I have heard so far in evidence, it seems to me that one of the first things we are going to have to consider in making recommendations is how we ensure that the limited health care budget is actually spent on providing clinical services to patients?-- Yes.

And one option it seems to me to leap out of your statement is that of the 300 staff proposed to work within the directorate, as much as possible of that should be transferred to local management and the starting point seems to be the workforce reform branch, which doesn't seem to have anything to do with providing the workforce and doesn't seem to have achieved any reform and at present only stands in the way of local management at various hospitals using their own initiative and making use of the limited medical services that are available in their community?-- Well, Commissioner, I mean, clearly the Commission will find what the Commission finds. My concern about that would be that it, I think, assumes that there is another option which is the option that you've described. I have some difficulties with that option because at the end of the day there is a zero sum situation. By that I mean, if we

can engage and I think we should engage many more of our private practitioners involved with public health care, I think that's obviously true.

Yes?-- That does not increase the number of medical services being provided in that town. What it does do is it means that the waiting list at the public hospital will get lower, less, and the waiting lists in private will get more. It must be that way. It won't be that way if we have a series of unemployed or under-employed doctors. I mean, that is true. If the hypothesis is that there are doctors in country towns or, indeed, in Brisbane who are unemployed or under-employed, then the hypothesis does remain valid that getting them more engaged in the public sector will increase the sum amount of medical services available. My anecdotal experience both in the country and in the city is that there are already significant waiting lists for both private and public. So if we can attract them more, and I guess my current allegiance is with the public sector, that will reduce the number of people waiting in the public sector and I think that's a great thing. It will, of course, increase the number of people waiting in the private sector. I guess what the workforce reform branch is trying to - and it is unbelievably difficult because everyone has a vested interest in this, this is all about power and money and professionalism. What it's trying to do is get two and two to equal six and that's quite a difficult proposition.

Doctor, I don't accept it is a zero sum game. The statistics we have seen is that across GPs in the state, the average working hours are equivalent to .5 of a full-time equivalent. In other words, GPs in Queensland on average are working half of a full-time job. Now, some of those are undoubtedly people who choose to work part-time, mothers with families, people approaching retirement who want to work fewer hours and so on, but there is undoubtedly a surplus of working capacity amongst the GPs in the state. We also hear evidence again and again from specialists who would be delighted to work in public hospitals if they were treated with the respect, and I don't mean respect in a fawning, silly sense?-- Sure.

But the respect expected of professional people of having somewhere to park their car-----?-- Sure.

-----of having somewhere to sit down and have a coffee when they've finished eight hours of operating, of having staff - having sufficient authority within the hospital administration that when it gets to 4.30 and the staff say, "Well, it's time to go. You can't start another operation", they can put the - they can authorise the overtime that's necessary or whatever else is required-----?-- Sure, sure.

-----to get through that operation?-- Sure.

To have sufficient-----?-- Sure.

-----flexibility to schedule their sessions when they want their sessions and so on?-- I think there is two parts to

your point. One is we should make it more attractive to visiting practitioners to join. I share that view. Again, there is - there are specialists in this state that are under-employed now. What that will do is increase private waiting lists, and, again, I'm not arguing that's a bad thing. That's - I'm saying that's the reality, unless we can change. With the GPs, I'm really very surprised by your statement. I'm stunned by that statement. We know that 30 per cent of the international medical graduates that come to this state go into general practice because they have documented - there are documented areas where they want to fill those positions. We do know that the number of hours worked by doctors, and this is one of the major workforce issues that we're facing and we absolutely know, that the number of hours worked by doctors is declining. It is declining for both men and women. It is declining at the same rate for men and women but the women are starting off at a lower base. So the men are working around I think it was 51 or 49, I'm not exactly sure of the number, three or four years ago and they're now down to about 47, and the women were returning at about 27 and they're now about 25. This is one of the major issues which the Australian workforce group has just not come to terms with at all. Our number of doctor hours available is actually declining and will continue to decline even as the new medical schools come on board. The view when we talk to these people about why, it's generally they think that they have seen people like myself and perhaps Dr Edwards and others and many of their colleagues who are now in their 50s and they say, "We don't want to work like that and we're not going to work like that. We are going to have a balance between our family and our work", and they are just not working those hours. But the outcome is that we have less hours available.

Doctor, the other thing I have to say, I don't think there is a trade-off between waiting lists in public and waiting lists in private?-- Mmm-hmm.

There hasn't been the slightest suggestion anywhere in any of the evidence we have heard or any of the submissions that we have heard that the private sector has difficulty in attracting specialists to fill the space needed. Indeed, what seems to be happening is that we're going have a brain drain from Queensland because states like Victoria are more innovative and a hospital, say, in Ballarat will advertise, "There a vacancy in this town for a specialist. If you come to Ballarat we'll make sure you get two days a week work at the hospital at the public expense and three days a week at the private hospital"?-- Yes, yes.

None of that happens in Queensland?-- No. But that - absolutely, and it should - and we should have more flexibility and we must become more competitive. I mean, the reality is we just - we do have to pay more people. It won't actually increase the total number of doctor hours available; it will just mean we keep more of ours and Ballarat is less well off. I have run a private hospital and it is true that we don't have trouble attracting private doctors. That wasn't what I said. What I said was that in the private sector,

people do wait. Doctors are already busy. My point was are there doctors who are under utilised who if Queensland Health is a better employer, and I think it must become a better employer, would become better utilised so that the Australian community or the Queensland community gets more doctor hours. My argument is that there are many doctors in the private sector who are working flat out. They would like to work in the public sector more for a range of reasons and I think if we get our act together, some will do that. They will then transfer some of those current hours from what they're doing now in private to the public, which I think is a good thing, but it doesn't increase the number of doctor hours. What I'd love to do, and the problem - the other problem we have is it takes 15 years to train them. I mean, we have a workforce shortage in ENT, urology, orthopaedics. It takes - and a solution to that is 15 years from now, if we have an undergraduate now to - or 12 perhaps, 12 to 15, it depends a bit, 12 to 15 years, I don't think we can wait that long. I think we've got to really try and look at what we can do. For example, our workforce reform unit is working with a particular doctor about whether one of the very common procedures that doctor does needs to be done by a specialist. Now, the doctor doesn't believe it has to be. He believes that a well-trained nurse can be trained within six to 12 months to do those procedures and free him up to do the very complex, difficult procedures that truly do take 12 years to do. To me, that's the only way of adding new capacity and that's what the workforce reform branch is trying to do but it is terribly difficult because there are many doctors who would say, "No, that's in our profession. You can't touch that. We must do all of those things", and that - that wouldn't - and that's not just the medical profession. It is the nursing profession, it's - every group has those boundaries and I guess what we're trying to do is work on the interface and it is really difficult and really hard because no-one likes you.

Well, Doctor, I had not intended to go down that path but since you've raised it, the concern that we've heard in a number of submissions from a number of rural medical lobby groups is that if you allow non-medical practitioners to perform procedures which are traditionally procedures performed my medical practitioners, there are two risks involved. One is you're lowering the standard of overall care?-- Sure.

They're the sort of procedures that may be 99 times out of 100 don't go wrong but in that one time out of 100, the patient benefits from the specialist's experience?-- Sure, yes.

That's one side of it. But the other side of the coin is a much more fundamental one, that if you're the GP in a small country town, a town of 1500 or 2,000 or 3,000 people, and if you have the routine work taken away from you, you're not going to have a GP in that town at all. It's a bit like in my own profession. I have no doubt that conveyancing clerks are capable of doing conveyancing without supervision from a solicitor but if you allowed that to happen, in the one case out of 100 which has a complication that the conveyancing

clerk can't handle, the client ends up suffering. But more fundamentally, if solicitors are deprived of their bread and butter in their country towns, there is not going to be a solicitor left there. That's how they make - they pay for the rent and make a decent living.

It is the same with GPs. If you take away their basic procedures, there's just not going to be a living for them in a country town. Maybe that's what Queenslanders want?-- No, Commissioner. I think that's so far away from where - what we are even approaching, it is not likely to happen. There's a couple of issues. Just to go into country towns, I think there is a major workforce crisis with GPs in country towns and I think, as a nation, we should seriously look at that. Maybe we give differential payments - maybe the Commonwealth or Queensland Government pays more people to go to the country because, at the end of the day, there are good reasons why people stay in Brisbane - schooling for your kids and all those things - and we have a real crisis, if you like, staffing general practice as well as hospitals in country towns and large - significant numbers of international medical graduates are going there. So, I think what we need to do - I think there are two steps: Queensland Health needs to engage with health practitioners in the country and get them in the hospitals, that's true, and look at things like fee-for-service medicine, paying for locums, paying for study leave. That's one issue. The other issue is that the GPs in the country towns say, "We have just got to get more GPs out here. I'm 50 years old. I'm tired. I've been getting out of bed now for 25 years. I just don't want to carry this burden." It is a two-step process. I think Queensland Health must do some of those steps. It will be more successful if it is a bigger picture. In terms of the other part of your question, which was about are we going to have less competence, I think that that's, of course, the critical issue, and I think we now have areas like the Skills Development Centre, which I think you went to last week. I was interstate, but, as I understand, you went out there. We can now - not now, today, but in the next six to 12 months - start introducing competency-based assessment. So, at the moment, all our assessment for medical professionals is time-based. You do five years' worth of training and at the end of five years, you are good at being your particular specialty. Why? Because you have done five years training and you have passed an exam. That's actually the process we have now. What I would argue the Australian community may want or the Queensland community may want is some assurance that when you have done your five years, you are actually competent at the procedures that you do. Now, what that allows us to do is sort out those procedures which do not need five years of specialist training plus three years as a junior medical officer plus five years as a medical student; what are those procedures which other health professionals could do relatively quickly, because, Commissioner, I think to wait another 12 years for more of these specialties, I think that's a really big problem for our community. We already have long waiting lists and we need to shorten some of the - sorry, I digressed. I think we can go to a situation where we can give people an assurance that we can test the competencies of the actual procedure. My personal view is that those procedures should be done in conjunction with the specialists themselves, and the other benefit which some of the specialists see is that this would then allow them to focus and get the volume up

of the really complicated difficult things that they are specifically trained to do, because at the end of the day, if you have to do 10 of these procedures to get one complex operation, then you are trained to do the complex operation. It is a benefit to the specialist to do one of those complicated - one of those operations every week. In other words, you get your volume up and you can do that if some of the more simple stuff can be done by someone else under your direction, and I think there is a sense that that would be an area that people would like to go into. It is possible now, I guess.

Doctor, dealing with rural hospitals, the other very basic problem that we keep seeing in - particularly in submissions we have received, is that the problem with exploring any of these changes is that there is a fundamental lack of trust between the rural medical workforce and Queensland Health. They have been dudded in the past and there is a very real and genuine concern - I'm not saying for the moment a well-founded concern - but there is a very real and genuine concern that they are going to be dudded in the future. A very good example is in a submission from Dr Lock, who is the GP at Springsure, which was the simple trade-off of - instead of having, I think it was, three days a fortnight leave, he wanted six days every four weeks, or whatever. You know, as you say, it is a no-brainer. You know, it is so simple. But he got an agreement from the then Minister, Mr Horan, to put it in place, and the then Director-General or the incoming Director-General squashed it, and not only reneged on the deal, but then tried to take more away by saying, "Well, if it is a four-weekly thing, you will only get five days every four weeks rather than six days every four weeks." They feel very genuinely they have been mistreated again and again by Queensland Health and they are not interested in promises from Charlotte Street. They would feel more comfortable dealing with the local administration who they know and trust?-- My response to that, Commissioner, is that - two things: first of all, Queensland Health has had a culture for a long time - and I don't exactly know where it came from - but a culture for a long time of delivering services in isolation and has not tried to deliberately form partnerships with people. Now, that clearly has been not helpful and not particularly smart. I don't know how it started or where it started. I'm not saying people have even had that intent. Don't misunderstand me. It is just the culture. Queensland Health delivers all of its services. So, I think that's part of the problem. The second part of the problem is that we must - Queensland Health must be an honourable organisation. If people don't trust Queensland Health, we cannot progress all of these issues this morning that we have discussed and I've raised as well. It extends right through to how we treat our medical graduates. I would propose our international medical graduates - they have a more intensive process around credentialling and assessment. I would argue that - and I think now at the Skills Development Centre we can do that. I also argue - it is a long conversation - I will stop it - but what if they are found not to be appropriate? I would argue that an honourable organisation would ensure that that person and his family is

appropriately repatriated, if you know what I mean, and all appropriate things done. We must be in the market place with an honourable name. I mean, it is absolutely a seller's market. There is a workforce shortage around the globe. Queensland Health - I will say this bluntly now - Queensland Health must urgently do things quite properly which rebuild its reputation. Queensland Health needs to be seen as an honourable, trustworthy organisation. If it is not, it must change, because otherwise the price will be paid in the recruiting and in service delivery, and I think I mentioned to you before, Commissioner, I am extraordinarily concerned about our ability to recruit by Christmas, and, in fact, to continue providing services. I think urgent work needs to happen now.

Doctor, when you emphasise the need for Queensland Health to be seen as an honourable organisation, how does that fit in with the history of concealment of waiting list figures, for example?-- Well, I mean, my first view would be that in an environment where we have more demand than supply, the appropriate thing to do, for me, would be to actually make all of this information available to the patient and the community, so they can choose. So you get - you can actually do all this stuff now. I mean, 10 years ago we couldn't, but you can put it on an Internet site and people can look.

I'm sure if you gave it to The Courier-Mail, they would be happy to print it?-- They probably would. I think it probably needs to be kept current and updated so people can make informed choices.

I am sure The Courier-Mail would be happy to print it once a month, if necessary?-- It is probably not my role to engage with The Courier-Mail in that process. Sorry, but in other states, just to give you the answer, the other states, they provide the surgical waiting lists, which is what we do. They don't provide any out-patients data. The actual-----

They don't have out-patients in the Queensland tradition?-- Well, it is very variable. In metropolitan Melbourne - I know I was there on Wednesday - last Wednesday gone - metropolitan Melbourne - the likes of your Royal Melbournes and your Royal Alfreds - they have quite prolonged out-patient waits in many areas. Other areas in New South Wales - country Victoria has virtually none. New South Wales it is quite variable. Again, it tends to be in the metropolitan areas they tend to have out-patients, but in country New South Wales they have virtually none, and I posed a question in a particular place I was - I said, "If in this town I had failing vision and I needed a cataract operation, and I wanted to see an ophthalmologist, could I come to this hospital and see someone?" - and I'm talking about a major hospital here - and the answer is, "No." I said, "Well, in this town, what role does the New South Wales Government have in saying that you can see an ophthalmologist and have your treatment for free?" - that is to say, "What's the role?", and the answer is it has no role at all. If you have a GP in that town that refers you to an ophthalmologist, they can charge whatever it is they wish to charge. Then if you need an operation, they will

refer you to the public hospital and you get it for free. I guess in Queensland - and again central Melbourne - and it seems to be central Melbourne and central Sydney, but particularly central Melbourne - there is still the option of having it done at no charge; however, as you have quite rightly pointed out, the very great downside is that there are significant waiting times. So, my view would be that it should be people making a choice; that we should put the information out there so they can make a decision, their GP can make a decision. They can make a decision about who they see and where. I mean, ideally, the waiting times in their private rooms would be up as well, but I think that's probably not going to happen and then they make the choice of paying or having it for free.

From the evidence we have heard, and I want to be careful because we haven't heard all of it yet, but it appears to me that Queensland Health's attitude to waiting lists has been inspired by the people who design fashion swimwear. There's no interest in speed or comfort or protection or safety, it is simply a matter of revealing as much as possible that people want to see, and covering up anything that's going to cause public disquiet. I realise you have only been in your present position for a few months, but you don't get 100,000 people on a waiting list overnight. That situation in June last year must reflect years of inefficiency?-- Well, I reject that. It reflects years of unmet need. That's not the same as inefficiency. It may reflect inefficiency or it may reflect a dysfunction between availability and demand.

I don't mean individual inefficiency - I'm sure the individuals are working as well as they can - but inefficiency in a system that cannot cope with its demand?-- I think very clearly the demand outweighs supply. There's no question about that. That's been well-known for many years. Certainly at Princess Alexandra Hospital in 1999, I did deal with The Courier-Mail on a number of occasions about the letters we were sending to GPs about long waits in ear, nose and throat surgery. That was certainly public knowledge then.

See, as I see it, even today, even after all that's happened, if my GP tells me I need, say, a colonoscopy, colonoscopies aren't on waiting list statistics because a colonoscopy is not treated as surgery, it is just a procedure?-- Yes.

I can be sent along to the Royal Brisbane Hospital and I may well be told that I can't even get on a waiting list to see a specialist. When I do get on a waiting list to see a specialist, then that could be two or three or five years, then I have the colonoscopy, and if it is found that I have a cancer or something else that needs treatment, then for the very first time my name will appear on a waiting list somewhere?-- Mmm.

Or my number will appear on a waiting list?-- Mmm.

Surely people are entitled to know how long it is actually going to take between a referral from their GP to receiving

the appropriate treatment. That's what most people in the community have in mind when they want to know how long the waiting list is?-- I think that's a very fair comment. I thought I agreed with that.

Mr Andrews, is that a convenient time for morning tea?

MR ANDREWS: Certainly, Commissioner.

THE COMMISSION ADJOURNED AT 11.29 A.M.

THE COMMISSION RESUMED AT 11.53 A.M.

COMMISSIONER: As Dr Waters is coming back to the witness-box, Mr Farr, I've received a letter from the Director-General, Ms Schreiber, asking about concerns which were raised about the Broncos sponsorship of Queensland Health. I think that is a matter of some public interest, and so the best way to deal with it is to make that letter an exhibit and they can have it on the record.

MR FARR: Certainly.

COMMISSIONER: Perhaps it is worth saying that my concerns are really four-fold in relation to that issue. One is that at a time when Queensland Health has very lengthy waiting lists, it is not immediately apparent to me that there is a need for sponsorship, which is usually a way of attracting customers, rather than dealing with the customers you have already got. Secondly, the cost of a million dollars some people would think could be better spent on providing health care rather than sponsorship. Thirdly, that if there were to be such a sponsorship, it might have been considered more sensitive to have it with a sport that is not male dominated; to choose a sport which appeals to all sectors of the community. Fourthly, that rugby league isn't one of those sports which, given the violence that's necessarily involved in the sport, readily assimilates to the picture of a good health care system. I don't want to sound prudish in saying that - I enjoy rugby league as much as anyone does - but it still strikes me as somewhat inappropriate. But, in any event, I'll make the Director-General's letter Exhibit 296.

ADMITTED AND MARKED "EXHIBIT 296"

MR FARR: Commissioner, you might find yourself in trouble from the rugby league fraternity saying that it is not women that participate in the sport.

COMMISSIONER: Well, it is not women who play it for the Broncos, anyway. I know there are women's rugby league teams.

MARK FRANCIS WATERS, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Doctor, I'm going to be quiet and let Mr Andrews earn his fee, but before I do so, there was one thing I wanted to ask you at a very general level: from the evidence we have heard already, I, for one - and I can't speak for the Deputy Commissioners - am convinced that at least two of the roles performed by your directorate are fundamentally important. I say "at least", because we haven't heard evidence about the other roles yet?-- Sure.

