Ex 319

Statement for Bundaberg Hospital Commission of Inquiry

Gordon Nuttall

Member for Sandgate

Minister for Primary Industries

Former Minister for Health

Introduction

1. I, Gordon Nuttall, am the Member for Sandgate. I have been the Minister for Primary Industries since been sworn on 28 July 2005.

2. Following the Queensland general election in 2004 I was sworn in as Minister for Health on February 12, 2004.

My approach to the Health portfolio

3. It was my intention to ensure that I acquainted myself with the portfolio by way of regular meetings with senior management and also by travelling the State to meet with those health workers who deliver the services on the ground.

4. These visits included visiting hospitals community health centres and our aged care facilities.

5. During those visits it was the norm to hold a meeting with staff members who were able to attend. At the conclusion of these meetings staff members were invited to an informal session to meet with me over light refreshments. This enabled me to discuss with staff on a one-on-one basis, their work or any other matters they wished to raise.

6. I also took the opportunity to meet with District and Hospital executives and District Health Councils. I took these steps in order to personally deliver my message to people at the workplaces and to ensure that they understood the importance of our role in the delivery of health services.

7. I advised the staff at these meetings that we needed to embrace change and that it was important the people of Queensland felt that they had some ownership of their hospitals. To this end I encouraged hospitals to have open days for the general public to enable communities to see and understand the services hospitals provided to the community. I also encouraged the District Health Councils to engage local community organisations so that communities could have more involvement and ownership of their hospitals.

8. On a number of occasions I also met with District Managers when they were attending their regular Zonal Forums to discuss with them issues around the portfolio, for example, the government's election commitments, changing our ethos to partner with the private sector and to gain a better understanding of the issues confronting District Managers at a local level.

9. It was stressed to all District Managers and Zonal Managers that as a Minister I did not want surprises and if there were problems and difficulties within their areas of responsibility it was imperative they bring these matters to the attention of senior management.

10. Early in my tenure as Health Minister, on April 29, 2004, I made a Ministerial Statement in Parliament stating:

11. "The job of ensuring that Queensland's health system remains one of the best is not just the responsibility of one person – it's not just the job of health staff or management – it is also the responsibility of every person in this House, on behalf of our constituents."

12. For the benefit of the Commission I attach a copy of the Ministerial Statement. (Attachment 1)

13. In addition to the Ministerial Statement I wrote to all Members of Parliament encouraging them to work with me in a bipartisan way to help deliver better health services. Also attached is a copy for the Commission. (Attachment 2)

14. I also stated that I would make the District Managers of Queensland Health available to all Members of Parliament to meet with them several times a year so they could be briefed on current developments and services within their electorates. As part of this process there was the opportunity for local Members to raise matters of concern directly with the District Manager and the patient liaison officer of the hospital so that a resolution could be achieved quickly.

15. This was a significant departure from the previous process whereby Members could only go through the Minister's office. My reason for this was to ensure that constituents could be looked after by their local Member expeditiously rather than in the former, cumbersome manner.

16. In regard to changing the direction for Queensland Health I felt it imperative that we could not deliver health services in isolation from the private sector. To that end I believed that it was important that my Department needed to embrace partnerships with the private sector so that we could better service the needs of the people of Queensland.

17. Health resources are not infinite and in order to achieve best outcomes Queensland Health can no longer work in isolation. In regard to the private sector it was obvious to me as Minister that Queensland Health did not have a collaborative attitude towards the private sector. Comments had been passed on to me by the private sector on numerous occasions on that issue.

18. In order to gauge how the private sector operated I took the opportunity to also visit the Wesley Hospital, the Mater Hospital and the Mt Olivet Hospital.

19. Outsourcing of some elective surgery and dental care was a significant step taken in partnerships with the private sector. On a number of our campuses we have collocation arrangements with the private sector such as Caboolture, Redlands, and Prince Charles Hospital as examples.

20. These partnerships need to be fostered and enhanced as we progress with future planning and service delivery.

The issue of Dr Patel

21. My ethos as a Minister both in this and my previous portfolio had been to achieve outcomes by way of consensus if possible. In addressing the issue of Dr Patel, I advise that prior to the matter of Dr Patel being raised I visited Bundaberg Hospital on two occasions the first being April 7, 2004. The normal meetings with Hospital Management and District Health Councils as outlined at the beginning of my statement took place.

22. At no time during those visits in the formal or informal sessions did any staff member talk to me about problems with Dr Patel.

23. On the second occasion, November 18, 2004, I visited the hospital to thank the staff for their work for the victims of the tilt train accident. At the second visit a BBQ breakfast was held and after presenting the hospital staff with a Certificate of Appreciation I again mixed and mingled with them on an informal basis. No matters about Dr Patel were raised with me. On March 22, 2005 Dr Patel was mentioned by name for the first time in Parliament.

24. Prior to this, I had received the usual representations by the Member for Burnett, Mr Messenger on behalf of his constituents and in all of this correspondence between the election date and March 22, 2005 there was no mention of Dr Patel in person. All of this correspondence regarding his constituents were replied to by me via the Department providing me with responses as is the normal practice.

25. Clearly in all the written briefings supplied to me by my Department and representations made to me by Mr Messenger between February 12, 2004 and March 22, 2005, Dr Patel's name was not mentioned. None of the written briefings mentioned Dr Patel or doctors like Dr Patel either in Bundaberg or any other hospital in this State.

26. Again I emphasize there was nothing in these written briefings to indicate to me that there were serious problems relating to Dr Patel or Patel-like issues in our hospitals.

27. On the day the matter was raised in Parliament regarding Dr Patel, I met with Dr Gerry FitzGerald, Chief Health Officer, to discuss this issue. Dr FitzGerald advised me that he had conducted an investigation and that a report was near completion. Dr FitzGerald indicated to me that it appeared that Dr Patel had performed surgery outside his scope of practice and he had advised the hospital for that to cease and that the report would be finalised in the near future. Subsequent to that Dr Patel resigned.