But at least two of them - the Patient Safety Centre, run by Dr Wakefield, and the Skills Development Centre, run by Professor Diver - seem to be doing tremendous work for the community at a cost which more than repays the expense to the taxpayer. Having said that, I'm inclined to the view that those organisations are so useful and beneficial that it is, in a sense, unfortunate that they are part of the public health system rather than part of the health system generally. One of the issues that the three of us have been contemplating and canvassing with a number of witnesses is whether there would be merit in splitting Queensland Health, as it currently exists, into, on one hand, a service provider, which has the job of providing health services to the public, and on the other hand a regulatory body, and you may be familiar with my discussion paper on this subject, but it does strike me that there is a real conflict in having a service provider also acting as a regulator, a conflict in a genuine sense that Queensland Health has a mandate to provide service to the public, and the introduction of the sorts of reforms that your directorate pushes, in the short term, can limit the capacity to fulfil that primary - in the long-run undoubtedly it is going to provide better care, but when one considers that conflict of interest, it seems to me the entire health system in the state would be better off if regulatory issues were separated out from Queensland Health, and it seems to me that at least those two functions, and possibly others - Patient Safety and Skills Development - would be better under the umbrella of a regulatory authority rather than as part of the service-providing branch of government. Do you wish to comment on that?-- Well, you have raised - gone to the centre of a range of difficult issues. First of all, I think that there would be many people who would believe that Queensland Health, as a service provider - there should be some other - I would argue community input into issues around regulation and performance.

Yes?-- I think regulation and performance - I would say regulation and performance, and they are not exactly the same, but you get my intent. There's a service provider and there

needs to be some system for the community to get a sense about performance. That could be at many levels. It could be at the local district level, and I think it probably would be; it can be at an area or zonal level, and again I think it probably easily could be, and then you could also argue that it could be at a state-wide level, particularly issues around safety, the community - I shouldn't use my hands, should I - and I will speak more slowly - a state system, I would think again that you would have not just community, but community and other input into monitoring performance of Queensland Health. If it is the community's money, they should have some understanding of where it goes. That's, to me, an obvious way to go. I am very concerned if - I think that - and it is unfortunate that perhaps in some ways our directorate was formed at this time in life - I'm very concerned if your Patient Safety Centre and your Skills Development Centre and your Clinical Practice Improvement Centre are seen as policemen, it will just stop us.

Yes?-- We should be there to add specific - when I say "we" - they, the workers, not me - the workers should be there to add specific skills, specific focused resources to people to make a difference, to make a change to their practice. At the end of the day - and I come back to some of your previous questions - if at the end of the day in 12 months' time patients aren't receiving different care, nurses aren't doing different things and doctors aren't working in different ways, then it is a waste of time. That would be my goalstand, if you know what I mean. So, it is very important that the doctors and the nurses want to be involved, and I just would - I mean, I don't know if I'm answering your question or not, but it is really important that the Clinical Practice Improvement Centre - and I haven't talked about the Clinical Practice Improvement Centre, and I'm happy to - Patient Safety and Skills Development is not seen as a regulator or an audit function or a policeman-----

Yes?-- -----because people will disengage.

I understand what you say entirely and, indeed, Dr Wakefield made a very similar point. Perhaps it would assist - I did this last week with Dr Wakefield and it may assist to do it again - the sort of functions that I think should be hived off from the service provider are seven in number, and I'll come to those in a moment. Maybe they don't all belong in the same organisation. Maybe there does need to be a policeman, but apart from a policeman, there should be a separate authority to look after issues of improving standards across both the public and private sector, but the areas that I think should be hived off are, firstly, registration and accreditation?-- By "accreditation", you mean accreditation of hospitals or accreditation of credentials?

Of medical practitioners?-- Registration and - okay, the registration process.

Yes?-- Not accreditation. It is just words we use in Health that have been - "registration" I understand.

Yes. But to pick up on your point, if it is the one I think you are making, I think one of the difficulties we have identified in these proceedings is that credentialling and privileging within Queensland Health is treated quite separately from registration with the Medical Board, and that seems to me to be a quite illogical - if someone has been approved for an area of need, and Dr Patel is a perfect example of this, if he's been approved for an area of need, it should be on a clear understanding of how his services are going to be utilised in that area of need. The Medical Board understood that he was going to be a staff medical officer under the supervision of a Director of Surgery. He winds up at Bundaberg as Director of Surgery under the supervision of nobody?-- Yes.

So, there needs to be some integration at least in that aspect?-- Yeah. I guess, Commissioner, I would think that what - an alternate position is that we shouldn't allow the people that provide the service to be in, if you like, the conflict around whether they credential them for various things, because the pressure to credential outside what should happen is so intense because you have got to provide the service. So, I would think the credentialling process should be done by a group of, if you like, health experts, but providing a service, I would think, throughout a zone or an area or whatever, but not locally, because Bundy - I mean, what might have happened would have been Dr Patel would have been registered, then the credentialling process - what he could or couldn't do would have been, for example, out of the Royal Brisbane Women's Hospital, because it is the hub for the central zone. I guess the alternative would be to do it actually directly within the Medical Board. I'm just - I just don't understand how that could happen to do it.

Well, without wasting a lot of time on the fairly tentative ideas that are going through my mind, I would have thought the Medical Board or its equivalent, whatever is going to be there in the future, would do two things: (1) is to give a registration in a formal sense?-- Yeah.

But also to have the role of getting feedback regarding credentialing and privileging so that when a person has been approved to practise in a particular area, it is not just a carte blanche to do any sort of surgery?-- Sure.

If we're talking about a surgeon?-- Sure.

It is an approval which is subject to the accreditation process or the credentialing/privileging process taking its course?-- Yes.

The second area that I think should be hived off from Queensland Health is complaints handling and we've tentatively talked about the idea of having a health sector ombudsman who deals with complaints from all divisions of the health community, whether it is public hospitals, private hospitals, GPs, even perhaps allied health professionals, not necessarily to investigate those complaints, but as a central body which the entire community know they can go to if they complained and it will then be referred to the appropriate person to investigate and deal with, whether that's the medical superintendent at a hospital or the chief of a private hospital, or a functionary within Queensland Health, but as a central collecting point for complaints, and also a follow-up system so that when a complaint has been logged and passed on, the ombudsman will then follow up we might say six weeks later?-- Sure.

And say to the medical superintendent, "What's happened with that complaint? What outcome or resolution has been achieved?", and ultimately with the fire power to be able to refer it up the line for further investigation or handling at a later stage. The third branch that I think needs to be hived off from Queensland Health is what I am tentatively referring to as the clinical audit and inspectorate. One of the difficulties that the management at Bundaberg had is that there was no straightforward system for having either ongoing monitoring of performance or having a flying squad come to deal with a particular problem when it arose, and, again, I think there is a conflict of interest in saying Queensland Health does that because it is in Queensland Health's interest not to rock the boat. The fourth category I have called as a working model research and statistics, which I think fits in with what you were saying about dissemination of information and providing feedback to the community as to whether hospitals are performing effectively, and so on. Again, there is an obvious conflict in letting Queensland Health be its own monitor. Five I have listed as mediation and dispute resolution, which is currently the primary function of the Health Rights Commission. I think that's something that should not be lost from the system, because so many disputes

can be dealt with with goodwill and with the interposition of someone who is trained and experienced. The sixth category is institutional standards, and I embody in that both private and public sector. One of the surprising things to emerge from the evidence of Dr FitzGerald is that his office, as Chief Health Officer, can impose standards on private hospitals which have to be accredited and receive annual reviews, and, yet, patients in public hospitals don't have that same measure of protection. And the seventh category I have listed as professional standards and discipline, which is again part of the current role of the Medical Board of dealing with that hopefully very small proportion of cases where things have to be taken further. Now, that's just a working list, doctor, but the real point I was asking you about is things like Patient Safety Centre, Skills Development Centre and Clinical Practice Improvement Centre would fit, I think, better into that model of a standards which is separate from Queensland Health rather than part of the organisation silo of the service provider?-- Well, I think it is a difficult definite answer to make. Having listened to what you have said, I would just urge caution if we have to get the staff to trust that we're trying to help.

Yes?-- I mean, working back a different way, what's the function rather than - then you can work out what the structure is.

Yes?-- We must engage our staff to want to contribute to change, to improve and to volunteer data and trust us.

Yes?-- So that's the function.

Yes?-- I don't know how - then how you structure it depends on, you know, where you go with the rest of it.

Yes?-- But if it is linked to, for example, clinical audit and inspectorate, I think.

That's got the-----?-- That would be terrible. I am telling you, they won't be involved.

Yes. Whereas if it is part of the search and statistics or something like that?-- Something like that, that might be a very different-----

It is quite benign?-- That's a different sense, if you like. Can I comment on any of these, or not?

Please do?-- Just in terms of a couple of things, the health sector ombudsman, it has been my experience - and I think there is some data around this - that complaints are best managed quickly and locally.

Yes?-- By trained people who are trained in complaints management, in open disclosure and investigation. So all I would urge is that whatever you come up with, there is a local immediate resolution process, obviously with feed up the line, because it is useful - I mean, complaints can be a great

source for quality improvement, for example, but I would urge that the quicker - I mean, when - when I get complaints I try to see whoever the complainant is that day, the next day, certainly that week.

Yes?-- Face-to-face.

If I can just engage with you for a moment on that, certainly statistics I have seen from within the private sector, the medical malpractice insurers suggest that efficient handling of complaints can save literally hundreds of millions of dollars in litigation costs, if nothing else?-- That's - there is good evidence on that.

Dealing with people quickly and efficiently is the ultimate, but the problems that we've encountered during this inquiry is that whilst, for example, the PA may have a world class complaints handling system, and on the evidence we have heard it apparently does, Bundaberg didn't have that?-- Yes.

It didn't have the right personnel to deal with things and patients were left in the situation, patients and patients' families were left in the situation where they got no feedback at all?-- Sure.

They got no sense that their complaints had been even taken seriously, let alone dealt with and addressed. I would strongly favour a model which allows each institution to deal with complaints at an institutional level but there must be a body which people can go to-----?-- Sure.

-----with their complaints, and one of the problems we have seen is people who have had complaints, including complaints from Bundaberg, specifically relating to Dr Patel, who having no satisfaction at the hospital level go to the department, they are told they should be speaking to the Medical Board, they go to the Medical Board they are told they should be with the Health Rights Commission, they go to the Health Rights Commission and they are told they should be with the department. There needs to be transparency. You had some other comments, doctor?-- No, look, I think - sorry, the other thing is professional standards and discipline. I don't know whether John - I couldn't see the transcript from Friday, so I just don't know what he raised.

Yes?-- There is a real issue which he and I have been trying to resolve for six months now, frankly. I know that's slow but we couldn't find an answer, this issue of clinical competence.

Yes?-- And we just - we have discussed some stuff with New South Wales and they really seem to have gone along the path - they have got three lines: they have got disciplinary action, they have got incapacity for - if the doctor's got a particular medical or dependence problem.

Yes?-- And they have got a competence area. So they have got three strings to that bow, and I would suggest that that's a

significant benefit, if we can go down that path.

That's very useful. We've already heard from the Medical Board, and from what evidence we've heard, I am convinced that they have two of those strings very, very well tuned at the moment?-- Yes.

Where there is an incapacity problem, whether it is through ill-health or addiction or whatever-----?-- Yes.

-----they have the systems in place to bring the lost sheep back into the fold, which is in everyone's interests, but they also have the capacity to be the policeman and to bring the charges if necessary, in a case of genuine wrongdoing, things like fraud and sexual interference with patients. But there is presently no-one who seems to have control over this clinical competence issue?-- Mmm.

One of the things that surprises me, coming from outside the medical profession, is that we lawyers are required to renew our practising certificates annually and to prove we have participated in appropriate professional development during the preceding 12 months. There seems to be no equivalent to that in the medical profession. I know that that isn't a guarantee against incompetence but it is at least a step towards ensuring that there is appropriate monitoring of ongoing professional development?-- Mmm.

I don't know how you feel about that?-- I think that the issue of monitoring and professional development is a difficult one. I think there is - some of the colleges do run professional development-----

Yes?-- -----documents. The issue is what if you don't do it and doesn't seem to be any result if you don't do it.

Yes?-- I guess that is another - I mean, I would actually argue we need to do multiple things to improve the quality of our care, all sorts of issues, registration, credentialing, continuing education. I think we need a system to tie some of the things we do and measure variances. I think - and, again, I am sorry I didn't read the transcript from Friday - I couldn't get it up on the weekend - but we really aren't cutting edge in terms of how we run our organisations. For example, the clinical practice improvement centre, what it is really trying to do is get groups of clinicians, like the cardiac collaborative and the renal collaborative to actually join together - can I give you an example of the cardiac collaborative, just to - what it is trying to do?

Just slow down?-- It goes to the heart of the clinical audit and inspectorate. The cardiac collaborative, it started in Ipswich as a very small thing in 1996, and then it went to PA, and now it involves 24 hospitals in Queensland. Okay.

Yes?-- So what it does, it gets groups of doctors and nurses together to look at those things that actually make a difference. For example, we know that if everyone who leaves

a hospital is on - who has had a heart attack who is on three particular drugs, aspirin, a betablocker and an ACE inhibitor, then they actually have better outcomes. We also know when we started doing this process, in fact only about 60 per cent of patients who should have received all these treatments were receiving them. Through a process of joining together, measuring those processes, giving feedback every three months to the participating hospitals, that has dramatically improved. In fact, the results were published in the MJA last year. I haven't got the results in my head - the MJA 2004 - and it was Scott Ide, who was one of the authors, if you want to look it up, which showed dramatic improvements in death rates and congestive heart failure because we have systematised what people do, we have easy scannable forms so there is not lots of paper to flow, and we feed back to doctors and nurses what's going on, and we have found that feeding back to people the best result. Doctors are terribly competitive. Feeding back to people the best results in an open way dramatically improved results. So, for example, with Dr Patel at Bundaberg, one option would be, which we are keen on progressing because we think it works, is having, for example, in the central zone, for example, which is the Royal Brisbane right up to Rocky, whatever, a collaborative around surgeons, and the surgeons meet every three months, they submit their data on infection rates, complication rates, death rates, et cetera, et cetera, et cetera, to them and they constantly feed back. So that what you get over time is a standardisation around the best practice. Now, that seems to work in the medical profession, and that data - I haven't got a copy of the article with me but it is the MJA - shows quite dramatic changes. We have done it with the renal collaborative, we now have a standardised system. Every renal physician in Queensland has now agreed on how to manage dialysis.

Doctor, the problem, as I see it, with all of that - and please understand I am not in any sense downplaying the importance and significance of that - but whilst it remains voluntary-----?-- Yeah, yeah.

-----it is going to be at best an advantage, at worst an inconvenience for people who are competent, and it is going to do nothing for those who are incompetent. And I draw the analogy from my own profession. When I started as a barrister 25 years ago attendance at lectures, and so on, put on by the bar association, it was entirely voluntary, and you saw the same people there again and again and they were all the competent ones. Mr Andrews was there, Mr Farr would be there, and so on. All the competent ones turned up?-- Yes.

Now it has become compulsory and people don't like it, they complain, but at least it is drawing the net around the entire profession and what you say about Patel I think is a perfect example. We've heard again and again about how Patel dissociated himself from the rest of the profession, didn't participate in a meaningful way in forums and M&M meetings and that sort of thing, didn't communicate with his opposite numbers in other hospitals and so on. If there is a voluntary

surgeons' group or surgeons' forum, it is not going to catch the Jayant Patels?-- Sure.

It is certainly going to involve those surgeons who have given evidence already and who are undoubtedly of the highest standard of competence?-- Sure. Look, I think that in Queensland Health - and I think you raised the issue with the private sector, which is interesting - in Queensland Health we could make those sorts of processes conditions of employment, and a condition of indemnity. The other thing that we are doing with the College of Surgeons Clinical Practice Improvement Centre has met with Dr Stitz, who is the Australasian present College of Surgeons, to introduce a mortality audit, both public and private. Again, I know should have done it but it will be up and running at the end of this calendar year. The question then is - it is a major question - is that voluntary or is that compulsory, and I think that's a struggle all health organisations are having in this country, and it may be the time to make it compulsory. Certainly in Western Australia, where it has been running for a number of years, it is still voluntary and that has raised some of the issues you have just described.

Doctor, that really leads me to another question. We have heard numerous complaints from people at all sorts of levels within Queensland Health, from District Managers down to Directors of Medical Services, Director of departments within hospitals down to individual clinicians that there is this bureaucratic gridlock within Charlotte Street - I don't suggest for a moment that's a feature of your directorate - no-one has suggested that, and I don't know - but on issues which are classified as policy, in inverted commas, it is just impossible to get a decision promptly and it is even more, if that's not a tautology, even more impossible to get any transparency, any window into the decision-making process. So that if - to take as an example Dr Johnson, the medical superintendent at Townsville, has a proposal, he came close to saying - and I don't want to put words in his mouth - but getting forgiveness is much easier than getting approval, and he put it in place, and wear the consequences. Has that been your experience whilst working in Queensland Health?-- Dr Johnson and I have discussed these matters at length over many years.

Yes?-- I am probably not the best person to ask because I am not - the answer is it is sometimes better to act and then see how you go.

If that's happening, isn't it better then to formalise the system and give the Andrew Johnsons of Queensland Health the authority to make decisions, subject, of course, to review and guidelines, rather than maintaining the pretence that Charlotte Street actually has its finger on the pulse of however many - 120 hospitals throughout the State?-- Look, I think - my personal - this is a personal view, personal view. Queensland Health is too big, too centralised. All decisions - I have been very privileged to be part of another review process over the last few months, so I have spent time in

Victoria last week and New South Wales the week before. There are many things about Queensland that other States are envious of. They are absolutely envious about some of the things we have centralised that are of enormous benefit, like information technology. In other States they have different systems in every area. They can't even talk to each other about who is admitted in hospital. We have made some real benefits in leveraging our size in terms of purchasing. For example, we are contracting actually much more efficient here than in other States, where, if you like, Johnson & Johnson - I will retract that - a major multinational - any major multinational can deal with a particular district - again, I will use your analogy, Mt Isa district and other States, whereas here the price that Mt Isa get is the price that all of Queensland gets, so there are enormous advantages. However, there are some downsides to centralisation and slowness with decision making issues, about transparency with decision making. New South Wales has just gone to a process of having a very decentralised model with 17 areas, to the middle course of about eight areas of about a million people. They have kind of gone from, if you like, the right-hand side of the spectrum of a very decentralised model, if you like Queensland Health is at the left end of the spectrum, which is a very centralised model, and I guess New South Wales has argued its gone some way in between, and I would argue that we have the bones of a process to do that in Queensland, where we actually have what we currently call zones which are of about one million people. But, really, they are very variable in resources, they are very variable in what they do, and it might be that there may be a process whereby the sorts of decision making and planning that you talk about, Commissioner, could be done at that level. For example, it would seem to me to be eminently sensible that Townsville takes a lead role, if you like, in the northern zone in the planning and whatever. To answer your question, Dr Johnson, if he just makes individual decisions, just about Townsville, and treats Townsville, fine, but Mt Isa closes - I am not sure we've progressed much for the rest of the country - you know, of the whole population. Because PA and Royal and Townsville they will be - well, particularly PA and Royal, they are in Brisbane, they are prestigious organisations, they will do okay. It is about how we get the rest of the State assisted.

Well, one thought that has crossed our minds - and I am really only thinking aloud; I am not suggesting for a moment this is the direction we will go down - is that there is only - it is a finite limit to the amount of budget funding available for medical care. Maybe the way to ensure that that is channelled towards clinical care is to abandon this system of historical funding-----?-- Mmm.

-----to go to a modern, sensible demographic-based funding scenario?-- Yep.

And to have the Queensland Treasury decide hospital by hospital, district by district how much money is going to be available. Bundaberg gets 80 million or 100 million, whatever the figure is, and the management at Bundaberg, whether it is

in its current form or with, you know, new immunity-based form, decides how best they want to spend that money. And if that involves having three surgeons rather than two but having fewer physicians or fewer physiotherapists, or whatever, that decision is made at local level. Now, I would accept that any such system must be conditional upon central control over various issues, and the sort of issues I have in mind are - I think probably the obvious one is financial auditing - has to be done from headquarters, information technology has to be centralised. Perhaps controversially I would say recruitment. I think that's one area which does need to be transferred from the provinces to a central organisation. Clinical auditing standards needs to be centralised. Industrial relations perhaps most importantly of all. You can't have each hospital negotiating separate awards for its own district, buying equipment, stocks, medical stocks, linen, everything else, should at least be offered through a centralised facility, and planning has to be centralised. On top of that I accept that there are some current functions of Queensland Health which can only sensibly be conducted on a Statewide basis, and that would include programmes like anti-smoking campaigns, public health and welfare campaigns generally, issues like indigenous health, the breast screening campaign, those sorts of things that have to be done centrally, but the sort of model that I am becoming more inclined to is to say to district management, "You do everything apart from those powers that are specifically reserved to Charlotte Street." The Minister or an appropriate authority would be able to say by regulation, "You must buy medical stocks through a central purchasing authority." But it would be on the basis that the districts do everything other than those functions which are specifically taken away from them, rather than the present system, which is Charlotte Street does everything other than what it is prepared to delegate to the districts?--

And I my response to that would be it's a balance, isn't it, what you've described. The only thing I would say to you is if there was a perfect way of doing it, then we would all be doing that across Australia.

Yes?-- When you go to the various states, you find Western Australia has a regional area type environment. South Australia has just changed again and I'm not quite sure what this year's model is. Victoria has stayed with boards, isolated boards, and they've got 100 them and that raises all sorts of benefits and problems.

Yes?-- New South Wales is just restructuring as we speak into the area model. So I would say, Commissioner, that again if we - if you or the Commission determine first the functions.

Yes?-- Then determine the structure.

I guess - needless to say, we've looked at models in other states and territories but I guess one of the points that has to be made is that it's not a one size fits all situation. Queensland is unique in many ways and probably the most important is the decentralisation of population and industry and that makes it all the more surprising that we have this centralised health care system. We have got a state in which - and I imagine Western Australia has comparable situations but we have got a state in which at a hospital at, say, Torres Strait or at Weipa, is dealing with an area the size of Germany. It is very different from Victoria or Tasmania-----?-- Yes.

-----where you can't drive for 15 minutes in any direction without moving into another hospital zone?-- There is no such thing as rural Victoria, I understand.

D COMMISSIONER EDWARDS: Dr Waters, I support generally the concepts that the Commissioner has said. The only thing that concerns me is that there has been a lot of experience in other states and in Queensland where regional and down to service level that budgets have just gone totally out of control, that - and therefore one of the reasons given for centralisation is budget control in a limited budget sense and all this has caused enormous problems. First of all, do you have a comment on that, and perhaps I can ask another question after you make-----?-- Sure. I have a problem with - well, my answer to that is that the issue of budget is a secondary question. The primary question is an issue of scope. At the moment as I understand it, and I've worked for a while, that Queensland Health promises to the Queensland community to do all things to all people at all times and yet, clearly, it has a defined budget. I think that is the root cause of any of the cultural issues that we deal with. When you have, if you like, fundamentally conflicting pressures, then I believe you get workplace dysfunction for a whole range of reasons, not because people are bad, not because they wish to be like this but because of the pressures on them. It was utterly paradoxical when I worked in the private sector where that whole conversation doesn't exist. In the private sector when

you are busy, you get paid additional funding from your health insurer. So issues of resources become simply an issue of if you can produce the product, if you like, at a price less than you're being paid, if you can produce what you're doing at a price less than you were being paid, then the busier you are, the better. I mean, it's - and all of these incredible perverse incentives we have in the public sector just don't exist. So my first answer to you, Commissioner, would be - Assistant Commissioner, would be that someone, before they discuss how to manage the budget, should discuss how to manage the scope because otherwise it's a bit like the conversation we had before about waiting lists. Rationing now occurs, it must occur, obviously it occurs, because we have a - we have a defined budget. But we haven't defined our scope. At the moment, rationing in my view occurs by individual clinicians, by individual District Managers. Now, often it occurs in a very sensible way and I don't wish to diminish that but sometimes it doesn't occur in a sensible way or in the most sensible way. So I'm sorry for being longwinded but I just can't answer the question about budget without - I mean, money to do what? Staff to do what? What is our scope? What is our plan? Because if we know what our plan is, we can determine how much money we need. Who are we treating and for what? And then we can determine how much - and to answer the other Assistant Commissioner's question before, if we determine what it is we wish to do so, then we can also determine how much money we need and we can also determine what staff we need but if we don't start at the beginning, then I would ask to do what? At the moment it is to do everything and I would suggest, Commissioner, you have heard many stories which are very distressing about how staff are distressed and certainly not part - I'm part of this other review which says our staff are distressed. Well, that's not because - personally, I do not believe it is because people are evil and bad. I believe they are put in a difficult - extreme, difficult situation. So I'm sorry for that long-winded answer-----

No, no?-- So to get back to your real question, I believe it is about values, okay. If we get over this issue of scope, and I don't think we should get over it but if we choose to get over this issue of scope, then it is about values. You can train and mentor leaders and they can accept the accountabilities around budget whether they are at Biloela or Bamaga or Royal Brisbane, or Charlotte Street. I would also say to you that budgets are managed by change in clinical practice. They are not managed by accounting. So I have a view that people need to understand the business they're in if they want to stay within their budget and, in fact, the more remote you are, the less likely you can do. All you can do is measure what's going on. And I have an analogy, if you like, that I use: you can determine exactly when the train is going over the cliff; you're just not in the engine and you're not pulling any of the levers. So I would argue the only way to manage budget is locally and, in fact, that's actually what happens because there is no other way of doing it. That would be my view.

My second question is if you - I guess this comes from another life that I have had but if you go to any centre in Queensland, they all want almost an MRI in every centre?-- Yes.

Yet it seems as well from the reviews we're doing and what information we've been provided, that there's really no long-term plan or scheme for Queensland relative to the scope of services that will be, for example, provided at Bundaberg and if those scopes are clearly defined, then perhaps the Patel doing a massive surgery would never have occurred and I'm just questioning you whether there is a program within scope of surgery - scope of surgery and scope of services is determined by head office and how that operates?-- Okay. Well, you asked-----

And should-----?-- I think you asked two questions. One is - the first is are there any frameworks for what should be done at particular hospitals and the answer is that there is a Service Capability Framework which is a guide. I think that's a lesser question. The first part of your question was everyone wants an MRI, is there a health services plan which defines the scope of what we're trying to achieve, and I would argue that there is not. In fact, I might try to - I was really making that point very strongly before.

I don't think you have to convince us?-- No, okay. I guess the other thing too is I would take some exception to the issue of developing budgets based on demographics. I think we should be developing budgets on the burden of disease. Burden of disease is a combination of demographics but takes into account private/public mix, age and things like Aboriginality, and I don't know how much the Commission has heard about where we're up to with Aboriginal health but, in fact, it is not terrific. In fact, it is dreadful.

COMMISSIONER: Doctor, I should make it clear that I was putting that very much in shorthand. I would accept that any proper demographic analysis would include not just the number but the age, the socio-economic position and most fundamentally of all, the health care needs?-- In fact, the burden of disease focus on the health care needs to because if we look at burden of disease now, we find in Queensland, and I think this was written about in the - in the other report, interim report, we have major issues with cardiovascular disease and mental health, and mental health is the growing sleeper if you like, and of course wherever you turn, we know, and I think everyone - I hope everyone here agrees, that there is a subgroup - subsection of our population that dies on average at the age of 50, and by that I mean the indigenous population, which is really I would have thought fairly unacceptable. So I would argue that there is an urgent need to have a health services plan but I would argue that means that we must engage with the community to clearly talk about scope and I'll use the R word - that means rationing. That means Queensland Health will do some things for some - well, for some people or at least some things and it will not do others. I just don't know how we can progress there. We

can't talk about budgets. We can't talk about culture. We can't talk about reform if we haven't said what - if we say that the task of people in Queensland Health is to do everything for everyone, then I think we will not progress.

I suppose though, Doctor, that approach - no-one would disagree that what you say is logically sound and correct. The real difficulty is that there is a finite budget?-- Absolutely.

The taxpayers of Queensland currently provide I think it's $5.3 billion or something for the health care system. One hopes and prays that's not going to reduce but it's not going to increase - it's not going to leapfrog. There will no doubt be annual increases and as I - the important thing as I see it is to get as much clinical services at the best possible standard you can for X number of dollars and I know I've said some intemperate things over recent times but ultimately I do find it very frustrating that such a large proportion of that budget seems to be spent on doing things other than providing services to patients. Doctor, I want to say, because there was an exchange earlier to which this is relevant, I see my role in this inquiry is to sit here and ask exactly the questions that the people of Queensland would like to ask-----?-- That's right.

-----if they had the opportunity and the knowledge to do so and I think the people of Queensland really do want to know how we can ensure that out of that $5.3 billion, there is going to be more spent on doctors and nurses and waiting lists rather than reports that no-one ever reads or frameworks that individual hospitals don't even have the funds to implement?-- Commissioner, I have spent 25 years delivering health services and six months in Corporate Office, so either I have got a very short memory or I would share many of your views.

Yes, yes. One way it seems to me that it can go towards achieving that is to earmark dollars at the source and say that, "This $18 million coming out of Queensland Corporate for 2005/2006 is going to be spent on clinical services at Bundaberg. No-one else can touch it"?-- Yes. I guess - and that may be one way of doing it. I am concerned that it is - it is just too complex and difficult and again I would go back - I would go back and this is - this is Mark Waters' personal view, that in 2005/6 we need to be aggregating to be saying - the same sort of thing you've said, which is that, "This money is for clinical services only. Musn't be touched", but that I would allocate that to a bigger group. I would allocate that to, for example, a group of about one million people. Because with one million people, you can run systems, you can get patient flows all linked so you're not mucking around transferring money back and forth following patients, the patient stays within the area. What you want to do is minimise transaction costs. We want to maximise how much money we put and to where we go and minimise all the - I use the word transaction costs. We understand what-----

Yes?-- So I would say that we need to aggregate to that level

at least and there are some pretty obvious aggregations.

Well, Doctor, I have to admit you're very good because you've anticipated the next point that I've spent three months cogitating on and that is that if you're going to have divisional management by - to look after the rural and regional hospitals, you need at the same time to have zonal budgets. We've now got the three zones and from all we've heard, they work extremely well and have a zonal budget for the - let's say the central zone running from the Brisbane River to Rockhampton?-- Sure, whatever.

And that zonal budget is to run the referral hospitals within that - within that zone and to run the retrieval and so on to provide the extra services that-----?-- Sure.

-----the regions themselves can't provide?-- That makes sense.

And that would fit in at least approximately with your model of a million people?-- Sure.

So you'd have the state with three zones for what would I say, zonal expenditure, expenditure that is for referrals, retrievals and essentially providing services which can't sensibly be provided at a local level?-- Yes.

D COMMISSIONER EDWARDS: The question I was going to-----?-- Sorry, did I answer-----

Yes, you did. The only other question I would like to follow up is the flexibility in local budgets to which I referred earlier is something that has been continually referred to us - to which has been referred on a number of occasions over the last couple of months. Can I ask you, have you a view as to how flexible they should be in light of demands and audit and accountability and as I referred to this, and I think I'm repeating myself a little, but I think it is one of the vital issues for governments to make sure that every dollar is spent appropriately but also to get the best value and I think some of the things we're finding is that that best value is not necessarily coming from every dollar as a result of the tremendous audit controls, approvals and so forth. I just want to clarify that matter if there's a simpler way by which we can get the best dollar spent for the best outcome for health programs?-- I would say to you that, and I'm sorry for being boring but it goes back to scope as I said before, and I just want to clarify something. I was a District Manager at West Moreton for three years and PA for three and a half years and then Royal Brisbane seven months, so probably six and a half years. My delegation in that time was I could spend pretty much, as long I didn't - you know, did it appropriately, I could spend - make decisions up to $400,000, and I did that all the time. That wasn't the problem. The problem was that many districts don't have the money to spend, okay. So it is not that there's not a delegated authority to make a decision. It's that if you are in the red if you like, if you are over budget, then virtually every decision you make

to spend more money after that really transgresses, you know, financial - I mean, if you're in a private company and you're a director and you keep spending money after you don't have any, you actually go to gaol. So the problem wasn't in the local - in my view, the problem wasn't in the local decision-making delegation. It was in the - actually having the funds to spend. So to me, unless we can ask districts or zones, or whatever it is, saying, "This is the amount of money you have and this is the - what we want from you. This is the scope of service. This is the volume and type we want", then there is always more work to be done. I mean, clinicians will always push to do more work. That's what they're trained to do and that's why they play such an extremely important role. So if at the beginning of the year you expand your offices because you think it is important for example and you then are running on a month-by-month at budget or over budget, then effectively it doesn't matter what your delegations are. You can't make any more local decisions. So I think it is a matter of scope-----

COMMISSIONER: But, Doctor, you really identify what I see as being the present problem. It's pointless saying that Peter Leck in Bundaberg has a delegated authority to spend $250,000 as long as the money is there-----?-- Yes.

-----without giving him the money to spend?-- Absolutely. If he's over budget, it is a null hypothesis. It just doesn't go anywhere.

Yes, yes. That's why I personally favour the idea of earmarking the funds and saying to the person who is making the decisions for the Royal Brisbane Hospital, "You have this many million dollars to spend"?-- But they get that now.

Well, they get it now, they get it now in a practical sense in two ways: the direct budget plus their share of what's spent at Charlotte Street and if they want some of the Charlotte Street money, they have to go and ask for it?-- Okay. I think my response to that would be health - without definitions of scope, then health will - I think you mentioned before that there will always be limited resources.

Yes?-- It is my view that we can provide in health virtually unlimited demands on the public purse.

Yes?-- And someone has to make a decision about where that boundary is. As you would well know, in the United States they spend 14 and a half per cent of GDP on health. We spend about 9.2, and the United States is a pretty big place. They actually have pretty - not so good health outcomes I have to tell you.

And they don't have a public health system?-- No, they don't - yeah, that's right, they don't have particularly good outcomes in many ways. So whatever it is we do and however much we give people, unless we tell them when they've done a good job, then they'll always be on this boundary of expansion which will always lead to this, if you like, paralysis -

that's my personal view - at a local level. So for example, Commissioner, let's find a lot of money corporately and give it to the districts.

Yes?-- That will fund that once.

Yes?-- And you would give it to them once because you won't, presumably, find more people all the time. Perhaps you would but perhaps you wouldn't. That would be good, perhaps, for one year which at the end of that year services will have expanded because we haven't told them what their job is, we haven't told them what their scope is. So for a year, happy days. The next year they would be on - bumping up against the budget again and then we'd have this paralysis decision making. That was really my point.

Doctor, you will have to forgive me but I really don't understand, though, how you define the scope of service on a statewide basis beyond saying the function of Queensland Health is to help sick people and try to make them better?-- Yes.

Once you go beyond that, we know that Queensland Health, by and large, isn't known for face lifts and tummy tucks. Once you leave out cosmetic surgery and things of that nature-----?-- Yes, yes.

-----how can you draw the line? Can we really say to the community, "Once you get to 90 you're not worth looking after"?-- Commissioner, I want to make it really clear I do not have the answer to that question and I think it is the obvious question and a relevant question. I'm just saying, I'm just suggesting, that at least it would be more overt. Okay. Be like putting the waiting lists on the Internet, then we would tell the Queensland population, "This is what your government will pay for. These are things we won't pay for", and then, within that organisation, our staff would know when they've done a good job. At the moment, what they are to do is more. That's the answer. More. And that's difficult and we're talking about cultural change and I think this issue has been change about conflict-----

Yes?-- Difficult to manage an organisation unless there is some rational process for managing - aligning demand with revenue.

Doctor, I cannot disagree with your logic, no-one could fault it, but it just strikes me as impractical to say, "Work out what the scope of service is and then provide the funding", because it just doesn't work like that. Queensland Health is like a very big family that is only going to have so much each year and they have got to make it stretch as far as they can. You don't do the family budget by starting off saying, "What are your aspirations for this year?" "We would like to have a holiday in Europe. We would like to send the kids to private schools. We would like to do this and that, a new car and a new home." You say, "How much we have got to spend? Let's make sure we get the most for every dollar", and that's why I

think, you know, as a practical solution to the problems that confront us, we have got to look at seeing that every dollar produced is the most in terms of clinical service?-- I think we have to do that of course but I think we have to do more than that, but we disagree. And by the way, I can't tell you where it works well because it doesn't. I guess what I'm suggesting is that the last 10 years has seen an unparalleled expansion of medical technology. We can do now far more than we dreamed of 15 years ago. It is just possible. The question is can we afford it? The questions for me are can we afford it and, more importantly, who makes the decision about what we do? My own view is the community should make the decision. Democracies aren't perfect but they're better than most of the alternatives and I think this is fundamentally a question for the community to engage in, otherwise it is the medical profession and the nursing profession in our public hospitals that are caught in the middle and I think that's where the issue is.

Doctor, let me try and define this debate by giving you what I think is a very central example taken again from the Patel incident, because that's what we've heard most about. Under the current funding arrangements, if Patel finds someone who needs a Whipple's procedure or an oesophagectomy, they may be on death's door; they may have six or 12 or 24 months to live. That being a particularly complex operation, the patient being in a very unwell condition, that brings in a lot of additional funding for the hospital. That seems to me so utterly counterintuitive to a rational use of budget allocation. A rational use of budget allocation would involve the management of Bundaberg saying, "What can we do to provide the best service with the limited funds? And what we can do is have lots of endoscopies and colonoscopies that will provide early detection of conditions and early treatment rather than doing very difficult operations which are unlikely to be successful on patients who don't have long to live anyway"?-- Commissioner, we ran a hypothetical at the PA in about 2002. That mightn't be exactly the year but around 2002, hypothetical at the PA. And the hypothetical was that I have lung cancer and I can come in and get seen and I can have surgery and chemotherapy and radiotherapy and that will happen emergently. Despite what you have heard about waiting lists, if you have cancer you get seen and treated. That was one. The other scenario - they've made it really easy for me - I have been a person helping out at the PA, a pink lady, for many years now. I am getting old and I have helped the PA for 20 years and now have a painful hip and I need a joint replacement and I am going to wait three or six or twelve months for a joint replacement but I'm in a wheelchair and I can't get out of my home, so I need Blue Nurses, for example. That's just a scenario. Now, the first case - and the lady making the hypothetical - it was a hypothetical, but my neighbour was the lung cancer labour who has been smoking all her life. What actually happens is that the lady with cancer comes in, gets seen, gets treated, subsequently dies because of the particular types of lung cancer are very difficult to treat-----

Yes?-- -----versus the lady with the hip who is at home in a wheelchair but is not in a life-threatening position waits. They're the sorts of dilemmas we face and I would welcome some enlightenment on how to work our way through that because now those sorts of dilemmas are facing us every day. There is a new drug coming out of genetic modification to do with the metabolism of copper and I won't into detail about it but it costs $300,000 per patient per year. Now, where are we going with this stuff? I'm sorry, I probably - this is not the right place to raise this stuff but this is stuff that's happening all the time, and I think we have got to go to the community because I can't think of anywhere else to go.