28. I visited the Bundaberg Hospital with Dr Buckland on April 7, 2005 to meet with staff regarding the uncertainty they felt following the resignation of Dr Patel and the adverse publicity about the hospital. My aim was to reassure the staff and I was surprised that my good intentions were misinterpreted by some people. None-the-less I believe the majority of staff understood that I genuinely wished to be supportive. I was asked several questions about Dr FitzGerald's report. I answered by saying that the report could not be published because it was incomplete; that in the absence of Dr Patel's version of events it could not be completed; and that there were privacy issues because the report referred to individuals by name. I assured the staff who expressed concern, that I would request that the Chief Health Officer Dr FitzGerald visit Bundaberg to brief staff on the preliminary findings on the following day.

29. Subsequent to these events the Government established the Bundaberg Hospital Commission of Inquiry.

30. I also attach (Attachment 3), my speech, which was in incorporated into Hansard to the Parliamentary Estimate Committee on July 8, 2005.

31. In this speech I outlined a number of opportunities and solutions to endeavour to address the issue of most concern to not only Queenslanders but also to our health staff. This document outlines the following :

32. i Overview

ii Options for working with the Commonwealth

iii Enhanced clinical roles

iv Midwife led models of birthing

v Providing services in rural Queensland

vi Maintaining health professional skills

vii Delivering health services

viii Partnering with the private sector (elective surgery)

ix Training in the private sector

33. The attached speech reinforces a clear vision for a health system _ one which I have proactively attempted to ensure is constantly evolving and accountable to all Queenslanders.

Memorandum from Senior Counsel assisting the Bundaberg Hospital Commission of Inquiry dated 11 August 2005.

34. The Commission of Inquiry has requested me to address the following issues:-

35. **The Minister's activities and relationship to the Director-General and the Department of Health.**

(a) Is the Minister briefed by briefing papers and other written documents and orally?

Response:

36. There were two ways by which the Health Department would communicate with my ministerial office in writing.

37. There were briefing notes. Their purpose was to provide information about different topics. They were "for noting"; they did not require me to make a decision or to take action. In some instances, the information would be required for a meeting that I was about to have. The briefing notes would be channelled through the Director-General or sometimes Dr Scott, although they were usually prepared by individuals with some direct responsibility for the topic in question. There were numerous briefing notes. Some briefing notes, for example routine monthly information reporting, were not brought to my personal attention. Figures supplied to me for a 42 week period of my ministry indicate that I received 560 briefing notes (average 13 per week) during this period.

38. Submissions were the other form of written communication. These did require action and would come to my attention. Mostly, they were expenditure submissions for the Governor-in-Council or related to overseas travel for staff. The same figures indicate that I received 475 submissions (average 11.5 per week) for that period.

39. Apart from briefing notes and submissions, some 4,314 items of correspondence (average 103 per week) were received from the Department during that period, as well as other miscellaneous documents.

40. This data was collected over a representative 42 week period. The following table demonstrates an extrapolation of this data over the full period I was Health Minister.

Briefings	**Submissions**	**Correspondence**
975	862	7725

41. I spoke to the Director-General on an ad hoc basis about any issues that he believed I should be aware of. I was also able to call the Director-General to discuss issues that he had identified. The Director-General was often engaged in meetings or travel which limited immediate access; however, alternative arrangements were able to be made to allow for discussions between us.

42. **(b) What is the significance of the oral briefings – would it be the case that most material would be contained in briefing notes to the Minister?**

Response:

43. Oral briefings were given in the minority of cases, usually as an elaboration of or clarification of the issues contained in the written briefing. I would ask for further information to be provided so that a more informed discussion could be held. If anything of substance was imparted in an oral briefing, it would be subsequently confirmed in writing.

44. **Was the Minister briefed about:**

(a) Long working hours of doctors;

Response:

45. I was made aware through the written briefings (for example, a briefing note received on 10 March 2004) of the working hours campaign by the Queensland Public Sector Union (QPSU) and supported by the Australian Salaried Medical Officers Association (ASMOFQ) which had been underway for a number of years and was an element of the enterprise bargaining claim in Queensland Health. I was also in support of the action taken to refer this issue to the Medical Board for it to be comprehensively addressed in both the public and private sector where shortages in the availability of medical workforce were pressuring doctors' ability to service demand.

46. **(b) Whether doctors were treated badly by administrators in the public system;**

Response:

47. To the best of my knowledge I did not receive a written briefing from the Department about "bad treatment" of doctors by administrators. The AMA may have raised this in conversation.

48. **(c) Low morale among doctors and nurses in the public system;**

Response

49. From time to time doctors would approach me at a particular workplace during a visit to complain about a variety of issues, some of which were to do with disagreements with the local management restricting their complete independence. I cannot recall an instance of significance that I decided should be handled differently to that proposed by the departmental staff involved.

50. I was also aware through their industrial campaigns when I was Minister for Industrial Relations that nurses had long standing complaints about morale. They felt that they were under-valued. I wanted Queensland Health to be far more focussed on staff.

51. However, I was never briefed along the lines that there was a major morale problem across the Department.

52. **(d) Erratic standards among overseas trained doctors;**

Response

53. When I became Minister for Health I was provided with a briefing folder containing issues for the incoming Minister. This briefing folder dated 5th February 2004 at page 28 noted one of the issues as being that of overseas trained doctors. (Attachment 4 is the front page, index and page 28 of the briefing) I was advised that Queensland Health had a high reliance on overseas trained doctors with approximately 30% of its medical workforce being trained overseas. I was advised that many overseas doctors had difficulty with the English language and cultural assimilation. The competence of some of the international graduates was stated to be "questionable". However, I was advised that Queensland Health would fund and manage the centre for overseas trained doctors from July 2004 to facilitate the processes of screening, recruiting and preparing such doctors for employment in the Queensland Health public hospitals.

54. On 16 February 2004 I received a written briefing referring to the issue of overseas trained doctors and advising me of the initiatives by the Australian government through the Medicare plus package to address the issues. I was advised by way of background that Queensland Health had been involved in the development of the initiatives (Attachment 5). These initiatives included:

"

- Queensland Health has financially supported the *Centre for Overseas Trained Doctors* (COTD), since 1996, specifically to facilitate the processes of screening, recruiting and preparing OTDs for employment in Queensland Health Public Hospitals. The COTD provided over 80 assessed and oriented OTDs to Queensland Health in 2002.
  - the General Manager Health Services has approved the relocation of the COTD, from the University of Queensland, to the Queensland Health Skills Development Centre from 1 July 2004.

- A joint Queensland Health / AMAQ Working Group was established to specifically address issues pertaining to TRDs. This was an inter-agency committee comprising representatives of Queensland Health, AMAQ, The Medical Board of Queensland, COTD, the Australian Government Department of Health and Ageing, and the Department of Immigration, Multicultural and Indigenous Affairs
  - this committee has met three (3) times with the latest meeting being in July 2003
  - there are no further meetings planned for this committee due to the establishment of a similar committee, with broader representation, by the Royal Australasian College of General Practitioners.

- The Medical Board of Queensland is introducing English language Testing as a mandatory requirement for overseas trained doctors from May 2004."

55. This briefing note (attachment 5) summarised the key issues as follows:

"

- The Royal Australasian College of General Practitioners (RACGP) has convened a group of key stakeholders to address public concern regarding quality clinical care and OTDs.
  - membership of this group includes representatives from QH, AMAQ, COTD, RACGP, Rural Doctors Association of Queensland and Queensland Rural Medical Support Agency.
  - at this stage, this group has met once but it is planned to continue.

- The Australian Government Department of Health and Ageing has established a Taskforce to address issues relating to OTDs. Queensland Health anticipates to develop further strategies for the management of OTDs based on work completed by this Taskforce.
- Initiatives of the Australian Government's MedicarePlus package are aimed at addressing issues relating to OTDs. Queensland Health is involved with the development of these initiatives and does not plan to expend resources on concurrent processes. The MedicarePlus initiatives include:
  - International recruitment strategies aimed at improving the coordination and consistency of current recruitment arrangements such as, assessment and pathways to entry into the Australian workforce.
  - Reduction of 'red tape' in approval processes aimed at streamlining the requisite approval processes for OTDs entering the Australian workforce such as, AMC examination processes, Australian and State Government processes for assessing areas of workforce shortage and recognition of overseas trained specialists' qualifications.
  - Assistance in arranging placements of OTDs which will support the establishment of a national information and referral service for OTDs, to assist OTDs efficiently navigate through the various approval processes leading to entry into Australia, registration/recognition and employment.
  - Improved training arrangements aimed at providing access to training opportunities for OTDs who require additional training prior to obtaining recognition by the relevant Australian medical college and medical registration board.
  - New immigration arrangements aimed at expanding on existing visa options aimed at encouraging TRDs to provide medical services in Australia for longer periods and to participate in further training so they achieve permanent residency. "

56. In my speeches at Parliament in 2004 I continually raised my concerns about the lack of student places in our universities to train young Australians in the medical profession. Our reliance on overseas trained doctors in my view stems from poor workforce planning back in the 1980's. Due to the decentralisation of our State we rely on overseas trained doctors more than any other jurisdiction.

57. Arrangements were put in place shortly after my swearing in as a Minister to meet several times a year with the Australian Medical Association (AMA) and the Rural Doctors Association of Queensland (RDAQ) so that we could regularly communicate about health matters in Queensland.

58. Immediately preceding their meetings with me as the Minister, my Director-General and/or the Director of Health Services would meet with the AMA and the RDAQ to address their agenda items. It is my understanding that the Department would deal with matters on the agenda and respond accordingly.

59. At the meetings between the AMA and myself and the RDAQ and myself the Director-General and/or the Director of Health Services would also be in attendance. There was a broad discussion around the agenda items with an understanding by all the parties that the matters would be followed through by the Department and that if there were any problems they were welcome to contact me.

60. In matters pertaining to overseas trained doctors that were raised in these meetings my Department supplied me with a number of written briefs which outlined actions that were being taken to address those matters. All of these documents were provided to the Commission of Inquiry prior to the commencement of hearings. None of these written briefs have shown anything that would raise concerns requiring ministerial intervention. None of these briefings indicated to me as Minister any warning or alarm that there were overseas trained doctors like Dr Patel operating in our system.

61. In addition these briefs did not contain any significant matters that were not being addressed at a State or Commonwealth level. It was always my desire to ensure that the matters that were raised by the relevant parties were resolved in a collaborative way.

62. I was aware that the Australian Medical Association (AMA), the various colleges of specialists (doctor's professional organisations) and the Medical registration authorities were working with Queensland Health to address the supply, support and skills development of doctors who were recruited as Area of Need doctors to work in the public and private sector in Queensland. Workforce issues such as this were also discussed at a national level under the umbrella of the Australian Health Minister's Advisory Committee (AHMC). The states and

territories would be represented at AHMC by the CEO of the various departments of health.

63. **(e) Lack of clinical input into management decisions in public hospitals;**

Response:

64. This topic was not raised with me in written briefings; nor was it raised orally with me to the best of my recollection.

65. **(f) Lack of community input into decisions made in public hospitals;**

Response

66. When I became the Minister I caused the department to work with a designated officer in my office to reinvigorate the community participation in our health services through a strategic approach to support and expected performance by the District Health Councils (DHC). It was my belief that the DHC had lost their purpose and had become moribund. I spoke to the chairs of the DHC at the visits to workplaces and told them of my expectation that they were to be advocates and community spokespersons for their district. It was a responsibility of their appointment to work with the District Manager to integrate the community into the service delivery by more active participation.

67. **(g) Access block at hub hospitals and the failure of the successor reversal of flow initiatives;**

Response:

68. To the best of my recollection, there were no specific briefings concerning these two topics. I am unacquainted with the expression "successor reversal of flow initiatives".