Well, let's agree on that at least. My strong view is that community judgment should be the local community. There is no efficient function for the community at a statewide level to make that sort of judgment anyway other than through the polling box every three years. But Queensland does have a long history from the 1930s through to the 1980s or the early 1990s of local communities deciding their own health care priorities through hospital boards, and in a world that doesn't provide a perfect solution, that seems to me as close to perfect as we can get?-- Yes.

Do you feel differently?-- The answer is that I think there is no answer.

Yes?-- To be honest. My view is that maybe we should have a state health advisory group advising Queensland Health on policy. And how you do that, the mechanisms of that are difficult, but I would think that that would be a very useful exercise to engage in. And that that group should look at quality issues as well, performance issues but - see, I think we need to - the people who are paying the money are the taxpayers; therefore, I think we should engage them as much as we can. I think - I just don't know how Mount Isa local groups, I just don't know how they're going to get the information and knowledge to make those sorts of decisions that we discussed. I just don't think it's possible, but it may be. In the absence of to find a better way, I'd accede that that's one way.

I would think that there is enough commonsense amongst the Burghers of Mount Isa that when they get the hypothetical situation you described, they might make the right decision or their own community rather than the wrong decision based on a Queensland Health directive that says you get-----?-- Sure.

-----money for the lung cancer patient but nothing for looking after the hip replacement?-- I'd be - the answer is probably yes, I don't know.

D COMMISSIONER EDWARDS: And following one other question, if I could follow up then, how restrictive therefore is the Medicare agreement on those decisions to which the Commissioner has just referred? As I understand the Medibank agreement, there is an enormous amount of argy-bargy in the development of the budget, the guidelines, so that it is

fairly restrictive as to expanding services and so forth?-- No, my understanding is that there's the Australian Health Care Agreement, AHCA I think it's called, and that's where the Commonwealth provides funds to Queensland. Queensland Health does not really participate in Medicare. That's a private arrangement for paying doctors and it's not - it's not particularly restrictive, as I understand it. That the Commonwealth provides to the Queensland government a bucket of money. That is then-----

Not earmarked?-- The quality and safety money that we have used for some of our initiatives, that's earmarked for quality and safety, or certainly in Queensland ever since 1999 we report back about how we spent it. It is not supposed to be for health services direct, but generally it is not earmarked, no. My understanding is, and I'm not an expert in health financing for the Commonwealth, but my understanding is it is much less restrictive than it used to be.

COMMISSIONER: Mr Andrews, I thought I was going to give you a free go for that session. I think we had better have a lunch break now.

MR ANDREWS: That's convenient, Commissioner.

COMMISSIONER: Otherwise we will never have one. 2.15.

MR ANDREWS: Thank you.

THE COMMISSION ADJOURNED AT 1.01 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.25 P.M.

MARK FRANCIS WATERS, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: For the record, can I just mention in the morning I'll be going with counsel assisting to a meeting with the Premier to discuss the progress and timing of this Inquiry. That's the sole purpose of the meeting. So, I just want everyone to be clear about that. Mr Andrews?

MR ANDREWS: Doctor, the expense of your Innovation and Workforce Reform Group and its six branches is, according to your statement, an expense which seems to be primarily met by the Commonwealth Government, am I correct?-- Yes, but I wish to point out that there were some functions previously running in Health that weren't new initiatives that would continue to be funded by State funding, but all the new stuff - the Patient Safety Centre, the Clinical Practice Improvement Centre, all of those areas have been funded by Commonwealth funds - so all the change, if you like.

Thank you. So, when there was discussion of one of the branches of your Innovation and Workforce Reform Group - that is the Workforce Reform Branch which has a staff of 32 - and when I look then to paragraphs 18 and 19 of your statement, I'm left wondering does the Commonwealth Government fund the employment of those 32 persons?-- Well, first of all, can I correct the record? I did discuss this at lunch. There is

actually 47 in workforce reform.

The 47 persons, does the Commonwealth Government fund their salaries?-- I would have to check. What has happened - if you would like me to explain what happened? There were people employed in Queensland Health and they were in various areas. There was a restructure in June of last year, and there was an amount of State money funding an amount of people employed, okay? So, nothing was changing. That was just continuing on after the restructure. What we have done is we have, if you like, merged the State moneys for accounting purposes and put them in certain blocks, so I'm not exactly sure which bits were State and Commonwealth, but can I answer this, which is that there is zero State growth moneys put into the initiatives around Innovation and Workforce Reform with the restructure. So, there was underlying State moneys prior to the restructure which continue on, and then the new initiatives around patient safety and clinical practice improvement were all funded out of extra moneys from the Commonwealth.

When at paragraph 18 you write, "The new initiatives of the IWR Directorate and its six branches are fully funded from Commonwealth funding with some State funding."-----?-- Yes.

-----are you able to say whether the Commonwealth pays the wages, or does it - or were the wages being paid by the State and the Commonwealth provided some further funding?-- If I go to the next sentence, the State funding is related to previously existing functions, so things-----

Actually, I have read that next sentence, but I'm still left confused as to whether the Commonwealth pays the wages or whether the State pays the wages?-- For those people who are additional people that we refer to in subsequent paragraphs that have been put on as a result of the new initiatives, the Commonwealth pays all of their funding. When the Directorate was formed, there's a thing called "State Growth Funding"; in other words, where new State moneys are allocated every financial year. You will find the only new moneys to come out this financial year for '05/'06 are about $2 million and that's to employ 60 new interns at Townsville, and it just comes through us and goes to Townsville, if you get my drift. So, the initiatives - the new initiatives we have started have been fully 100 per cent funded by the Commonwealth, and that comes out of Commonwealth Quality and Safety funds. Those funds have been in the AHCA agreement since 1999. Before this year, they used to be distributed to a whole series of projects - something like 23 different projects for varying periods of time - and this year they have been collated into a separate - we have actually made them sustainable by putting them into particular areas.

On the same topic, you have referred in your statement at paragraph 25 to page 818 of the transcript?-- Yes.

Paragraph 25. The transcript you will see upon the monitor before you?-- Yes.

A question seems to have been put by Ms Kelly of counsel as to - to one of the witnesses as to the witness' awareness of a budget of $1.7 million that was used to fund a range of new AO7 positions?-- Yes.

Is it your evidence that that funding came from the Commonwealth?-- In its simplest and most honest form, the answer is yes. It didn't come from any State clinical budget that could be used for clinical services, that's the case. I mean, we merged the various buckets of money, so I'm not exactly sure which particular one funded which particular one, but the new initiatives, the growth, was fully funded from the Commonwealth through quality and safety money and zero came from funds that could come out of the State-----

Thank you, doctor. Is it your evidence that that money, which was provided by the Commonwealth, was provided on a condition that it wasn't to be used to engage more clinicians, it was to be used for other worthwhile purposes?-- It is specifically to be used for initiatives around quality and safety. It is specifically targeted and-----

But not to engage a clinician to do clinical work?-- To provide front-line clinical services, it is not proposed to be used for that.

Thank you?-- It has been used in the past for multiple projects, but we actually wanted to make it more sustainable - we wanted to actually make it better utilised, if you like.

On the 13th of May, you were appointed by the then Director-General, Dr Buckland, to investigate and report on certain matters relating to the Bundaberg Integrated Mental Health Service?-- Yes.

And you completed a report within about two months?-- Yeah, around July, I think.

You met with Dr Buckland to hand him a copy of the report and to discuss it with him?-- Yes.

You forwarded him the three copies of that document about a week later?-- That's my recollection, yes.

You have discussed it with Dr Buckland immediately after it was complete?-- Yes.

That is, on the 13th of July?-- Yes. I discussed it with him when it was completed. I had done the report and I had discussed it with him at that stage, yes.

And Dr Buckland, indeed, was satisfied with it?-- Yes.

Now, you observe at paragraph 38 that you expected the report to be released and anticipated that there would be some public attention given to the issues raised within it?-- Yes.

Is it the case that the report was not released?-- I think it very clearly was not released, yes.

COMMISSIONER: Were you told why?-- No, I was still - I was not - I did the report as an external consultant from the Wesley, so I did the report, and, in fact, I kind of lost track of it after that. I did the report, handed it in, I subsequently got recruited to the Innovation and Workforce Reform, and I must say I just got busy and lost track of it. It wasn't until a few months later that I realised that it hadn't been made public.

MR ANDREWS: And I gather it is your opinion that there would have been some public benefit if the public had given its attention to your report?-- I think the reason I thought it was going to be made public is because, as I recall - in fact, I do recall this was raised in Parliament by Mr Messenger, so I had made some assumptions that the outcome would be made public. That was really why I felt it was going to be made public.

COMMISSIONER: Have you ever taken that up with Dr Buckland?-- Yes, I have.

What response have you received?-- He spoke to me - I said - it was informal. It was informal, and he said, "From your report, it is - you are able to identify individuals." From the way I had written the report, it would be possible to identify individuals, and for that reason the decision was made not to release it publicly.

I take it there would have been no difficulty in de-identifying the report? I was asking it wouldn't be difficult to de-identify the report so the public could know the facts, even if they couldn't identify the individuals?-- I hadn't mentioned names in it.

Yes?-- I had not mentioned names. But in retrospect I think the point he was making - but you need to ask him, clearly - is that I had identified positions which could very easily be identified.

Yes.

MR ANDREWS: And when was it that you had this informal discussion with Dr Buckland?-- It was around mid-July, I think, from my recollection.

I see. It was around mid-July-----?-- Sorry, I have done this again. Which conversation?

The conversation - the informal one with Dr Buckland in which you raised with him the issue of whether the report would be made public and he told you that it would not because it was possible to identify persons within your report?-- Look, it would have been November/December. It was an informal meeting. I guess the conversation occurred when I realised it hadn't been made public. It was a slow dawning on me that I

hadn't seen anything about it. So, probably November or December or something.

Now, in July of 2004, when you handed Dr Buckland a copy of your report for the first time, it was in that conversation, was it, that Dr Buckland offered you a new position within Queensland Health?-- It was at that time that he asked me to consider coming back to a new role.

That position in Queensland Health, did you, in that conversation, discuss the terms and conditions?-- Not of the actual - not salaries and stuff, no; just what the job would be, yes. I was unaware - I had not been following Queensland Health's restructure in any degree of closeness, so I didn't really understand the new structure until that conversation - and what the job entailed - and so at that time he talked to me about what he thought the job might mean and do and what - you know, what could be achieved.

From the fact that you accepted the new position that was offered, is it reasonable to deduce that, objectively speaking, the terms and conditions were better than those of the job that you held?-- That would be incorrect.

Why did you take it?-- Because it is exciting. It is just exciting, yeah. It is worth - the safety and quality stuff is what it is all about. That's why I came back.

At paragraph 42 of your statement, you speak of the importance of VMOs to hospitals and you say they provide a body of staff large enough to allow an after-hours system of care to occur in the absence of enough work to allow enough full-time specialists to occupy these roles?-- Yes.

Now, that seems easy enough to understand, but the Commission will hear from another expert - or another person experienced, in any event, with VMOs, that there's a difficulty in engaging VMOs, in that they are not as flexible as staff specialists at times, in certain specialties; in that VMOs need to finish work on a particular day in time to be refreshed for their private patients the next day. Now, are you able to comment on that apparent difference of opinion?-- Well, look, I'm happy to. I think it is a great tragedy that we, in Queensland, have somehow got ourselves involved in this "what is the worth of a VMO and what is the worth of a full-time specialist". I'm pretty confident I do go on later in my statement to say that I think the best environment is where we have a mixture of visiting medical officers and full-time staff. VMOs do have other commitments. They are not fully engaged with the public hospital, because they are also running their own business and their own private practice. Full-time specialists can be more fully engaged. However, visiting medical officers bring with them different skills, different attitudes, different technologies - if you like, a different complexion - so it would seem to me that the ideal system is to have them both. There is sometimes a bit of tension between VMOs and full-time staff around, you know, who is most committed to the public sector, who provides most

time, and, of course, visiting medical officers in private practice have the opportunity of being involved with the Commonwealth and patients such that they can generate significantly higher incomes. But I would answer your question by saying that a robust public health system would have a good - a combination of both visiting medical officers and full-time staff, and hopefully that their relationships would be warm and that each would see the strengths of the other.

COMMISSIONER: Doctor, from evidence we have heard, I'd suggest the possibility that what Mr Andrews has outlined to you from someone else's statement really is a misunderstanding that, in many instances, VMOs are keen to provide increased flexibility, but they find that the system simply doesn't allow them to do that. They have a set period, for example, to perform surgery, and if they have got through eight patients and the ninth patient is waiting but that patient won't be finished by the end of the session, then they are prevented from going on. They'd like to be able to give flexibility to the system by saying, "Well, although the scheduled finishing time is 5 o'clock, we will go on to 6 o'clock to make sure that this patient doesn't go back on to the waiting list.", but they just don't have that option. Is that your experience?-- My experience is that how we manage our elective surgery could be looked at. The short answer - I will give you the short answer and the long answer, if that's okay. The short answer is that that is sometimes correct. There are real budget issues around the rest of the staff providing overtime to run past. So, the short answer is that is correct. I guess the longer answer is that we would want to examine what we do in the elective surgery lists. We want to be confident that they start on time, that everyone is there on time, that the - if you like, the exchange between the patient going out and the patient going in is most efficiently run. So, the short answer is, yes, there are times, I am sure, when, for budget reasons, elective surgery lists could go longer and they don't, but I also think that it is important for everyone to look and try and get, if you like, the most value - and you talked about this before - the most value out of the resources being applied.

The suggestion that comes across to us is that the real reason that some hospital administrators don't like VMOs is that they are difficult people to deal with. They insist on the highest standards; that if something is out of place, they'll complain about it, whereas with particularly overseas trained doctors in areas of need, they just don't have the teeth to make those sort of complaints. They're in the nature of, as someone suggested to me recently, the 21st century equivalent of the Kanakas in the cane field 100 years ago. They have to do what they are told or go back to where they came from?-- Well, I would say to you that in my time as a District Manager and as a medical superintendent - that goes back really to about 1990 - I would think that many people value the input of visiting medical officers. It is also true that visiting medical officers, like full-time specialist staff, can be of varying personalities, which brings with them varying challenges. The

initial part of your question, I thought, was going the path of is there a significant difference between full-time staff and VMOs, if you like, in their standards, and I refute that absolutely.

I wasn't suggesting that?-- Then you were going on to the overseas trained doctors-----

I'm suggesting more in their capacity to complain about things which they regard as sub-standard. The suggestion really is that overseas trained doctors, in particular, have to grin and bear any problems they see, whereas - and to a lesser extent, salaried staff doctors have to work with the system in which they are full-time employees, whereas a VMO is able to say, "Look, this is not acceptable. This anaesthetist is drunk.", or, "This nurse isn't competent.", or, "This machine isn't working properly. I want it done properly or I'm not going to operate."?-- Well, I will respond quite resolutely about that, Commissioner. It is my absolute view that a full-time staff specialist will maintain the same standards as a visiting medical officer, and will complain - it is my experience - as fiercely and as independently. The whole culture - the medical culture - you talked about the legal profession before - is about advocacy for patients. I would stand strongly and say that I have never experienced a difference in terms of the willingness of full-time specialist staff to advocate - full-time specialist staff as VMOs, and full-time specialist staff in particular - they have many job options. There is a huge ability for them to leave and work in the private sector if they wish. As I said before, it is absolutely a seller's market. So, I think in any case they wouldn't - and I've been around, if you like, in a managerial role since about 1990, and I just can't recall an instance when full-time staff would even indicate that they would accept an unacceptable situation. They are fairly fiercely independent about their profession. The second part which I haven't answered - and I'm not trying to obfuscate - is about the overseas trained doctors and whether they are in the same position. My personal experience - because of the time I was around, I didn't have experience with overseas trained doctors who were specialists. When I was at Ipswich, we did have some South African anaesthetists, but I think they were actually specialists. I can't recall their registration. The PA and Royal, it didn't seem to be an issue, so I can't speak from experience there - either agreeing or disagreeing with-----

Let me give you a practical example and I'll choose one that isn't related to clinical safety, because I take the force of what you say that all members of the medical profession are equally dedicated to issues of clinical safety. We have heard many anecdotal stories of medical practitioners who have a contractual entitlement to attend conferences. The stories we hear are that in numerous instances, staff specialists in regional and rural hospitals put in their application, the conference comes and goes, and months later they are told, "Yes, you can go to that conference." The only problem is that it is already over. In that sort of situation, where contractual entitlements are being disregarded by the

employer, one would not be surprised for a VMO to say, "Look, I'm just sick of this. I can make more money down the road at the private hospital. Unless Queensland Health is going to treat its employees equitably and fairly, I'm not going to have anything to do with it."?-- Sure.

A staff specialist can do that, but with increased difficulty, because it involves moving into private practice. An overseas trained doctor can't do it at all. That's the reality, isn't it?-- I think my response to that would be frankly it behoves anyone involved in that system to actually seek that out. I know you used it as an example rather than the whole argument, but there's two things we can do and this is the thing we are trying to do in the whole Directorate. We can actually fiddle around and try and improve a process around how people take conferences, for example, or put on more clerical staff, so that the paperwork - or we can just do away with it and cash out the entitlement - you know, a radical change, so we don't need - instead of mucking around with fine-tuning a process which doesn't make much sense, let's change the whole process. So, we have - I was engaged with a VMO negotiating early on and the proposal there was just to cash out their leave. I understand in EB6, which was the full-timers, that there are proposals on the table to cash out. We have got to stop driving our own staff crazy by actually making it more sensible. So, I agree with that.

But there is certainly a midway as well, which is to say, you know, "We trust - we, Queensland Health, we the taxpayers of Queensland, trust the manager of a particular district to spend up to $400,000 of public funds to buy a new machine." Can't we trust that person to approve a trip to a conference that's going to cost $10,000?-- We should be, of course.

Yes.

MR ANDREWS: You propose an opinion at paragraph 50 that a reason for the loss of specialists in the public system who are going to the private system, has something to do with the growth in private insurance coverage?-- That's my belief.

Is that since 1999 that we see the growth in private insurance coverage?-- Yes.

And do you, what, as a result of your anecdotal evidence and observations perceive that there has been since then an increased loss of VMOs?-- Well, I think there are anecdotes, but there are also facts, and I guess the Commission and I discussed this before, it is this fundamental concept whether you believe there is unused medical capacity and unused nursing capacity. I believe that every doctor I know is working as hard as he or she wishes to work, that there is no lack of opportunity to work. So what happened in 1999 is the Commonwealth introduced lifetime health insurance and a range of other initiatives, including tax rebates for insurance. At that time - and these figures may not be exactly accurate, but at that time Queensland was running about 25 per cent insured, something like that, and subsequently it went to about 42 per cent insured. I mean, it might be 43 or 41, but roughly. Now, effectively that's 100 per cent increase in the pool of people who are insured, if you know what I mean. So - but no more doctors got created, so there was still the same number of doctors. At the same time we know the private hospital admission accelerated in 2000, and so it is very clear that more work was being done in the private sector. There is actually data on that. We had - nothing changed about the number of doctors we had. We had the same number of doctors in 1998, effectively, if you know what I mean, as 2002, but what changed is that proportion of the population that was able to access private hospitals and private health insurance. At the same time, what that means is that there is a very great difference in the relative incomes that were possible between 1998 and 2002. For example, in 1998, roughly, if 25 per cent of the population is insured, then it is not so that if you go into private practice your books will be full, you will be busy - and there may actually even be relationships - I don't know how the law works, but I imagine if you set up first, there is a slow period - not in this room, but slow period where it starts and then it-----

COMMISSIONER: A very long slow period, but, doctor-----?-- Sorry.

-----I think you have covered this?-- Okay.

Can I say, frankly, I am not in the slightest bit concerned about the situation in Victoria, or New South Wales, or anywhere else - perhaps I should be - perhaps I should be worried about the whole Australian system - but our concern for the moment is how we get more doctors into Queensland service?-- Yes.

And that means we have got to be at least competitive-----?-- Absolutely.

-----with the rest of the country, not only in terms of salary and package value but also in terms of offering the flexibilities and the options-----?-- Sure.

-----which they can get elsewhere. I mean, I am - having been born and lived all my life in Queensland, I am of the biased view that if everything else was equal, people would choose to live in Queensland and work in Queensland rather than probably anywhere else in the world. It takes some incentive to get a Queensland trained doctor to move down south, and unfortunately the public hospital systems in other States are offering those incentives to take our home grown doctors away from us. That's the problem, isn't it?-- That's one of the problems. A bigger problem, in my view, is that many of our doctors trained in the public sector are moving into the private sector because now - and this is quite new - this is new in the last three or four or five years, really - when you move into the private sector now, you are busy within a month or two months. Certainly within three months your books are full, you are flat out. That's quite new. When you talk to some of the older specialists around town, they will say when they moved into private practice there was this slow build up. So we have - so, yes, I am sure we are losing some interstate, and in case you think I am - we must be competitive, the answer is of course we must be that, plus many other things. We must be a good employer, we must have a fine reputation. There is a very steep hill to climb here.

Yes?-- But given all that - can I - I just give you some example - can I just give you an example, a real example? If you work privately as an ophthalmologist, the item number for a cataract extraction - I took the 42782, the scheduled fee for that, which is what the Commonwealth government believes is a reasonable price to pay - I haven't got - $748 of which the 75 per cent rebate, which is what the Commonwealth will pay you for an inpatient service, is $561. So the Commonwealth will pay an ophthalmologist in private $561 for a cataract extraction. There would be - I would argue very confidently they would do two an hour. I don't - I suggest you could do more than that but if I said two an hour, I would not be over - I wouldn't be exaggerating. I am sure you could do more than that.

Is that two patients or two eyes?-- You only do one eye. Two patients. I am sorry, two patients an hour, and you can do more than that. So the Commonwealth will pay you about $1,100 an hour. We would pay in the public sector a VMO about $120

an hour. The taxpayer is paying both. More than that, the real income of the ophthalmologist is actually much higher than that because when you look at the HIC data, I think it is only about 17 per cent of all specialist attendances in Queensland are bulk billed. By that I mean that 75 per cent figure I talked about, which was $561 - I can't say exactly that applies to ophthalmologists; I am saying all specialists - about 17 per cent bulk bill. I am hypothesising that many ophthalmologists would not bulk bill and therefore they may be earning much more than $1,000 an hour. I guess the dilemma I have is that we have taxpayers' money in the Commonwealth paying at this rate and we have taxpayers' money in the State paying at this rate, taxpayers are paying both, and my argument, which is where we disagree, is that it is only a single pool of doctors. There aren't different pools, there is a group of doctors available to do medical work and I would argue that not only are we competing from one State to another, we're actually competing from one State to the Commonwealth in how we pay our doctors. Of course, it is possible that if we go to a local industrial relations set-up within each district, that we'd then even be competing between one district and another for the same body of work. And I am aware, Commissioner, that there may be some concerns about the workforce reform issues, but at the end of the day it seems to me that we must work very hard and very fast on creating more ability to do work currently done by specialist - some doctors because it will take us so long to get extra doctors to add into the pool - not to shuffle around within the pool, but to get into the pool.

The example you gave is actually a perfect one because I earlier gave you the example of Ballarat Hospital that was based on an advertised position which was drawn to my attention by a staff ophthalmologist outside Brisbane. That position involved the person going to Ballarat, working two days a week in the public hospital at public rates, having the public hospital provide a consulting room which that doctor could use the other three days a week. The doctor could bring private patients into the hospital as private patients, all of those benefits. The person was, in effect, given a package, which isn't costing the Victorian government one cent more, but is so much more attractive to a potential employee than anything Queensland Health has ever thought of offering anyone?-- Well, with our full-time specialist staff - and it is horses for courses - with our full-time specialist staff, there is a thing called option B option B is where they can earn their same salary again in private practice. So, for example, if the salary of a staff specialist is about - in cash about $130,000, under option B they can earn another $130,000 through billing private patients. That is most used and most useful - and there are some paradoxes in how the Health Insurance Commission pays for things - that is most used and most useful for the ologists, for the people that do things. I mean, we're really entering some interesting times now where people do not want to go into those professions, like, for example, geriatrics and other professions where the Commonwealth payment system is much inferior. So your cardiologists, your radiologist, your ophthalmologists,

gastroenterologists, those sorts of groups, can use option B in the public sector, and frequently do. But if you are a physician, or geriatrician, or an anaesthetist, it is actually much - because the rates of pay are so much lower, it is not - they can't earn as much money, basically. So there is a bit of that in Queensland Health, but before I seem to be defending it, I think we have got to do a lot more of it. I think we have got to seriously look at whether people work a limited period of time in the public sector and time in the private sector because, you know, Queensland has to understand that it is one system, and if the Commonwealth changes what it does, Queensland has to react because the Commonwealth is the 800 pound gorilla and we have to sort of understand that. That would be my view, because there is a fixed pool of doctors, and if they work at Ballarat, or if they work at the Wesley or St Andrew's, somewhere else, they are still not working in the public hospital.

Yes.

D COMMISSIONER EDWARDS: Haven't we also got to be flexible in the amount of theatre time available and beds available, and so forth?-- Yes.

It is just not the ability or offer from the private specialists to do this work?-- Of course - yes, we do. We have to be flexible in our theatres.

That flexibility seems, from some of the comments we've heard, not there at the moment?-- There have been really tight budget restraints driving productivity very hard. I don't think that's a secret. I mean, if you ask the next question, why have they been run so hard within such constraints? Well, it is the money.

COMMISSIONER: But, doctor, it is not always the money. That's the point I keep coming back to. It is making the money go as far as you can?-- Sure.

And if you can attract someone by offering a package, which includes seeing private patients, that's a way to spend your money more wisely?-- Absolutely. Couldn't agree more. And we need to actually have a look at some IR stuff, industrial relation stuff to make sure that's up to speed.

Yes.

D COMMISSIONER VIDER: And, doctor, could I just add that it is a bit sad that it has taken this inquiry to bring this discussion right out into the open, because I think if we want to talk about IR things, if we want to talk about demonstrating that we value staff, we demonstrate how we value them by the value we put on the service they provide, and in our society that's partly in monetary terms?-- Yes.

And I think it doesn't matter what you want to say, for the doctors to see how lowly that they are paid by Queensland Health, must send them a very powerful message.

COMMISSIONER: I can only agree with Deputy Commissioner Vider, and one of the frustrating things about this process is that people talk about the crisis in Queensland Health. I think a crisis is something like the Asian tsunami, which happens literally overnight. The situation within Queensland Health hasn't happened overnight. It has been developing for years. Over three months we have heard so many positive and constructive views as to what should be done and we can't - we haven't yet heard anyone who can explain why none of this has been done before the crisis reached this point rather than getting to a crisis and thinking, "Well, how can we get out of this problem?"?-- Mmm.

You used the expression this morning no-brainer. So many of these things are - perhaps it is unfair to say no-brainers because they may not have occurred to me unless they had been suggested - but as soon as they are suggested, you are simply driven to ask the question why wasn't that done years ago? Why has it taken Jayant Patel and all the deaths in Bundaberg, and so on, to get people to stop and think, "Well, this isn't the right way to run a health care system." I suppose I am being unfair asking you those questions?-- If you want a response, it is difficult - it is difficult for me to answer it. I will just try and collect my thoughts about what might it be that allowed this to happen in the way that it has. I think one of the issues is - I am just trying to collect my thoughts because it is kind of a big question.

Yes?-- Look, I think - well, if you want to go back another few years, there was a period up in the early 90s when there was a very great - the same sort of difficulties we're facing now were faced then. There was a significant difference between what doctors could earn public and what they could earn in private. That led to a crisis in about 1995. And at that time there was quite a dramatic revamp of the package that was available to medical staff, essentially. From about 1995 to 1999 it was an equilibrium. There wasn't that much options in private practice so we were getting multiple applicants, marvellous applicants, multiple choice. It was terrific. Since 1999, my view is it has actually swung back the other way now, that the opportunities in private have actually significantly enhanced, and I guess I would say to you that we should have recognised that sooner and tried to redress the balance again, would be my response.

Yes, Mr Andrews?

MR ANDREWS: Doctor, it would be your Innovation and Workforce Reform Division which would be the division of Queensland Health most concerned with such matters as how to encourage more VMOs to remain in the public system? Yours is the division?-- Yes. Well, I think that's fair, in that we would be significantly involved with leadership training. I mean, a lot of the things Commissioner Morris has raised with people issues.

Would your division be the one that considers whether or not

you should add an option C to the option A and option B terms of contract?-- I wonder what option C is.

Well, wouldn't it be your division that would think about more flexible forms of contract to be offered to encourage people?-- We would work with the industrial relation section, who is actually negotiating enterprise bargaining groups. So the industrial relations section in Queensland Health would do the direct negotiation but we would seek to have input to ensure that the flexible options might also include ways of reforming our practice.

And I'm fairly sure I heard you mention this morning the fact that VMOs want carparks. Would it be your group that would speak to the industrial relations group and suggest to that group that carparks might be - make a significant difference?-- Look, it would be - the answer is that what I would like - and I think - I would like to make a point that I think is important - other people may not - many of the issues that have been raised about culture, and fixing up the leave, and dealing with doctors and getting them carparks - and I have a view that that's about leadership. I have a view it is about expert leaders, expert managers, people engaging with their staff, people been good communication skills, people who understand how to introduce change, and I would argue that it is absolutely our group's job to talk to existing district managers, potential district managers, existing clinicians, potential clinician leaders, and put around them support and training and expertise to enable them, if you like, to blossom and grow so that these issues you talk about just get fixed. These shouldn't become issues for a Royal Commission, these should be fixed locally and on the spot. But just simply telling people to do better - you know, Einstein said the definition of insanity is to continue doing the same things and expecting a different outcome. I would argue we just inject expertise into training and support. I would also argue it should be in a rational environment, where if you get more work, somehow you can get paid for more work, but I think that's the human stuff, and the people stuff is where we have to invest and many of these things will just get resolved locally.

Well, if you are going to address a human thing such as, for example, the recurrent complaint of VMOs, that if only they'd provide us with carparks, rather than addressing it by trying to get better leaders, who is going to suggest to the different hospital managers or directors that it is a problem that seems to be complained of-----?-- Yes.

-----throughout the State?-- Yes, and the answer is those suggestions have already been made to Queensland Health, they were made, of course, as part of the interim report from Peter Forster, issues around that, and my understanding is that there will be - I can't speak for Queensland Health because I am kind of working in another area now with Mr Forster - but my understanding is those sorts of irritants, people will be seeking to address as we speak, is my understanding.

COMMISSIONER: Doctor, I want to pick you up on something you said, because you talked about people from your office talking to people at various hospitals and so on?-- Yeah.

I am just concerned that there has already been too much talk. We read all these submissions we have got and what we read is these things have been talked about in Charlotte Street since Adam was a boy. It is beyond the time for talk. What we need is not merely leadership, but leaders who have the capacity to carry things into action?-- That's right.

And, you know, I have no doubt, for example - and I don't want to keep using him as an example - but Andrew Johnson at Townsville came across in the witness-box as a man with extraordinary leadership capacity but none of the powers or flexibility needed to put that into practice. Here is the sort of man that where you said, well, you negotiate things with the VMOs at the local level and say, "What do you want, doctors? It is not going to cost us anything more to give you a carpark, we have got an empty storeroom down there that we can turn into a doctors' waiting room, and we can even give you a coffee machine and a couple of lounge chairs." It is not going to cost anyone a cent, yet it will make life easier for you as people who are coming to work in our environment. Isn't that what we need to give those people that autonomy?-- I agree. It goes back to the issue of complaints and dealing with this stuff. I think that rather than a central body dictating and determining, I think we should have local resolutions to local issues. I guess what I was saying is that whilst Andrew Johnson may well have all those skills, our challenge is to try and put in place systems where the visiting medical officer at a particular place, their work experience is not solely determined by the individual skills of that individual person. We'd like to put, if you like, some underpinning skill sets and training so that people have a very clear understanding of how to do their job better. I guess that's really it.

You earlier used the example of the corporate sector, and I think you might have mentioned a particular company's name, but we will put that to one side. I sat here on Friday listening to what Dr Wakefield was telling us about reports that were prepared and systems that were developed. The only problem being that individual hospitals had no funds with which to implement those things?-- That's right.

You know, if I were on the Board of Johnson & Johnson, or BHP, or Westpac, or any other public company, and someone with a workforce of 30 spent a couple of years putting together a project without first finding out whether there were the resources to implement it, they would be sacked. I mean, it is as simple as that in the real world, that's what happened to people who waste the company's funds?-- I would like to answer that, Commissioner, if that's okay. I mean, that's precisely why we've restructured previous to July or August, really September, really. We started our directorate in January of this year.

Yes?-- Previous to that there was this Commonwealth money, projects were started, there was no real focus on implementation, there was no real focus on how much it would cost to roll this stuff out. That's how it was going. Very good work happened and there is some stuff that came out of Queensland that is across the nation now. But having done that initial work for a couple of years and, if you like, changing some of the expectations around safety, it was the view of myself and many others that precisely what you described must stop, and so it is for that reason that we have actually pooled all this Commonwealth money that you were talking about before, and we will not do anything that does not have an implementation plan and people and money to do it. A policy which is not implemented is an utter waste of time. That would be my strong view, and we have started that process. You asked me before of some examples of what we have actually done, and I was at cross-purposes, I wasn't quite sure which area you were looking at. Correct site surgery, as an example, I am sure John mentioned to you it is easy to do a policy, the policy was done. We now have a senior specialist surgeon in the State who is travelling with John and a senior nurse, and meeting the operative nurses and medical staff actually at all their sites to work through with them the local issues and progress - in other words, go from a policy, to an implementation, to action, to review. That's where we're going and I think it is really important.

The Clinical Practice Improvement Centre has money which is not allocated to staff at all but just as you start a particular thing that a hospital wants to do, we will go in with experts, change experts, and cash so they can bring their own staff off-line and pay them to actually implement the change. I could not agree with you more. We must stop doing that. I would argue that we have set our directorate up specifically because of that, because I guess a number of us, John Wakefield, Professor Michael Wood, whom I don't think you guys have met yet, and myself have all had a fair bit of experience in districts and we don't want to do that. It's just not useful to anyone. That would be my view.

The other thing that I find very frightening, frankly, since I have interrupted already, is this. We're told about these extraordinary sort of futile systems within Queensland Health where you have got the Minister or the Director-General at the top and then all these layers down to the pawns at clinical level?-- Mmm.

But it takes six or seven layers of administration for the Director of a clinical unit to get a proposal approved at the highest levels. Again, I know Sir Llew has been on the board of a major trading bank and we've all had experience in the private sector and anyone who has set up or defended such a system would be perusing the positions vacant column in the newspapers the next weekend?-- Sure.

It is so obvious that it can't work and yet it seems to have been there for years without anyone saying, "Surely there's a better way to do things"?-- Yeah, look, I think - I think - whilst I don't dispute what you say, I think the real issue goes back to the point I think Sir Llew made before which was about discretion at the local level. There are abilities to do and start things at a local level but if you are constantly trading or if you are constantly in a situation where you don't have, actually, any financial ability to exercise your delegation, then what you have to do is kick it up a level to see if they've got some money to fund it, and if they have got no money to fund it, then you kick it up a level to see if they've got money to fund it. The reality is decisions can't be made, that's absolutely true, but what is the cause? Is the cause because we have a process which requires approvals? Well, it's related to that but it's really because there is no discretionary funding available at the various levels to action it. So it kicks it up to get the money, not to get the delegation. And that's a challenge how we-----

I'm sure that's part of it but certainly what we're told by Dr Johnson and Mr Whelan, that there is this magic word of corporate policy within Queensland Health and if you ask for approval to do anything that has a policy label on it, you just don't know how long you'll be waiting because there will have to be committees to review it and position papers written and arguments and discussions and forums and reviews and you just don't know when it's going to be dealt with. There is no transparency in it. You don't know who is going to be making the decision. You can't speak to the decision-maker because

you don't know who the decision-maker will be. You don't know when you're going to get a decision and when you do get a decision and if it goes the other way, you don't know who to speak to to find out why. I can feel for that level of frustration. Is this something you've encountered?-- Oh, look, I think - absolutely. It goes to that point about what should be centralised and what shouldn't be centralised and we had that conversation before lunch, which is there are some benefits to centralisation and there are some big disadvantages to centralisation. What you've just described is one of the disadvantages of centralisation.

MR ANDREWS: I have no further questions.

D COMMISSIONER VIDER: Well, I would like to make one further comment. Are you aware or have you had comments made to you, particularly from the VMOs, about those layers of bureaucracy that they have to go through for different funding submissions that they might put in, if not for leave but for equipment? And the way it's relayed to us commonly is that they put submissions in and it moves through six layers but they never get any answer back. It very much appears that the communication flow is one way and I think that people in today's hospital environment understand they're not going to get everything they ask for but they are - they're very unimpressed with the fact they don't get a response. So if something they put a request in for is not going to be granted, they would like to know it's not going to be granted, why and who made the decision, and it seems to them that it just moves off into the ether and that's very demotivating?-- So - well, of course - we should be giving feedback to our staff and I am sure that I would have failed in doing, that I'm sure in my time - I'm sure there are times when we should have got back to people and we didn't. I think we don't emphasise that enough so I would agree with that. The example - so in general terms I agree. The example of equipment is a little different. For much - normal replacement of equipment, that is actually dealt with at a local hospital level under the health technology replacement process, so much of the local replacement equipment is dealt with at a hospital level and hopefully the feedback is better there but it may not be. For very major - for example, I think someone mentioned an MRI somewhere before. Well, clearly, that's a huge investment both in terms of the capital cost of many millions of dollars and of course the running costs. Now, that would be made in Queensland currently at the very highest level - at the very highest levels would be my call on that and would be a slow process, and whether the feedback gets back to - it should. I think probably it doesn't. Again, I think it's got to do with bureaucracy and size.