69. **(h) Problems with the system of financial incentives for elective surgery targets – allegations that public hospitals were giving priority to performing elective surgery at the expense of devoting resources to other health care problems – allegations that hospitals were manipulating their own waiting lists so that their waiting lists would receive the same number of new patients as were being removed by elective surgery. Allegations that inappropriate surgery was being**

performed so that more weighted separations could be achieved by hospitals seeking to show that more elective surgery was being done;

Response

70. Funding for elective surgery was provided so that hospitals would receive the money to pay for a nominated amount of surgery. If they demonstrated a capacity to carry out additional elective surgery then further funds would be provided to pay for that additional surgery. I am not aware of any allegations that hospitals undertook extra elective surgery at the expense of other services or any alleged waiting list manipulations as a consequence of the extra elective surgery funded by the election commitment.

71. I am not aware of any inappropriate surgery being performed in order to show increased activity towards the targets for the campaign to reduce the number of people waiting too long for elective surgery (the election commitment).

72. **(i) That published waiting lists were concealing the numbers of persons waiting to get onto the waiting list;**

Response:

73. During my time as Minister, the only waiting list of which I was aware is a list published of patients assessed as requiring surgery. This waiting list was published quarterly via the internet. This list assisted medical practitioners because it enabled medical practitioners to know the shortest waiting time for surgery.

74. To the best of my knowledge, during my time as Minister there was no system in place to produce for me any separate lists of patients waiting for appointments to see specialists. The focus was always on the elective surgery waiting list.

75. I was not aware of any concealment of numbers of persons waiting for appointments.

76. **(j) The Health Department's apparent practice of keeping from the public embarrassing reports and in particular the Lennox report on overseas trained doctors, the Bundaberg Base Hospital report by Dr Fitzgerald finished on 23 March 2005, the North Giblin report into the Fraser Coast Orthopaedic Department problems; and the Miller report.**

Response:

77. When a report was raised in the public arena in a critical manner I was advised that the department needed to ensure that any reports were correct and sustainable in a public forum given the important matters of privacy inherent in reports of a clinical nature and relative degree of significance of human health to the public.

78. **Was the Minister briefed on how and why there was a trend towards fewer Visiting Medical Officers (VMO) and more staff specialists?**

Response:

79. This issue was not raised by the Department. It was raised however in discussions with then President of the Australian Medical Association (AMA) Dr David Molloy. I indicated that the AMA should be pursuing this in the industrial negotiations for a new VMO agreement.

80. **Was the Minister briefed about the cut-backs forced upon the Prince Charles Hospital between October 2004 and 1 January 2005 after public criticism of Queensland Health by Dr Aroney and removed on 1 January 2005 and the reasons for the cutbacks and whether they are consistent with a departmental desire to punish Dr Aroney?**

Response:

81. To the best of my knowledge, there were no "forced cut backs" at Prince Charles Hospital and there was no "punishment" of Dr Aroney. I did not receive any written briefing about "forced cut backs" at Prince Charles Hospital or "punishment" of Dr Aroney.

82. **What were the reasons for keeping the report confidential?**

Response:

83. The Mahar report was not kept confidential. As it dealt with particular patients there needed to be proper support offered to the relatives of the patients identified in the report prior to its public release. The report was provided at a media conference at the Prince Charles Hospital on April 6, 2005 following its completion.

84. **The hospitals' budgets:**

85. (a) **How does the system respond when there is a greater clinical load than was anticipated when the annual budget was fixed?**

Response:

86. Responses to particular instances of this kind are operational matters which the Director-General and his senior staff would coordinate in consultation with the relevant Health Services District.

87. (b) **What knowledge did the Minister have of budgets being fixed in circumstances where it was anticipated that it would be insufficient to meet the clinical load?**

Response:

88. I am not aware of any circumstances where budgets were deliberately set to be insufficient. Of course, I was aware that the dollars allocated to Health in the budget could never fully satisfy the almost infinite and insatiable demand for health services.

89. **Was the Minister briefed as to why problems in Bundaberg identified by Dr Fitzgerald were not picked up by standard data collection?**

Response:

90. I was not briefed as to why the problems were not picked up by standard data collection.

91. **The Fitzgerald report:**

92. (a) **Evidence suggests that it was supplied to Mr Nuttall on about the 24th of March 2005 and that it had been completed on the 23rd of March. Was the Minister aware that the report had been completed and forwarded to him on about those dates?**

93. (b) **Evidence from Mr Headley Thomas proposed to be lead suggests that on 7 April 2005 one David Potter a media advisor to Mr Nuttall advised Mr Thomas that Mr Potter had just returned from**

Bundaberg with Mr Nuttall and Dr Buckland and advised Mr Thomas that the Fitzgerald report:

(i) Would not be completed;

(ii) Would not be released because Dr Patel no longer worked for Queensland Health and any outstanding issues would be handled by the District Manager and District Management.

94. **Was the Minister aware that the media advisor would be or had reported these maters about the Fitzgerald report?**

95. **(c) Had a decision been communicated to the Minister that the Fitzgerald report would not be released?**

96. **(d) Had a decision been communicated to the Minister that there were good reasons to withhold publication of the report.**

Response:

97. I asked the Chief Health Officer to verbally brief me on the report, the day it was raised in Parliament on March 22. Prior to that, I had no knowledge of the existence of the report.

98. Mr Thomas was aware that I had been to Bundaberg with the Director General. Mr Potter told Mr Thomas, what had already been relayed to staff at Bundaberg Hospital, that the report could not be completed because Dr Patel no longer worked for Queensland Health and had left the country.

99. Mr Potter also said that in light of Dr Patel's absence and that the report was incomplete, and that because the report contained confidential patient information, it would not be released publicly.

100. After speaking with the Director General, I was of the same opinion, that the report should not be publicly released for the above reasons.