COMMISSIONER: I have to say that we have even received submissions criticising the health technology replacement process and the criticism is along these lines: you might have four of a particular type of equipment in a regional hospital, four ventilators or whatever; under the process as it exists, you can replace one of those every number of years

but there's no point replacing one every number of years because then you have different models and different ages and so on, that you don't have new capacity to transfer spare parts from one piece of equipment to the other?-- Sure.

You have to train your staff on each of them and so on?-- Sure.

And what is suggested in the submissions we received is that this is a typical example of Charlotte Street myopia, that a bureaucrat thinks it is a good idea to have this replacement program where you get a new machine every two years whereas someone who is on the spot who actually knows what's going on or who can speak directly to the people who do know what's going on will say, "Well, instead of replacing these once every two years, we have to make them last for six years and then we will replace the whole lot"?-- Well, I mean, the - I don't know the specifics about what you're talking but from a, if you like, quality and safety point of view, and I do have a big bias about, I would be arguing we should be standardising what we do. So I would be asking for replacing all at the same time or, indeed, if we do replace old for new, try to get, if you like, a new old model so it continues to be standardised. And, in fact, I have been one of the people who have, if you like, had some fierce conversations with some of our consultants who have often wanted the very newest, latest one and I've said, "If we have a number of them, issues around safety are better served if we continue to standardise what we do." Now, that's also a tension as you can understand because at some stage you have to make the leap but I would support the idea about standardisation and consistency and for all the - quite apart from the parts and the training, but it's about safety as well. So - no, I can't answer your statement because I don't know the detail of it but, you know, I would accept that - that that could happen, yes.

Mr Farr, any further evidence-in-chief?

MR FARR: Just a few questions, thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR FARR: Dr Waters, do I understand from your evidence that you were enticed back to Queensland Health because you have a passion for safety and quality and that you were provided with an opportunity for what you considered to be very worthwhile work?-- I was excited by the thought of looking at big system change rather than - I spent my life managing hospitals and small - well, districts and local areas and I was excited by the prospect of looking at a bigger system, yes.

You did so, as I understand it, without going into any figures but with a quite large reduction in pay?-- I'm interested to know that that's known.

I don't know the figures?-- No, I found-----

In any event, you seem to be suggesting that an approach to health administration, if you like, in this state requires imagination and passion and flair, to think outside the square is really what you've been speaking about in many respects; am I correct?-- I think that it's - I think if I go back to the - what I talked about before about scope, I think it's a very difficult business. I think it's - there are perverse drivers, how you manage the internal conflicts of clinicians who want to do everything, you know, now for everyone, a fixed budget, various workforce groups, how you introduce change in that environment, how you deal with community expectation and of course the patients. I think it's a complex environment and I think it's a challenging one and I think we need to try and ensure that the people involved are as well trained and supported as they can be. It is a longwinded answer I know to a reasonable question.

That's all right. It was suggested to you earlier in your evidence that it's time to stop looking at what can be done and time to start in fact doing it, whatever it might be?-- Mmm.

And I think you agreed wholeheartedly with that approach. As I understand it, that probably has been the philosophy behind your establishment of the innovation and workforce directorate?-- Yes.

By way of example, from what you have told me in conversation, you were given the opportunity to spend some lengthy time working out just what would be required, how it would function, the cost of it, what would be needed in staff, facilities, that type of thing, or you were given the option, at least suggested the option of just starting it and you will work your way through it as it goes and try and make some worthwhile contribution at another stage?-- Yeah, well - I mean - and it touches back on some questions I was asked before. We would have an opportunity to go back and review everything that was being done as the directorate was formed and, you know, painstakingly look at each position. I guess I took the view that you can do that but it takes an awful lot of time. Some of the things we wanted to do were in five major areas. We had an idea of standardisation and systemisation. If you are seriously interested in quality and access, if you're seriously interested in getting best value for money, if you look at all successful companies around the world, you will see that they systemise what they do and then they innovate around that systemisation. They standardise what they do, they measure, they get high quality outcomes and then they improve on those high quality outcomes. We took a strong view that we need the if you like - if you need to get the maximum benefit out of our dollars and out of our doctors and out of our nurses, it would be just unbelievable if we didn't look at what other industries have done and that's what they've done. The second thing we thought we needed to seriously look at was patient safety because I didn't think

that we had gone from the project based environment that we were under the old money to a systematic, sustained cultural change process around patient safety. The third thing that we did was we had a great opportunity with the Skills Development Centre, was just being built. It was opened I think two or three weeks after we started, so in September. And whilst - well, the reality is I think it's got a huge future and I think we've just tipped the iceberg and I would like to see it functioning six or 12 months and, it will cost money, I would like to see 200 staff a day going through that place seven days a week 24 hours a day, nurses, doctors, allied health, a whole - an intensive training process for skills, competencies, communication, training, crisis, team management, all of those sorts of things which I think in this century the community would expect that that is learnt in a simulated environment rather than, if you like, under the old apprenticeship model which perhaps some of us are more familiar with in the past. The third thing is that we think - there was a real need to connect with our staff and we had a view that we needed to drive - we couldn't change the world so we tried to drive down through the bureaucracy, so an innovation program was started called Innovate where people have - anyone with ideas can send them directly through, it gets very quickly to me and to an innovation board. That's been going since March I think. We have had 500 ideas including supporting a patient for a new process for diagnosing sexually transmitted diseases; including retractable ECG leads, which are so easy - I mean, why didn't anyone think of them, that's the issue; including just little Velcro straps on pulse oximeters, because they keep falling down. So what we've done is try to - so what we've done - so we've started the innovation program because we really need to connect with our staff so they knew we could get things actioned and moving.

I take it that would be an example of breaking down the bureaucratic gridlock that you spoke of earlier in your evidence. An example of how one can go about overcoming such issues?-- That's what we're trying to do. So, for example, one of the ideas was adding food additives to various types of waste to make it easily recognisable came from North Queensland, Bamaga. We had wardsmen sending in ideas how you change cleaning trolleys so it is more easily used. It was really an exciting part of how people can feel part of the organisation.

All right?-- The other thing we felt was that it is hard out there. These are really difficult times. People are really busy, under a lot of pressure. So we felt - not in a monetary way but we felt we had to connect with our staff in terms of staff health. I think many private corporations are much more active in staff health than Queensland Health, which is kind of interesting, isn't it. So we started the 10,000 steps project in about January or February and that was about encouraging people to form teams and we had a bit of fun and we gave prizes for the best names, and they asked me how many pedometers we thought we should buy and I said probably 5,000 and I thought we could use them again next year if people

don't want them. Anyway, to cut a long story short, 17,500 joined in. This is now rolling on. We are now working with the heart foundation to see if we can spread those nodes in our district into more widespread in the community to get community people walking more, I guess is the answer. So I guess we just thought we'd do it, and then my plan was that in 12 months' time, using the standard that the Commissioner talks about, which is if it's not providing at least as much value as front line care then we shouldn't be doing it, so our thoughts were in 12 months we would review the previous 12 months - get external people in because it is hard to review yourself. That's where we were going but time has overtaken us and a lot of things happened.

Yes. As I understand it, the review, the Forster review, which you've been commissioned to or seconded to for some period of time has eaten into your ability to be able to oversee the functions, if you like, of your directorate for some time now, that you're hoping to get back there shortly?-- I have been fully seconded out. I have not worked in the Queensland Health building since May, beginning of May I think.

The other thing I wanted to ask you or two other things, the first of which is the term "scope". You spoke on a number of occasions about identifying the scope of what is to be offered or what should be offered. Can I attempt to paraphrase what you meant by that term this way, and please tell me if I have this correct or whether I have misunderstood something, but you refer to scope as being (1) what services Queensland Health deliver, (2) where those services are delivered and (3) to whom they are delivered. That's the scope - that's what you mean by scope-----?-- That would be my definition of "scope", not as eloquently put but yes.

As I understand your evidence, your view is that those are questions for governance?-- Yes, assuming - they're questions for the community.

Yes?-- And therefore I - therefore the government, yes.

All right. Finally, can I just ask you this: do you have in mind a future for the Skills Development Centre or the centre - or the Centre for International Medical Graduates?-- I think it only just opened in September and by that I mean actually opened, we were still commissioning equipment at that stage, so it is really just getting up to the speed. And we took over the Centre for International Medical Graduates in about June last year from the University of Queensland. I think it gives us a window into a new way of training our staff and, also, I think it will be of assistance and we have spoken to the Medical Board and we have had the Medical Board out to look at this issue of assessing international medical graduates, also assessing not just their skill levels but also their training needs. There have been programs being run there but it's come to my attention some months ago that we - it was difficult sharing that information. So we've now talked to the Medical Board and their new registration process

requires anyone seeking to be registered to provide any information from the Centre for International Medical Graduates or any breaching courses and we also want to share that with the medical superintendents so we can actually tailor all the information we have around training and assessment and actually bring what rigor we can to this issue of international medical graduates.

Thank you, that's all I have.

COMMISSIONER: Thank you, Mr Farr. We might take a 10-minute break. We will resume at quarter to 4.

THE COMMISSION ADJOURNED AT 3.34 P.M.

THE COMMISSION RESUMED AT 3.55 P.M.

MARK FRANCIS WATERS, CONTINUING:

COMMISSIONER: Mr Harper?

MR HARPER: No, Commissioner.

COMMISSIONER: Mr Allen?

MR ALLEN: No, Commissioner.

COMMISSIONER: Ms McMillan?

CROSS-EXAMINATION:

MS McMILLAN: I appear for the Medical Board. The last answer, in relation to your dealings with the Medical Board in relation to the training centre dealing with overseas trained doctors, could you expand on that in terms of, practically speaking, how you have been able to formulate, if you like, the consent issues, et cetera, in relation to the training and supervision of overseas trained doctors?-- Sure. I mean, the Centre for International Medical Graduates has just recently come under Queensland Health, and, of course, the Skills Development Centre is now open and it is up and running and runs various courses. So, what we thought would be prudent to do is to actually make sure, in our view, whatever information we had was available for the Medical Board and, indeed, medical superintendents at the various hospitals to ensure that, you know, whatever information we did have was available. So, we've spoken to the Medical Board, got Mary Cohn, the Chairman, to come out and have a look at the Skills Development Centre, and the new President of the AMA - I can't recall his name - Hamilton - I got him to come out and look at the Skills Development Centre as well and see if there are issues he thought might be helpful, and we finalised with the Medical Board their new request for registration process, which obliges anyone who requires to be registered - to provide to them any assessments, any training, any outcomes from the work at either the Skills Development Centre or the Centre For International Medical Graduates. We made sure there were consent processes for people going through bridging courses such that we can share that information back with medical superintendents such that we can tailor appropriate training. So, what we are trying to do is these services that have come on-line, see if we can maximise their benefit both for the doctor and for other bodies.

The consent in relation to information sharing, had that been

a difficulty in the past?-- We first went under the Medical Act to see whether we could just give them the information, but as we understand it, to give information to the Medical Board, you have either got to - I'm not an expert - you have either got to be a complainant or a disciplinary process or something like that. We didn't fit into any of the categories. We just wanted to share the information. So, we thought - in fact, Jim O'Dempsey, came up with the idea that what we should do is put in a request for consent process, so it becomes a non-issue.

But the information being passed as part of the-----?-- Yes.

-----registration form?-- Yes.

Thank you. Thank you, Mr Commissioner.

COMMISSIONER: Mr Diehm?

MR DIEHM: No.

COMMISSIONER: Ms Feeney?

MS FEENEY: Nothing, thank you.

COMMISSIONER: Mr Boddice?

MR BODDICE: Nothing.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Nothing, Commissioner.

COMMISSIONER: You are excused from further attendance. Can I tell you before you go how all three of us have greatly appreciated your insights and input. The usual experience, at least within my profession, is that a robust exchange of views is often a helpful thing to get to a clear view of matters. There are times when I have been criticised for being overly robust, and if I was that in your case, I apologise for it, but I think you'll understand where I'm coming from and these are tremendously important issues, not just for the present time, and for the present generation, but more importantly for the future, and I, for one - I'm sure I speak for both of my colleagues - are very grateful at the way you took up the challenge and gave us your frank and candid views on the various points we canvassed. Thank you again for your time?-- Thank you again. Thanks for the opportunity. Thank you.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen of the jury, I propose now to do something that I haven't had to do previously during this Inquiry, and that is to go into a closed session. It

will only be for five or 10 minutes, but during that period, I would ask that the public and press leave the room. If you would be so kind? Thank you.

IN-CAMERA SESSION ENSUED

PUBLIC SESSION RESUMED

COMMISSIONER: Do we have another witness ready?

MR ANDREWS: Yes, Dr Farlow.

COMMISSIONER: Splendid.

MR ANDREWS: And we can call Dr McNeal, if you think there's time.

COMMISSIONER: I have read Dr Farlow's statement and it seems to me that what he says is tremendously important, but I don't think particularly controversial, so it seems to me to be one of those situations where the statement can speak for itself, but I'll leave that to your judgment, Mr Andrews.

MR ANDREWS: Thank you, Commissioner.

DAVID JOHN FARLOW, SWORN AND EXAMINED:

MR BODDICE: Commissioners, we seek leave to appear on behalf of Dr Farlow.

COMMISSIONER: Such leave is granted, thank you. Can I place on the record for the benefit of the present media, the brief private session was to deal with a matter which has arisen in which a patient's name should, we feel, be given appropriate confidentiality, and that's why the matter was discussed behind closed doors. I can promise everyone that there were no secret deals being done or anything corrupt or improper. It was just a matter of being very astute to ensure the privacy of a particular patient was respected. Thank you, doctor. Can I ask whether you have any objection to your evidence being filmed or photographed?-- No problem at all.

Thank you.

MR ANDREWS: Dr Farlow, have you produced a statement of 16 pages annexing your personal details?-- Yes, I have.

And are the statements of fact true to the best of your knowledge?-- Yes, they are.

And the opinions you express, are they honestly held by you?-- My opinions.

I tender it.

COMMISSIONER: The statement of Dr Farlow will become Exhibit 297.

ADMITTED AND MARKED "EXHIBIT 297"

MR ANDREWS: Dr Farlow, you are the Director of Medical Services at the Proserpine Hospital?-- That's correct.

And in that role, you perform clinical services?-- I do.

You are also the Executive Officer, and in that role you perform administrative services?-- Correct.

In your administrative role, you administer a budget of $6.1 million?-- Yes.

In your clinical role, you perform obstetrics, general surgery, anaesthetics, emergency medicine, you teach, you have hands-on clinical and ward rounds and you are the Government Medical Officer?-- That's correct. Probably best described as Jack of all trades and master of none.

COMMISSIONER: I'm sure you are far too modest, Dr Farlow.

MR ANDREWS: You recommend the creation of a specialty for rural medicine?-- Yes, I do.

You are on a northern zone rural committee which meets every three months for the purpose of credentialling and privileging persons?-- That's correct. Approximately every three months.

You see a need for better credentialling and privileging or more frequent than can be done by your committee?-- Certainly the - I assume we will go further into that side, but certainly there are changes that I could recommend.

And what changes do you recommend that aren't already set out in your statement?-- You would need to have some history behind the credentialling process. If we go back to the mid-1990s, essentially there was no process, and in terms of - you qualified with an MBBS if you did your degree in Australia, and essentially, after one year as an intern, you were then registered as a medical practitioner - in fact, probably the late '80s. It was assumed that the person who was given that ticket would practise within their scope of knowledge and practice. Come to the mid-'90s - and it was obvious that there were a number of practitioners who certainly were not practising within their scope of practice, as well as perhaps not keeping up with their standard of practice - Queensland Health did introduce some guidelines in the '90s, and so we went from a process of having no process to the process we have today that is certainly much better, but still with some holes in it.

What do you recommend as a practical but improved process?-- Currently we have a division between rural medical practice

and specialist practice, and it is divided so provincial centres and major metropolitan centres have their own credentialling committees, whereas the rural medical practitioners are done in a zonal capacity - so, the northern, central and southern zone - and the whole process of credentialling and awarding clinical privileges is based on peer review. So, it is essential that part of the process - that if you have a rural doctor that's after privileges to a particular facility, that you have rural doctors that do that assessment.

Can I interrupt for a moment so I understand?-- Yes.

You distinguish metropolitan and regional from rural?-- Yes.

And so, for instance, Bundaberg would be regional?-- Regional provincial, yes.

COMMISSIONER: Can you tell us what you regard as the dividing line? Is it a town of 10,000 people, for example, or-----?-- If we talk about credentialling, virtually general practitioners are done in the rural sector, whereas specialty staff are done in the major centres.

Right. I mention, though - I'm just trying to bring an example to mind - a town like Dalby, for example, I think has a specialist - some specialists, anyway - but the hospital is essentially run by GPs?-- Yes.

Do you regard that as a regional or rural hospital?-- I would regard Dalby as a rural hospital, knowing that there will be visiting specialists there, that part of their credentialling process would be done with peer review, and you would expect that they would be done by specialist credentialling committee. It is an important distinction. It is peer review, and so with general practitioners, rural generalists - so, all of those who are not designated as a particular specialty - are done by the general practice, for want of a better word, committee, and above that the specialty colleges represent the more major metropolitan centres. Have I confused-----

Not at all. I raised the question because we have received submissions from the Rural Doctors' Association and the point they make, I think, is a very valid one - is that people who live in Brisbane think that anything west of Ipswich or north of Nambour is rural, but obviously the challenges of running a one doctor hospital at Mitchell or Springsure or somewhere like that are very different from the challenges of running the Townsville or Rockhampton or, for that matter, Bundaberg hospitals, and the talk about rural medicine has tended to get distracted, because with a Brisbane-centric viewpoint, you think of the big rural medicine centres as places like Toowoomba, Townsville and Rockhampton, whereas they are not rural at all?-- It is actually probably the number one problem that rural medicine has had in getting acknowledgment - first of all, what the definition is. In our centralised system, one of the problems is how do you fix rural medicine,

and before you start and work out the general principles around that, you need a definition, and certainly - and within rural medicine itself, there are several subgroups, each with their own specific problems, and unless you identify them as specific subgroups, you are never going to fix the problems. In other words, one size certainly doesn't fit all. Could I use the example for - well, in my statement, I use remoteness - it is one example - but also population size. You can have a reasonably large population, by my standards, of 20,000 people in Mount Isa, but it has the same difficulty because of its remoteness as, say, a 500 population centre in the tip of The Cape, so when you are looking at solutions, it is not only just remoteness or population size, but the internal demographics of that population. So, all those factors need to be considered when you look at solutions for rural medicine.

Whereas on the other side of the coin, you could have - I'm not sure if there's a hospital at Boonah, but it is close enough to Ipswich or Brisbane that even with a limited population, they don't have many of the problems that beset most rural practitioners?-- That's correct.

Could you give us a working definition of what you would regard as being rural practice?-- That's put me on the spot. Probably non-metropolitan is a good way to start, and - because when issues are looked at from certainly a corporate direction, they think non-metropolitan. My personal view is that rural medicine is population of 20,000 and less, because that encompasses - acknowledging there are some populations of 20,000 or so that are close to a metropolitan centre, but certainly corporately they tend to view non-metropolitan being the Bundaberg size, Mackay size, whereas I personally view rural medicine as around the 20,000 and less, acknowledging the Mackay, Rockhampton-sized populations and hospitals have specific issues that are certainly different to metropolitan. For example, in Mackay, probably 85 to 90 per cent of the doctors there are overseas trained, and a number of them are deemed specialists, and there are a number of issues there that may be not in Rockhampton or Bundaberg or elsewhere. So, you almost need to look facility by facility, but as a generalisation, you have got large rural, like the Mackay size, and then what I regard as true rural - and probably the best - incorporated in any formal definition is when the services are totally run by so-called non-specialists, that's general practitioners - or I prefer to call them rural generalists - then I think that's true rural medicine.

Doctor, one of the things that we have been thinking about very seriously is whether there needs to be more decentralisation of decision making in Queensland Health?-- Mmm.

That doesn't necessarily mean turning the clock back to the old hospital Board days of 15 or 20 years ago, but to give an example of a district I know personally very well, I would have thought if you take a town like Roma, which has a substantial hospital and outlying single-doctor hospitals within an hour or so's drive of Roma, it would make a lot of sense to have the decision making for not only for Roma itself, but for Mitchell, Injune, Wallumbilla, Surat, made within that local community. The difficulty with that, though, is that if you then translate that to other parts of the State - let's say Rockhampton - you have got quite a major hospital in Rockhampton, and if you had the decision making based in Rockhampton for Biloela or some of the - Clermont or Emerald, the people of those towns feel they will be swamped because they have such a little voice in that catchment. That's why a working definition would actually be quite useful?-- Probably a better way to look at it - and I couldn't agree more with the idea of having some local decision-making passed down.

Yes?-- Certainly the lower you are on the food chain in the corporate ladder, the softer your voice is, but, saying that, I recognise there are certain things you certainly have to have centralised, and I have the fortune, if you can call it that, to have worked under the hospital board model.

Yes?-- Following that I worked as a representative on the Regional Health Authority model, which is similar to what you have just mentioned, it is a functional drainage area, and now work under the district model, and there are advantages and disadvantages with each of those models. Certainly as a general principle I think you need to pass delegation or authority for decision-making down to the lowest feasible level. Disadvantage of local hospital boards, I don't think we can go back to that because you would then have whatever number of hospitals in Queensland competing with each other-----

Yes?-- -----and there is probably too much local interference. There are advantages of the regional model in that you had - they virtually were functional drainage areas. And my area, for example, Mackay, Sarina, Proserpine, and in the hinterland, Moranbah, Dysart, Clermont, it is where your natural population drains for their services, and it seems to make sense to draw your boundaries around those particular areas. Then you need to set up an administrative structure to ensure that the services are equitably represented. One of the problems in the regional model - we were fortunate in our region, we have a fairly proactive region, but if you had a CEO that did not favour services in a rural area, then the small centres can certainly miss out. So you need a balance, and I think the functional drainage area or regions had the potential to certainly operate more efficiently.

Doctor, it is not a very scientific approach but, I must say, an approach which I find attractive, is to look at district by district and say, "Where do the people in that town go for their other services? Where do they go if they need to buy a new fridge or a new car? Where do they go to see their solicitor or accountant?", as a broad-term definition of a drainage area. Hence, to go back to the example I gave you earlier, Roma is a natural drain for the surrounding towns like Mitchell, Injune, Surat and Wallumbilla. Again, that creates the difficulty we have when you get to the larger expanses of the State where the people in Weipa, for example - Weipa is a one-hospital drain. You know, if you have a chronic condition in Weipa, you can't jump in your car and drive to Cairns or Mt Isa for treatment?-- You cannot, but I think what we haven't done successfully is look at innovative ways of servicing those centres, and, again, Mt Isa, for example, is - it certainly has lurched from crisis to crisis. The staff there do to the best of their ability, but what's not determined before you - well, before you determine how you service a particular area, you need to decide on what services can safely and reasonably be offered there, and I think the service capability framework that Queensland Health has got up and running has real potential. In other words, identify a site and agree not only Queensland Health, but, in fact, politically and community to agree upon what services can be safely and effectively offered. And, if I again use Mt Isa, you have to look at what must be offered. Even if the politicians said, "Sorry, we're going to close it down", of course, you have got 20,000 population, it must stay open. What things you must provide, you must provide emergency work-----

Yes?-- 20,000 population you must provide obstetrics. You must provide some form of surgery, some form of anaesthetics. Do you need to have the high level specialties in each of those? Perhaps or perhaps not. But the point being is decide on what must be offered, that's a given, and then the more sort of elective type procedures. Do you really - have you got the staff that are willing to stay in that centre for a long period of time? Or perhaps do you look at what do the mining industry do? Very few people like to go and work in the mines. They don't do that by choice, they do it for two reasons. They get significant time off and they get well remunerated. So the options, for example, of fly in/fly out, pay them well, give them significant time off, but whilst they are there, they may as well work. So I don't think we have looked at that adequately in the past, and I think if you look at each segment across the State, they will have specific problems that need specific solutions.

D COMMISSIONER VIDER: Can I ask you a question, doctor, and I am coming back to the credentialing and privileges?-- Sorry, we were on that topic.

From your statement you are currently the chair of the Northern Zone Rural Credentialing and Privileging Committee?-- That's correct.

Is it common to have to define privileges granted for a practitioner? You know, do you set limits?-- To understand the committee, the role of the committee is really to review the credentials and then to recommend to the district manager what privileges should be considered for that practitioner for the particular facility, and it is important to know that the committee does not set the standards. So, for example, if we have a rural practitioner that wants to perform anaesthetics at Roma Hospital, we don't set the standards for that; federally, or the colleges, the college of anaesthetists, the College of GPs, and the College of Rural and Remote Medicine form a joint Board and they get together and work out what is a reasonable standard that is required for a rural doctor to practise anaesthetics. And rough rule of thumb for anaesthetics is one year in a major centre, signed off by a specialist in anaesthetics to say, "Doctor A is proficient in providing low or - low and medium risk anaesthetics." So our job as a committee is to look at their credentials, ensure they have the appropriate referees, they meet the standard that's been set. We then write to the district manager and say, "Doctor A has fulfilled the criteria to perform anaesthetics at Roma Hospital." So privileges are site specific and you need to have that so that the facility can manage. For the ridiculous example, neurosurgery, Dr Eric Guazzo at Townsville, very good neurosurgeon, but, of course, he would never get clinical privileges to Proserpine Hospital because we couldn't support that. So you need to consider the infrastructure of the facility when awarding those privileges.

COMMISSIONER: And by the same token, doctor A who is qualified to do low to medium complexity anaesthetics at Roma isn't going to be appointed as an anaesthetist at the RBH?-- No, they are not, no they are not. Same could - they could perhaps work in that department doing the low and medium risk anaesthetics, yes, but certainly not the high risk.

D COMMISSIONER VIDER: But it would be your committee at that local level - for example you might have someone who really doesn't have enough cases up in obstetrics, so you might say, "This person is acceptable tada-tada-tada, except they can't practise obstetrics alone?-- Yeah, the procedural aspects from a committee's perspective are far easier to measure because the standards are much more clear-cut.

COMMISSIONER: Yes?-- But in terms of general practice, it is how long is a piece of string? It is more difficult to make an assessment. In saying that - and it has particularly become a problem in the last few years with our influx of overseas-trained doctors.

D COMMISSIONER VIDER: Yes?-- There is no disrespect to them because by far the majority of excellent practitioners - and we would not - our system would be in disarray without them - in fact, if we go back to the 1990s and I was given a choice of a well trained Australian graduate or a well trained South African graduate of similar years' post grad, I'd take the South African doctor because of their procedural ability,

their exposure to surgery, obstetrics, emergency. So I would have in fact taken that doctor. The global market has - it is a global medical market and I think the - we have skimmed the cream of the crop, so to speak, and we are - our system is such that we have certainly had some holes in it, and assessing credentials and awarding of clinical privileges for overseas-trained doctors is problematic, and part of our role is to ensure that we minimise the risk of a practitioner going to a rural centre that is not appropriately qualified.

COMMISSIONER: Doctor, I have been - sorry, you will find that we all tend to go down our own dry gullies?-- That's fine.

And the one I would like to take you down at the moment is this: in your position as medical superintendent at Proserpine how many doctors are there full-time and VMO at that hospital?-- We have got a senior medical officer and two principal house officers, so three doctors, and I regard myself as .5. So this half does administration and this half does the medical.

D COMMISSIONER EDWARDS: How many private-----

COMMISSIONER: Just for the record, the division is horizontal, not vertical. I must say - perhaps I have got very old fashioned views, but I find some attraction in the notion of the medical superintendent who is an active clinician. Do you find that your skills and your responsibilities as an administrator are sharpened and enhanced by the fact that you are in the operating theatre or in the wards or on ward rounds and dealing with patients day-to-day?-- I think it is certainly - it makes a difference having a voice in the decision-making when it comes to budgets. I don't particularly enjoy the administrative component but certainly I find it a challenge. But certainly when you have some input there and you are practising - you're a practising clinician, you can see where the dollars can be best spent.

Yes?-- In saying that, I think that the concept 15 years ago was fine. Health has become, unfortunately, far more complex, the technology side, the budgetary processes where you need a balance, and certainly I can't see a return to the days of where the medical superintendent ran the hospital, particularly the major hospitals. What is certainly needed is very good clinical leadership. That's - that's more the key. And the clinical leadership needs to have some involvement in the budgetary process but not absorb all their time in budgets.

You really anticipated what I was going to come to next. One of the views that I have to say is pretty firmly lodged in my mind - and it will take a lot of work to dislodge it - is that at least in contexts where there is a full-time administrator as Director of Medical Services or Medical Superintendent, there is a desperate need for some sort of role within hospitals, whether it is Chairman of Clinical Services or Chief Clinician, however you would describe the function, to

have a clinician who is a mentor for the clinical staff, a problem solver, a Court of Appeal, if you like?-- Yes.

And who is a voice in administrative decisions which is at least as loud, if not louder, than the voice of the full-time administrators?-- Yeah, there is - there certainly needs to be a balance, and I think one of our major problems is that - and it has been well documented, that we have been budgetary driven, and therefore I think the general view of practising clinicians has been the non-practising medical superintendent tends to lean towards the side of the district manager's. From the point of view of district managers, they are under pressure to come in on budget, and as part of the executive, the non-practising or non-clinician medical superintendent is under real pressure to make sure that budget integrity is there and you have almost - almost a conflict of interest. Obviously budgets need to be considered with all decision making, but when the medical superintendent goes to the troops and his clinical departments and says, "We need to cut elective surgery or we need to do this because of budgets", it actually puts them off side. It is very difficult to be a clinical leader if you are always leading based on budgets. Now, my own thoughts around that is that your Director of Medical Services or Medical Superintendents, their major focus should be clinical governance, and that's safety and quality. In other words, making sure the medical services that are under them are operating a five star, safe and quality service. To do that, of course, dollars need to come with it. I can see a structure where they are the clinical leaders, but provided they are taken away from the budgetary process and clinical governance is all about safety and quality, and for them to manage in that fashion they need to be given that charter, so to speak. Not to say that the budgets don't come into the equation, however if you imagine a hospital that's - you determine that in intensive care there is a problem with repetitive chest infections in ventilation. Now, the Medical Superintendent, Director of Medical Services, interchangeable terms, talks to the Director of Intensive Care and they work out where that particular problem is. Now, there may be three recommendations. Now, the job is virtually then to report that to the decision-maker, who is the District Manager, in our current context, and leave the decision making, the budget process separate to their advice on clinical governance. I am not sure if I have confused-----

No, that's very helpful?-- I feel strongly there needs to be a separation. So the whole focus should be on safety and quality, and I know I am going slightly off track here, but quality has this connotation of policies and procedures, and people with clipboards running around, and, in fact, if you provide a safe service, then a quality service follows from that, if you are doing things safely. And so I see quality as a result of making sure your system is safe. Virtually everything you do medically is about safety.

D COMMISSIONER EDWARDS: I think you have answered my question.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: Doctor, the credentialing and privileging process you say needs to become part of the recruitment process for overseas-trained doctors?-- For all doctors.

Well, when - I gather that means you regard it as something that should be done in advance of the meeting of your northern zone rural committee; it should be done by somebody else at the time that recruitment is considered?-- Yeah, we have this situation where doctors' credentials, their ticket, so to speak, is considered by the Medical Board, and the process involved in that is fairly lengthy. And so they jump over that hurdle and then they need to commence work at a particular site, and so they fill in their HRM package, and then they start work and some application is made to the credentialing body, and some months down the track that person's been practising and a decision is made can they practise safely and effectively? So it is not rocket science to know that clearly the process has flaws and to me there certainly needs to be - the process needs to be linked very closely to the initial recruitment process as well as linked closely to the Medical Board. It just seems the Medical Board are already doing one of the steps, ensuring their tickets are in tact. It is not much of another step to tie the process there. So I really think it needs to be done prior to employment. But saying that, what happens when the Roma Hospital doctor becomes unwell, they need to urgently recruit somebody. Locum agency says there is somebody available from Pakistan, there is real pressure on getting that doctor - getting that - excuse the expression - getting that bum on the seat to start work, and certainly our processes need to improve. And I listened to some of what Mark Waters had to say. There are some processes where it can be improved, but we still need to be able to provide the service. So it is a balance between urgency and making sure they are appropriately qualified.

COMMISSIONER: Doctor, I don't think you need to persuade us both as to the importance of credentialing and privileging and as to the likelihood, as is demonstrated by the Jayant Patel case, that unless that's integrated with registration, people are going to slip through the cracks?-- Yes.

My view, for what it is worth, is that before particularly an overseas-trained doctor is registered, one has to say that is registration for a particular area for a particular service and that's where credentialing and privileging has its interface with the registration process, and it makes sense that one authority ticks both boxes?-- Yes, absolutely.

MR ANDREWS: I have nothing further, Commissioner.

COMMISSIONER: Thank you. Mr Boddice?

MR BODDICE: Thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR BODDICE: Dr Farlow, you spoke about your clinical role that you have. You said you were a .5 clinical workload. You also said that you have the position as being the executive officer for the district?-- Whitsunday Health Service, which is actually a demographic area, it is not a district. The district that Whitsunday Health Service falls under is Mackay Health Service District.

So the Whitsunday District, for the Commissioner's benefit, you said that you are the Director of Medical Services and you have a half time role effectively as a clinician?-- Yes.

And you also have this additional role. Does that mean you look at other hospitals as well within your area?-- Part of my administrative role is I sit on the executive for the Mackay Health Service District, and so - and that executive is responsible for three hospitals plus community health centres, Sarina, Mackay and Whitsunday. We also do get some certain population drainage from Bowen. For example, the obstetric service there was reduced and closed some time ago, and so locally at Proserpine we deliver significant percentage of their - of the public from there, that we don't have any direct management responsibility of Bowen.

Now, one of the issues that the Commissioners have raised in the course of this Commission is the question of a determination at a local level of what services are provided?-- Yes.

You have the benefit of obviously working in one hospital but having seen what other hospitals in your district provide - or in the area provide. Are you able to assist the Commissioners as to whether that's a relevant factor that has to be considered in determining what services a particular place can provide, that you need to look also at what services are being provided elsewhere in the same area?-- Absolutely. Again, it comes down to the functional drainage area. You look and see what can reasonably be provided for that functional drainage area in consideration - and budgets are important - so that what you want to do is ensure that you can offer as many services as possible locally without duplication of what I will call the sharpened services, and that's the high end technology, the cardiac bypass, the transplantation surgery, the MRI scanning. So you would - there are certain level of services that I think should be provided to all rural sectors, the smaller places, but certainly it would not be feasible or economically viable to provide all services to all people.

So in this context you may look at if a service is provided 50 kilometres away in a more regional centre, and say it would be better for the people to travel to that service because they will get a better service which is better resourced than what the local community may be able to provide?-- Yes, you need

to look at each drainage area and provide that service. Sometimes it is better for a visiting medical officer, for example, to go from the major centre to see 30 patients in the smaller centre, but from a practical point of view, at other times, for particularly vascular surgery, it is more relevant that the patients actually travel to the vascular surgeon. So you need to look at the functional drainage area, each facility, what the infrastructure is and see what services are best - can be best offered.

And is that one of the benefits of the regional system you work under?-- I think so. You can then decide as a region what is reasonable to be offered, but saying that there is still the danger of being low down in the pecking order, is that some rural facilities can miss out. But saying that, that would not happen if you got fair and equitable representation from an administrative point of view. One of our biggest problems in rural medicine has been the lack of voice right throughout our system and the - not being derogatory of any individuals, this is just a systemic issue - that we continually bang our heads against the wall to get our voice heard in corporate office. So no disrespect to anybody there, but we are a small part of a monstrous system. So, yeah it is difficult to get the voice heard.

When you were giving evidence-----

D COMMISSIONER EDWARDS: Lacking of medical voice, do you mean?-- Yes.

Or overall regional?-- Yes, more the medical voice, yes.

COMMISSIONER: Particularly the funding voice?-- Well, yeah, the funding is an issue for all of the services.

You see, doctor, you may have been here when I canvassed this with Dr Waters, but it seems to me to get the most bang for the buck in terms of health care budgets, one approach is for the health care budget to be provided district by district and hospital by hospital, so that the people of Proserpine can decide, you know, we can either hire another geriatrician, to take one example, because we have got an ageing population, or we can spend money on an MRI, but given that there is an MRI an hour down the road at Mackay, we're going to spend our money the way that our community wants it spent?-- Mmm.

And I am very impressed with the idea of making that sort of budgetary decision at local level, really on the footing that instead of the local administration having to go up the ladder to the district and the zone and head office in Charlotte Street, they know at the outset of the year we have got X million dollars to spend and we decide how best to spend it for our community?-- You do need the balance because - and no disrespect to individual communities, they sometimes find it difficult to judge what actually - if you ask them for prioritised lists or what they want or need, it may vary from the practicalities or the reality. So you certainly need community consultation.

Can I use - go back to the early 1990s of regionalisation. When they first got rid of the hospital boards, Mackay region decided to consult with all the communities to gauge what their feelings were in terms of local services in each of the areas and they divided the community up into men, women, non-English speaking backgrounds, et cetera, about eight or nine groups. What came out loud and clear is the number one priority was access to speciality services. Now - so the community were telling the region they wanted access to speciality services. What they didn't really say is that they didn't necessarily want the MRI scanner, there wasn't one at that point, but the MRI scanner at Proserpine, but they wanted reasonable access to it. And so, I think the role of a region is to provide ready access. And so, whereas if you went to my town of Proserpine, yes, we'd love an MRI scanner but of course it wouldn't be cost effective or practical so you would site one at Mackay and the patients would travel to that.

Yes?-- Yes, the community expectation is - has got to be tempered with reality. In saying that, at the moment our District Health Councils, I'm not sure what's come out in the Commission on that. The District Health Councils are a community and there's community consultation but they have no teeth at all. Whereas in the regional days, they were actually legislative, they had the legislative responsibility to manage the region, and you need, I think, a balance between.