101. At that stage I was not aware of the widespread ramifications of Dr Patel's time at Bundaberg. Nevertheless I requested the Chief Health Officer travel to Bundaberg to brief staff on his preliminary findings.

Letter from Senior Counsel assisting the Bundaberg Hospital Commission of Inquiry dated 12 August 2005.

102. The above correspondence from the Commission requested me to advise on two issues:-

(a) Whether media releases were provided to me for approval before documents were released to the media?

Response:

103. Any media releases containing comment from me would be approved by me prior to release.

104. **(b) Comment upon the proposition that the recent Director-General, Dr Buckland, had a closed door policy to all Ministerial staff and to the Minister so that anyone wishing to see the Director-General was obliged to make an appointment?**

Response:

105. I was not aware of any action by the Director General to operate a closed door policy.

Memo from Junior Counsel Assisting the Bundaberg Hospital Commission of Inquiry dated 22 August 2005

106. The memorandum from the Commissioner dated 22 August 2005 invites me to consider some 18 topics. A perusal of these topics reveals that a good number of them are addressed in the responses I have already given in this statement to matters raised in senior counsel's memorandum dated 11 August 2005. There is nothing I wish to add to those responses.

107. I now turn to topics that are raised in Junior counsel's memorandum which are not addressed in the earlier memorandum and respond as follows:

Topic 2 - Media Reports

Response:

108. In my office a team of advisors would receive Media Monitors newspaper clips and broadcast news alerts regarding matters relating to the Health portfolio. I was also given a copy of the Media Monitors press clippings which I was able to read when I was in the Ministerial Office.

Topics 3 and 5 – Lennox Report

Response:

109. I received a copy of the Lennox report on about 18 April 2005 when I requested it following media attention this year. I had not received any prior briefing about the Lennox report.

Topic 7 – Briefings regarding "dangerous and unacceptable" waiting periods

Response:

110. I was not provided with any written briefing regarding "dangerous" waiting periods for patients. If this question refers to patients who wait longer than recommended for surgery the issue is reflected in the Government's 2003 election commitment of $110 million over three and a half years to reduce the numbers of urgent and semi urgent surgical patients. The election commitment is summarised at item 4 in the briefing note dated 25 May 2004 (Attachment 6).

Topic 12 – Performance Bonuses

Response:

111. Directors-General are contracted to the Premier and my understanding is that there are no performance bonuses paid to Queensland Health staff.

Topic 13 – Review of Orthopaedic Health Care in the Fraser Coast Health Region

Response:

112. I first became aware of the "Review of Orthopaedic Health Care in the Fraser Coast Health Region" in April this year when the issue was raised publicly. Upon learning of the issue the steps I took were:

- on 14 May 2005 to seek and to receive assurances from the Director-General that orthopaedic services were currently safe given that the report had been written some time before;
- to cease orthopaedic services at the Hervey Bay Hospital due to the resignation for the Acting Director of Orthopaedics.

113. I have not addressed topics 15 and 17 as I am no longer the Minister for Health and it would be inappropriate for me to do so.

Dated this 30TH day of AUGUST 2005.

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Gordon Nuttall MP

MINISTERIAL STATEMENT – 3 MINS
HEALTH MINISTER GORDON NUTTALL

- I rise to make a Ministerial Statement - **and to issue a challenge** to my colleagues this morning.

- Mr Speaker – the job of ensuring that Queensland's health system remains one of the best, is not just the responsibility of one person – it's not just the job of health staff or management – it is also the **responsibility of every person in this House**, on behalf of our constituents.

- I have been to more than 20 hospitals and community health centres right around this state in the last 10 weeks – **talking to thousands of staff, to management, to health councils and to patients about their care.**

- I can tell you FIRST HAND there is **NO crisis** in our health system.

- But there IS **a crisis in public confidence** – driven by stunts, by emotive and unsubstantiated arguments in the media and in this House - and by attempts to ignore the very process that exists to help these people.

- One of the most frequent comments to me – particularly from elderly patients has been that they were very nervous about going to hospital and I quote "because of all the bad things we'd heard."

- Mr Speaker – these same people told me they don't know why they'd worried – and most of them went on to talk about the **great care** they'd received by staff.

- Patients pulled me up in corridors to talk about how good the staff were – one man at the **Princess Alexandra hospital** had been partially paralysed and he wanted me to know how the staff had helped him to walk again. Another elderly lady couldn't thank staff enough who helped with her weekly dialysis.

- So Mr Speaker – **I want to issue a challenge this morning** - to every member of this house – on both sides of politics.

- I'm asking every person to bring their patient issues, or their questions about the health system – to my department where we can try to address any issue. If every member is **serious about helping to improve patient care** – then you will help me on this.

- I am going to arrange for **District Health Managers in all 38 districts around the state** to have a quarterly meeting with their local MP to talk through the issues – AND the good things that are going on in our health system.

- Providing health care for 28,000 patients EVERY DAY isn't easy.

- Yes, like any industry – at the end of the day – **some of these people won't be happy with the service** they've received, and we should be fixing that, not looking for one-time headlines

- And it's not just individuals. I'm talking about medical experts who should know better – who the public look to for direction – **like the College of Emergency Medicine** – whose unfounded arguments about emergency departments this week were appalling.

- I am challenging each and every one of you this term – to **PARTICIPATE in the drive to improve health care** for patients.

2

Gordon Nuttall MP
Member for Sandgate

Queensland Government

Minister for Health

0 2 JUN 2004

Hon Jim Fouras MP
Member for Ashgrove
5A Ashgrove Avenue
ASHGROVE 4060

Dear Mr Fouras

As you will recall on 29 April 2004 I made a ministerial statement regarding the responsibilities of Parliamentary representatives to ensure that patient complaints are resolved between the patients and their health professionals and that Districts are responsive to the public.

In order to meet this objective I have directed Queensland Health to make arrangements with the 37 District Managers to be available to the Member of Parliament on at least a quarterly basis to discuss any issues concerning the provision of health services in the electorate.

Additionally I encourage you to seek to resolve any constituent matters with the Patient Liaison Officer for the District. Of course if matters are unable to be satisfactorily resolved at this level the option of referral to my office remains.

The contact details for the Health Service Districts are as follows

District	District Manager	Phone	Patient Liaison	Phone
RBH and RWH	Mr Richard Olley	3636 8201	M/s Lorriane Birtwell	3636 8216
Prince Charles Hospital	Ms Gloria Wallace	3350 8224	M/s Christine Riley	3350 8479

Yours sincerely

GORDON NUTTALL MP
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SPEECH TO PARLIAMENTARY ESTIMATES COMMITTEE

HONOURABLE GORDON NUTTAL
MEMBER FOR SANDGATE
MINISTER FOR HEALTH
July 8, 2005

Overview

Providing health care to all Queenslanders, across the length and breadth of this State is a great challenge.

When I became Health Minister a lot of people said to me it was a 'poisoned chalice'. I simply don't accept that.

As the Minister I'm prepared to publicly acknowledge the problems, I'm also a Minister who will work through the solutions and I look forward to the challenge.

I have said before we should never be complacent about the services we offer. We must balance the desire to offer services with the very real need to ensure that the services we provide are safe and effective.

The people of Queensland want, and deserve, the best health care we can provide. Everybody understands that desire.

However as a Government and a community we need to be honest about the environment in which we offer these services.

A chronic national and international shortage of trained medical professionals, increased costs associated with advances in medical treatment and changes in our lifestyle are just some of the pressures being placed on our hospitals.

Nobody can honestly suggest we can continue to operate the way we have. With the current shortage of doctors, demands for health services are outstripping our ability to provide them.

Without radical change, continuing to care for people in some parts of Queensland will not be possible.

To put this into perspective, in Queensland last year 226 medical students graduated from our universities, the same number that graduated in 1976. Over this period of time Queensland's population has more than doubled.

The result of this can be seen when looking at the latest report by the Australian Institute of Health and Welfare which provides information from 2002.

This report paints a bleak picture of Queensland's medical workforce.

In 1997 Queensland had 236 employed practitioners per 100, 000 of the population, by 2002 this had decreased to 220 per 100, 000 – the lowest of any State or Territory.

The report shows that between 1997 and 2002 the number of medical practitioners in Queensland grew by just 1.7 percent. The national average over the same period of time was 12 percent.

Figures from the Medical Board of Queensland show that between 2002 and now our position has gotten worse.

The number of medical practitioners we can rely on is decreasing.

In 2002, 13 754 doctors were registered in Queensland, this year there are only 13 643. Over this period of time our population has increased by more than 300 000.

When you look at these facts it becomes clear that if we are going to continue offering safe and effective health services we need to make radical changes.

Options – working with the Commonwealth

There are no easy answers to the challenges that face us, long term solutions will only be found if Governments, both State and Federal and all healthcare professionals are prepared to work together.

A large part of our medical workforce is divided between public and private systems leaving two levels of Government responsible.

This has severely impacted on our ability to successfully plan and manage our medical workforce.

A practical approach to address the problems with Australia's medical workforce would be to streamline this system - to make the Commonwealth responsible for all doctors and the States responsible for providing equipment and infrastructure.

This would ensure clear and simple lines of responsibility and reduce administrative burdens for both the Commonwealth and State Governments.

This approach would ensure better workforce planning with only one level of Government responsible from university through to specialisation. It would provide a truly national approach to these problems.

State and Commonwealth relations will always be prone to ideological debate and arguments about who pays.

This idea will involve putting those differences aside and with the best intentions working together to find a solution.

State solutions for a Queensland problem

We have reached a point where endless talk and debate is simply no longer an option.

If we are to continue to offer safe and effective services we need to radically change the way we work.

While I have outlined a way for the Commonwealth to work with States and Territories to do this, we can't rely on this alone. We need to look at solutions for Queensland that can be implemented now.

Enhanced clinical roles

Recently both the Premier and I released publicly a submission to the Morris Royal Commission outlining options to enhance the clinical roles of a number of nursing and allied health professions.

I won't take time now covering these ideas again but will say without these types of initiatives our medical workforce will never be able to meet the demands placed on it – that is, treating all patients who need help.

Midwife led models of birthing

The Hirst Review into maternity services in Queensland identified this issue and showed useful ways to fully utilise the medical workforce we have.

This review called for the establishment of mid-wife led birthing units throughout the State to combat the closure of maternity services in many rural and regional areas.

Under this model we would see midwives delivering birthing services for low-risk births across the State. We have already established a pilot site for this model of care in Mareeba and I have asked my Department to identify a further three potential sites to trial this service.

This is aimed at safely providing maternity services across the State – allowing mothers to birth in the community they live in.

I am committed to finding new and innovative ways to provide safe and effective health services to all Queenslanders, wherever they live.

Providing Services in Rural Queensland

However maternity services are just one example of the impact the shortage of doctors has had in rural and regional Queensland, in both the public and the private sectors.

If we are to continue to provide services throughout Queensland we need to be innovative.

One possible solution is to partner with the private sector.

To say to doctors in rural and regional Queensland here are the facilities, base your practices in our hospitals and using our resources care for all patients, not just private patients.

This approach would see local doctors partnering with Queensland Health in running our hospitals.

Doctors involved would receive a financial benefit through basing their practices in a ready made facility with support staff at no cost. This approach would also ensure public patients could see a doctor when they needed to.

Work is underway to identify four pilot sites that may be used to trial this model of health delivery. My Department is currently identifying hospitals that may be suitable and once this is

completed will make contact with local doctors to discuss the initiative.

This approach could be further enhanced through the co-location of ambulance services at our hospitals.

In effect this would create health service hubs, allowing local doctors, nurses, allied health staff and paramedics to work together to provide services.

Maintaining Health Professionals skills

Another vital area is working to maintain the clinical skills of doctors working in Queensland.