Yes.

MR BODDICE: When you started giving evidence you spoke about you've been in the local board system, you have been in the regional system and the district system. You mentioned the pluses and minuses of the local board and the regional area. Just for the benefit of the Commissioners, are there any pluses and minuses of the district system that you have worked in?-- I'm probably a little bias with the district system. I had an excellent District Manager for the last five years who was a very experienced nurse who had seen many, many systems, worked in New South Wales, Director of Nursing at Prince Charles many years ago, so had been around the game and so you could present good argument to her and she listened to everybody and was a very, very good administrator. So I think districts can certainly work. The District Manager - the actual structure that we have at the moment, the District Manager can make or break a district. At the moment I think the downfalls of the district are we have got some districts that are just too small. Back to my original point: functional drainage areas. Draw your boundaries around functional drainage areas. You can then determine what's the best way to offer services around that.

So it is not simply a matter of that the district system doesn't work but that perhaps there may be too many districts under the present system?-- I think so.

Doctor, at paragraph 23 of your statement you refer to the innovation of tele-health?-- Yes.

Could you just explain to the Commissioners how that works and its importance from the rural medicine point of view?-- Well, telemedicine has been around for a number of years but rolling out it so that it's regularly used to the best of its ability is - hasn't been done but certainly is being looked at. And, again, you talk about access to services. Telemedicine can provide rural people with much better access to speciality services that can't be offered locally. For example, in Prosperine we just recently commenced doing a once a week orthopaedic telemedicine clinic and that consists of simply half an hour linked to a specialist at Mackay. We have patients that are - may have been operated on at Mackay who will come for follow-up and that consultation is done by telemedicine. We also use it for - we have our own mini-fracture clinic and we will also show the specialist certain X-rays that we're uncertain about or we want some further education around a particular clinical condition, and it seems to be working well. The concept needs to be expanded dramatically. Can I use one of my pet topics, is oncology, an absolute classic. Rural people who get cancer. They have to travel to a major centre and that's either Brisbane or Townsville and there's a lot of the state that's in between. And so, for patients - for the initial work-up, naturally they need to go to the major centre and have their assessment and their initial treatment but following that initial assessment and treatment, there is no reason that they need to go for their follow-up visits unless there's some special reason. So telemedicine offers the opportunity for those people to link with their specialist. They've had radiotherapy, they have had chemotherapy, they're sick; they don't want to spend three or four hours travelling. And it is just commonsense that we should be trying to promote the use of telemedicine for those particular groups and it can certainly be expanded. The rural centres are screaming out for it. It is the actual coordination in the major centres that is falling over. In saying that, in Brisbane there has been some excellent examples used. The Centre for On-line Health and Professor Jenny Batch for example, she is a paediatric endocrinologist, her aim is really to have all children with diabetes seen by her once a year so that people who are in Weipa, a diabetic child in Weipa, can get the same quality of service that they can in Brisbane. So it has got enormous potential. It comes to coordination, funding.

You have indicated that in recent times, that is in the last 12 months, tele-health has been overtaken by the Innovation and Workforce Reform Directorate and it is now being used much more?-- Absolutely. I see it being rolled out over this next couple of years.

Doctor, you also spoke about the privileging system?-- Mmm.

And you were asked some questions by Deputy Commissioner Vider in respect of whether that limits what - as part of the privileging process, you may limit what a particular doctor can do. In the rural context, I take it that one of the difficulties is that the doctor, of course, needs to be a

generalist?-- The - yes, I suppose that reaches another topic that's not just related to - I suppose to clinical privileges but - and it's - it is a major one and this is a worldwide issue in terms of how you offer the same level of service in a rural environment with minimal numbers of doctors as they do in the city, and if I can use the example if somebody walks through the Royal Brisbane Hospital who is pregnant, they immediately go off into the obstetric department and looked after by specialists. Somebody who fractures their arm, they go into the orthopaedic department, and so on. In a rural centre, that person, those same people walking through the door, they see the one doctor, the jack of all trades master of none, and the actual training that I think is required to reach a level where you have a knowledge across all the specialities is lacking. There is no coordinated structure to train doctors. Now, I'm not suggesting for one moment that rural doctors can possibly ever understand all the fine detailing of each speciality but reality is in obstetrics, we do 85 per cent of the work of an obstetrician. Our high risk people are sent off, so twins, major medical conditions, they're sent off, but 85 to 90 per cent you can do locally provided you're appropriately trained. Orthopaedics, you're setting arms, you don't operate and insert pins and rods but you certainly do a certain percentage of orthopaedics. Accident and emergency, we can't call the emergency physician for multitrauma. We regularly treat multitrauma. So how do you train - you have got doctors who have been trained in just one aspect, specialists emergency - specialists in emergency medicine. The other - psychiatry, a big problem in - across our community. You've also got to have a knowledge on when the police bring in an acutely psychotic patient, how you treat them. Paediatrics, we have a neonate that's born and cannot breathe. You can't get the neonatologist or you can with a Medivac service. You need to incubate and ventilate that baby. I can go across the specialities but an example of what our work is, our day-to-day, every day work and I think rural people are entitled to expect a quality service in each of those areas, not the high end - high end but certainly with the common things, that they would expect their doctor to have the same level of understanding and treatment can be offered as somebody walking into a major centre here. If your family walked into a country hospital with a particular condition, I think you would want that doctor to be able to treat that condition to the same level of a city hospital, and if they couldn't, then obviously they would refer. But our referral distances require rural doctors to have a broad spectrum knowledge. We don't currently have a training system that are a breeding ground for rural generalists. It is one of the reasons we don't - junior doctors are scared of rural medicine because of what can walk through the door.

COMMISSIONER: I understand that's being addressed though with the Townsville graduates and the program for rural training for that cohort of graduates?-- Not quite. The actual training program actually needs - for rural generalists or for rural medicine, you need to have coordinated hospital based training.

Yes?-- And there is a philosophical difference between in fact the college - I'm getting into some medico politics here so forgive me but it highlights the issue. The College of General Practitioners tend to record office space practice as their area.

Yes?-- The Australian College of Rural and Remote Medicine regard hospital based practice as their domain. And I look at it in terms of rural medicine needs both, but certainly you can learn office based practice within a hospital setting but you certainly can't work - learn hospital based medicine in an office, a fundamental difference, and the reason why we need a training program that trains rural doctors in a hospital based setting in a coordinated fashion so they get their terms of psychiatry, obstetrics, orthopaedics, paediatrics and so on. Once they have had that coordinated training you can then put them out to the bush and cope and manage. It is just unfair what we have done with our junior doctors, expecting them to go out and manage the things that we manage.

MR BODDICE: And is one of the reasons in the credentialing process that you look, for example, at whether for obstetrics it can be a low or medium level because you are looking at the fact that the doctor will have to do a range of things so you look at what level they might be able to do those things at as opposed to whether they can do or-----?-- Absolutely.

Now, you spoke about the services capability framework?-- Yes.

And you set out in your statement about the importance of that. Is within that framework also a consideration of what the facility can safely do in terms of numbers, that is, what backup support there may be?-- Yes. There - it's still a reasonable generic document and it is a document in - that's - that will be updated and I think it needs to go from its more generic basis to being more prescriptive. So, for example, in surgery, Bundaberg seems to be the topic of the month. That, in surgery, it has a certain capability and for surgery, that the following procedures can be done. At Proserpine Hospital in surgery, the level of procedures that can be done are lower again.

Is that because you have regard to what backup facilities are there to deal-----?-- Absolutely. You cannot just consider the ability of the medical practitioner. In a smaller, rural centre, you may not even have a high dependency unit. Some of the bigger rural facilities have a higher dependency unit. So that if you're doing an operation, you might have a visiting medical officer doing a slightly higher level procedure such as a laparoscopic cholecystectomy. It is fine for the doctor to be able to do that but the nursing staff, the monitoring, the pathology access all needs to be part of the infrastructure to do - to offer the follow-up.

That's considered in this Service Capability Framework?-- Yes, but - as I said, it is still at that level of a bit more generic. I think it needs to be a bit more prescriptive.

Finally, at paragraph 58 you deal with the clinical risk management committee?-- Yes.

That was set up for the Mackay Health Service District?-- Yes.

Is there anything that you wanted to expand on in relation to that committee?-- Another hobby horse of mine. I suppose it ties into the patient safety issues. Patient safety sparked my imagination several years ago when I went to a program called Human Error in Patient Safety and I had no appreciation that we had such problems within our health service. I always acknowledge there was a certain complication rate for procedures but had no idea it was to that degree and it is now recognised sort of worldwide that even the five-star services have a certain complication rate and - or adverse events and that we can put systems in place based on the aeronautical industry that will minimise adverse events, and it sparked my imagination and with my Director of Medical Services at Mackay, we formed a group, got our - all the Clinical Directors together and said, "We need to do this. We recognise it has to be done", and so went down that pathway. We have been functioning for two and a half to three years now and the basis of it or the concept behind it is if there is an adverse event, it gets reported. If it is at a low level, for example a pressure ulcer or a medication error, they get studied as a group and people look at interventions. The high end problems, the unexpected deaths, the unexpected adverse outcomes comes to our committee. We do analysis - there is a critical analysis or a root cause analysis done of that and then recommendations made to hopefully prevent such an error occurring. Now, that's - we have been doing that for two or three years now and it's been - been rolled out, a similar concept, across the state and I would hope within sort of five years that we have major advances in that system.

And this is a system where it depends on people being open and not - or blamed?-- Absolutely, absolutely.

Yes, thank you, Commissioner.

D COMMISSIONER VIDER: Can I just ask the doctor a question. In relation to the Service Capability Framework, and we have had some discussion about that from other witnesses to the Commission, would you think further work on that that would sharpen its definition for its application in particular areas, that that would be an appropriate vehicle to involve the community so that they as well develop an understanding about what the service capability of their local hospital or even their local district can offer them, so that you get a reality check if you like and people know?-- Yes, actually, I think that's - that is a good idea and in terms of involving the community, community are not silly.

No?-- And it's just that they need rational explanation.

Yes?-- And one of the problems I think is that we have divorced the community to some extent. Certainly in our local

hospital, where in Proserpine we're very fortunate in having great community support, that we'd need to involve them more, that's for sure.

Thank you.

MR BODDICE: If I can ask one more?

COMMISSIONER: Yes, of course.

MR BODDICE: Dr Farlow, you also have an interest in the bargaining team at the moment in terms of negotiating conditions for full-time medical specialists?-- Yes.

And one of the things you raise is that in the course of rural medicine there are extra matters that have to be considered which just aren't dollars and cents. That's things like accommodation and those things. This process that you're involved in at the moment, this bargaining team, are they looking at things beyond just dollars and cents?-- They're in fact - the enterprise based bargaining group has met today for the seventh day and it is looking at all issues associated with medical workforce infrastructure. So, every topic that can be thought of. It is not just dollars. In fact, accommodation issues, study and conference leave, classifications. At the moment we have four classifications of doctors. So that's a process currently in its infancy and I really - we need to see what sort of outcomes come from that. I'm not really in a position to make any sort of - really any further comments about that process because it really is in its infancy.

Yes, thank you.

COMMISSIONER: Thank you. I see it's after 5 o'clock. Doctor, are you booked on a plane to go back somewhere tonight?-- No, no, I've - in fact, we're on day 8 tomorrow of the enterprise bargaining.

Does anybody have questions for the doctor?

MR ALLEN: I'll be five minutes at the most.

COMMISSIONER: Ms McMillan?

MS McMILLAN: No.

COMMISSIONER: Mr Diehm?

MR DIEHM: No questions, thank you.

COMMISSIONER: You have your five minutes.

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Farlow, John Allen, representing the Nurses Union. You mention in paragraph 35 of your statement the report which you co-authored with Dr Andrew Johnson in 2001?-- Yes.

And that report was after an investigation in relation to a south African overseas-trained doctor?-- Yes.

Who was appointed under the area of needs system as Medical Superintendent of Charters Towers Hospital?-- Yes.

You concluded that that doctor was not competent to perform in unsupervised clinical practice?-- We did.

And that his negligence may have contributed to the death of a patient?-- That was our conclusion.

And you concluded that the appointment process of senior medical staff from overseas had numerous risks associated with establishing levels of clinical competence relative to the Australian experience?-- Yes, that was in 2001, exactly.

And that that doctor had been given inadequate orientation?-- In terms of orientation, question mark. I don't recall the orientation component of that.

I haven't put it correctly. The orientation process for that doctor was inadequate to identify his actual level of skills or to provide him with adequate knowledge of the Australian system for him to function independently?-- That's a fair comment.

And one of your recommendations was that there'd be a review of the appointment and clinical privileging processes for senior medical staff in the northern zone?-- Yes.

And as a result of that, indeed there were changes made to that process in the northern zone?-- Yes, they were.

This report and the recommendations you were making in mid-2001 I expect, although the report seems to be dated in February 2001, seem to be quite apposite to the situation that subsequently arose in Bundaberg regarding an appointment of an overseas-trained doctor in unsupervised clinical practice?-- Yes, the - my comments about the mid-'90s of having no process and then now we have a much better process but still some holes, and you have got to remember Bundaberg, as far as I understand, it was not under the rural committee. It's certainly in the central - central zone. So in terms of the process that exists at Bundaberg or did exist at Bundaberg from a credentialing perspective, I am uncertain but, certainly, I assume it was under - it was not under the rural system.

COMMISSIONER: In any event, Doctor, if Jayant Patel had applied - been offered a surgical position in the northern zone in a rural hospital, he would have gone through the rigorous credentialing system that you've described?-- In fact, because he was a specialist, then he would have been reviewed by a peer review committee based in either Mackay, Townsville or Cairns. So, in other words, of a peer. So, it's - we do not do peer review processes of specialist staff.

Yes?-- So if, for example, a Mackay surgeon who visits Proserpine, the credentialing of that or the offering of privileges is done by the specialist's group.

And there's been some suggestion in the evidence we've heard that Dr Patel was not put through that process because he was viewed as a locum or a temporary appointment being appointed only for 12 months. Do you have that loophole in the northern zone or-----?-- No, I mean, it comes to every practitioner that works in a Queensland Health facility has to go through a credentialing process. Black and white.

Yes.

MR ALLEN: Do you know whether your report, which identified matters of general concern such as the risks involved in appointment of senior medical staff from overseas, found its way above zonal level?-- I'm not certain. I got asked that question in the Coroner's Court just recently but, certainly, I do - what I am aware of is that it went certainly to the zonal manager and he took some particular actions. As you would know for any report that's commissioned, the role of the investigation officer is to make recommendations similar to what the Coroner does and then it is up to the people who commission that report to action those or not.

Yes?-- So certainly there were some recommendations that were actioned and some that may or may not have.

And you don't know whether it went higher up than the zonal manager?-- I'm uncertain of that.

Thank you.

COMMISSIONER: Thank you, Mr Allen. Does anyone have any questions arising out of Mr Allen's?

MR DIEHM: No.

COMMISSIONER: Mr Boddice?

MR BODDICE: No.

MR HARPER: No.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Doctor, can I tell you how grateful we are to have your testimony. Over the three months that this inquiry has been going, it's rapidly becoming clear to us that there are some very significant changes required in Queensland Health and we feel it is very important to get the greatest diversity of views, to have you come here from Proserpine, and I know that's not the only reason you're in Brisbane, but to have someone come from Proserpine in your rather unique position as both a superintendent and effectively manager of the hospital and also a practising clinician has been hugely valuable to us. We realise that you haven't had the chance to discuss everything that's contained in your statement but don't suppose for a moment that we haven't studied it closely and we won't give it the very considerable weight which it deserves. We appreciate your time very much and you're excused from further attendance?-- Thank you very much.

COMMISSIONER: Ladies and gentlemen, just one thing before we adjourn, during the closed session, we discussed certain documentary material, and I just think that so that the record is clear, that should be marked as an exhibit but made a confidential exhibit not to go on the Commission of Inquiry website or disclosed to anyone. I wonder if anyone at the Bar table has any concerns about that course?

MS FEENEY: No, Commissioner.

COMMISSIONER: All right. Well, the letter of 22 August 2005 referred to earlier, plus the attached medical reports, will together form Exhibit 298.

ADMITTED AND MARKED "EXHIBIT 298"

COMMISSIONER: Ladies and gentlemen, we will adjourn now. In the morning, as I mentioned, I have a meeting with the Honourable, the Premier. For that reason, I propose not to start until 9.45. Does that suit everyone? Adjourn to 9.45.

MR ANDREWS: Commissioner, may I announce that there may be a change in the witnesses for tomorrow. It seems appropriate to begin with Dr Keith McNeal, whose statement has been circulated. There had been a proposal to call both Dr Scott and Professor Stable tomorrow. That tentative plan is becoming more problematic. I understand that while Dr Scott would be personally pleased to give evidence tomorrow, he is concerned to have legal representation and it has not yet been determined whether his current legal representatives have a conflict.

COMMISSIONER: I see. Understood. So, it will be Dr McNeal.

MR ANDREWS: Yes.

COMMISSIONER: And then Dr-----

MR ANDREWS: Professor Stable had been willing to give evidence tomorrow, but I understand that a comprehensive statement is still being prepared and it may be that it won't be complete in time.

COMMISSIONER: There was a third witness you were expecting to call today. Was that Dr McNeal?

MR ANDREWS: Yes.

COMMISSIONER: Well, you tell me, Mr Andrews - and I see Mr Douglas is at the back of the room - if either of you see any problem with this, rather than starting at 9.45 and then perhaps attenuate in the morning, would it make sense if we start later in the day, say at 11.30 with Dr McNeal and then

maybe Professor Stable will be ready to give evidence in the afternoon?

MR ANDREWS: That's certainly convenient from my point of view.

COMMISSIONER: Mr Douglas?

MR R DOUGLAS SC appeared as counsel assisting the Commission

MR DOUGLAS: The issue involving Professor Stable will have to be the subject of some consideration on the adjournment, Mr Commissioner. That's a matter I will need to discuss with Mr Andrews and perhaps the Commissioners as well.

COMMISSIONER: Well, given your knowledge of the matter, what's the most sensible thing? Shall we resume at 9.45 as I indicated earlier, or if we do that, is it likely that we will have a waste of time during the morning?

MR DOUGLAS: It would be better to start a little later. I would be hopeful that after Dr McNeal, Dr Scott could be organised. I'm hopeful - optimistic that that can be so, given the scope of his evidence and notwithstanding representation issues. May I suggest that you start at half past 10?

COMMISSIONER: Yes.

MR DOUGLAS: Because I believe that notwithstanding matters can go on whilst the Commission is proceeding, I would like to resolve the issue involving Dr Scott, and it may well be that that extra half an hour or an hour may well entail that being resolved.

COMMISSIONER: Very well. We will adjourn then until 10.30 tomorrow. I should just mention for those members of the public who are unfamiliar with this that Mr Douglas, of senior counsel, has joined the Commission of Inquiry team. This is, I think, your first formal mention on the record, Mr Douglas, but-----

MR DOUGLAS: My first speaking role, thank you, Commissioner.

COMMISSIONER: Welcome on board.

MR DOUGLAS: Thank you.

COMMISSIONER: Adjourn until 10.30 A.M. tomorrow morning.

THE COURT ADJOURNED AT 5.20 P.M. TILL 10.30 A.M. THE FOLLOWING DAY