Studies show that each and every year in Australia approximately 18 000 patients die through medical misadventure – adverse outcomes from seeking medical treatment.

Medicine is a human science delivered by people. We will never find a faultless system. What we can and must do is work to ensure human error is limited.

Other industries such as aviation and the nuclear power industry have worked tirelessly over the last decade to limit human error. Each year airline pilots undertake an assessment of their skills, conducted in a simulator, before being allowed to continue flying.

Do we need to look at a similar system for medicine?

Some form of periodic assessment, conducted in conjunction with the Medical Board, when doctors renew their registration.

Each year doctors travel extensively to medical conferences to learn about advancements in medicine from their peers.

This is useful and essential, but you can't learn medicine simply out of a book – you need to study the practical work as well.

Through bodies like the Skills Development Centre there is no reason why we can't provide practical assessments to monitor doctors' clinical skills and ensure they are adequate.

Any doctor not competent to perform surgery or other important medical interventions would be identified and their registration limited until they became competent.

This would ensure our doctors continue to be trained in the latest surgical techniques and are all competent to perform interventions appropriate to their area of practice.

By conducting these periodic reviews we could ensure that doctors in both the public and private sector were checked, ensuring all Queenslanders could be confident in services they are receiving.

Delivering health services

A number of these initiatives will assist in delivering safe and effective healthcare to the people of Queensland.

They will not however address the fundamental issue of demand for services outstripping our ability in the public system to deliver services.

For this issue to be addressed we need to see a dramatic increase in the number of doctors we are training in Australia. Unfortunately even if this were to happen tomorrow it would still be 10 years before we would see the benefit.

In the meantime we need to better manage the health resources we have.

Partnering with the Private Sector

In Queensland we have only just started to explore innovative ways to partner with the private sector. The Government's current elective surgery program is a good example of how we can work together, with a number of patients receiving their elective surgery in the private sector.

We need to look at how we can enhance this relationship and ensure that our health service capacity, in both the public and private system, is used effectively.

One possible way to enhance this partnership would be through the use of a voucher system. Giving patients the ability to decide where and when they receive their surgery.

The vast majority of non-urgent elective surgery patients could be provided with a voucher, allowing them to access their surgery in the private system with little or no cost to themselves.

This would relieve the pressure on our public elective surgery waiting lists and fully utilise the capacity of the private system.

Through these more highly developed partnerships we may also see a wider scope to provide training to doctors who wish to become specialists.

Training in the Private Sector

Currently the public system is responsible for the vast bulk of specialist training.

This vital role places a heavy burden on our public hospitals. It's compounded by the fact that following their training many specialists leave the public system to pursue their career privately.

As part of this training our surgical specialists spend a lot of time working on non-urgent elective surgery, gaining experience on the less complicated cases.

If we implemented a voucher system and moved the bulk of this work into the private sector this would have implications for the training of specialists.

Private providers would need to start playing a role in the training of new specialists. Providing them with theatre time and supervision to give them the experience they need.

Queensland has already pioneered a system of allowing junior doctors to train privately in Queensland Hospitals, as highlighted by the Productivity Commission's Health Workforce Paper earlier this year.

If we are going to partner with the private sector we need to extend this arrangement and encourage all private facilities to offer training places.

Conclusion

As I have said before there are no easy solutions.

We need to look at new and radical ways to deliver health services to the most decentralised state in Australia.

To improve our health system we need to work together. We have to put vested interests aside and look for solutions.

I've started today by outlining a number of ideas that could be looked at. I don't pretend for one minute that they are the answers to all our problems but they're a starting point.

The challenge is now for all stakeholders to debate these ideas, put their own on the table and for all of us to start working towards solutions.

Briefings folder for the Incoming Minister for Health

Queensland
Government
Queensland Health

5 February 2004

LABOR GOVERNMENT

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Medical staffing:

Medical shortages exist in rural areas and in specialties. This is especially the case in the specialties for which advances in technology and treatment are increasing demand, but for which the public sector is unable to compete with the lucrative returns available to private sector doctors.

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

An Australian Medical Workforce Advisory Committee report in 2002 identified a gap of 234, between the number of medical school graduates and the number of vocational training places. With additional places progressively being added, increases will eventually realise 450 Queensland graduates, (an increase of 100 per cent) by 2010. Student clinical placement and intern placement and supervision on current models will not be possible due to this increase, and Queensland Health is currently exploring its ability to provide clinical training for the increased numbers.

Contentious issues in recent months include the following.

Overseas trained doctors: Queensland Health has a high reliance on overseas trained doctors (OTDs) with approximately 30 percent of the Queensland Health's medical workforce being overseas trained. Due to the increasing competition in the international medical labour market, many overseas doctors recruited under various arrangements have difficulty with English language and cultural assimilation. The competence of some international graduates is questionable. Queensland Health will fund and manage the Centre for Overseas Trained Doctors from July 2004, to facilitate the processes of screening, recruiting and preparing OTDs for employment in Queensland Health Public Hospitals.

Vocational Training: Queensland has 16.5 per cent of national specialist training positions for 18.7 per cent of the Australian population. The Australian Competition and Consumer Commission imposed a range of reforms on the Royal Australian College of Surgeons, aimed at balancing the College's involvement in surgical training and assessment standards and concerns about the College's processes. Queensland Health has concerns about College processes for the selection of trainees and is continuing to meet with the College in relation to those concerns.

Australian Medical Graduate Numbers: The Australian Government has announced the funding of additional medical undergraduate places. It is expected that by 2010 the number of intern positions required in Queensland will double. This will not be sustainable with the current intern training and placement requirements, and Queensland Health is exploring the options for managing the additional medical graduates.

General Practitioner Workforce: The Australian Government is proposing to fund additional training places for General Practice training. The available medical graduate numbers are insufficient to support these additional places. The current emphasis by the Australian Government on the General Practitioner workforce is not a sustainable model for the future.

Dentistry staffing:

Queensland Health has significant shortages in dentistry professions, with vacancy rates of 21 per cent for dentists, ten per cent for oral health therapists, 12 per cent for dental therapists and seven per cent for dental technicians. These shortages are effecting health service delivery.

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Queensland Government
Queensland Health

A BRIEFING TO THE MINISTER

RECEIVED
RECORDS TEAM
29 MAR 2004
DEPT. OF HEALTH

BRIEFING NOTE NO: BR020126

REQUESTED BY: Sherrie Bryant

DATE: 16 February 2004

PREPARED BY: Leanne Chandler, Principal Project Officer, Health Advisory Unit, ext. 40200

Linda McCormack, Principal Project Officer, Employment Relations and Strategies Unit, ext. 54343

Bernie Ridsdill-Kenny, Principal Policy Officer, Legislative Projects Unit, ext. 40405

SUBMITTED THROUGH: Suzanne Huxley, Principal Medical Adviser, ext. 41386

CLEARED BY: Gloria Wallace, State Manager Organisational Development, ext. 41046 A/GMHS

DEPARTMENTAL OFFICER ATTENDING: Not required

DEADLINE: 16 February 2004

SUBJECT: **Meeting with the Australian Medical Association of Queensland**

MINISTER'S COMMENTS:

GORDON NUTTALL MP
Minister for Health
Member for Sandgate

PURPOSE:

To provide information in preparation for a meeting with the Australian Medical Association of Queensland to be held at 4pm , Tuesday 17 February 2004.

BACKGROUND:

- Issues which may be raised include:
  - Overseas Trained Doctors
  - Intern Positions in North Queensland for Medical Graduates
  - Medical Indemnity
  - Vocational Training
  - Fees paid by Retired Doctors
  - Recency of Practice.

ISSUES:

OVERSEAS TRAINED DOCTORS (OTDs)

Background

- Approximately 30% of the Queensland Health medical workforce trained overseas.
- Media coverage late last year highlighted a number of issues pertaining to overseas trained doctors (OTDs) / temporary resident doctors (TRDs), including a perceived lack of:
  - competence
  - assessment prior to employment.
- Queensland Health has financially supported the *Centre for Overseas Trained Doctors* (COTD), since 1996, specifically to facilitate the processes of screening, recruiting and preparing OTDs for employment in Queensland Health Public Hospitals. The COTD provided over 80 assessed and oriented OTDs to Queensland Health in 2002
  - the General Manager Health Services has approved the relocation of the COTD, from the University of Queensland, to the Queensland Health Skills Development Centre from 1 July 2004.
- A joint Queensland Health / AMAQ Working Group was established to specifically address issues pertaining to TRDs. This was an inter-agency committee comprising representatives of Queensland Health, AMAQ, The Medical Board of Queensland, COTD, the Australian Government Department of Health and Ageing, and the Department of Immigration, Multicultural and Indigenous Affairs
  - this committee has met three (3) times with the last meeting being in July 2003
  - there are no further meetings planned for this committee due to the establishment of a similar committee, with broader representation, by the Royal Australasian College of General Practitioners.
- The Medical Board of Queensland is introducing English Language Testing as a mandatory requirement for overseas trained doctors from May 2004.

Key Issues

- The Royal Australasian College of General Practitioners (RACGP) has convened a group of key stakeholders to address public concern regarding quality clinical care and OTDs.
  - membership of this group includes representatives from QH, AMAQ, COTD, RACGP, Rural Doctors Association of Queensland and Queensland Rural Medical Support Agency.
  - at this stage, this group has met once but it is planned to continue.

- The Australian Government Department of Health and Ageing has established a Taskforce to address issues relating to OTDs. Queensland Health anticipates to develop further strategies for the management of OTDs based on work completed by this Taskforce.
- Initiatives of the Australian Government's MedicarePlus package are aimed at addressing issues relating to OTDs. Queensland Health is involved with the development of these initiatives and does not plan to expend resources on concurrent processes. The MedicarePlus initiatives include:
  - International recruitment strategies aimed at improving the coordination and consistency of current recruitment arrangements such as, assessment and pathways to entry into the Australian workforce.
  - Reduction of 'red tape' in approval processes aimed at streamlining the requisite approval processes for OTDs entering the Australian workforce such as, AMC examination processes, Australian and State Government processes for assessing areas of workforce shortage and recognition of overseas trained specialists' qualifications.
  - Assistance in arranging placements of OTDs which will support the establishment of a national information and referral service for OTDs, to assist OTDs efficiently navigate through the various approval processes leading to entry into Australia, registration/recognition and employment.
  - Improved training arrangements aimed at providing access to training opportunities for OTDs who require additional training prior to obtaining recognition by the relevant Australian medical college and medical registration board.
  - New immigration arrangements aimed at expanding on existing visa options aimed at encouraging TRDs to provide medical services in Australia for longer periods and to participate in further training so they achieve permanent residency.

INTERN POSITIONS

Background

- The Australian Government has announced the funding of 234 additional bonded medical undergraduate places. The number allocated to Queensland is not known.
- In addition to the medical schools at the University of Queensland and James Cook University, Griffith and Bond universities are establishing medical schools. These additional schools are expected to be operational from 2005.
- Medical graduates are required to successfully complete a postgraduate "intern" year in order to be eligible for general registration. This year has to be undertaken in an accredited facility. It is unlikely that the currently accredited 13 facilities will be able to employ all additional medical graduates and continue to meet the requirements of the Medical Board of Queensland for general registration.
- It is expected that if all medical students from Queensland universities over the next 7 years graduate, then by 2010 the number of intern positions required in Queensland will be approximately doubled.

Key Issues

- The number of medical graduates from Queensland Universities is expected to almost double from 232 in 2003 to 450 in 2010.
- The impact of the additional medical graduates will not be restricted to North Queensland.
- Contact with the Northern Zone indicates that they are keen to retain all medical graduates from the James Cook University (JCU) in North Queensland, however based on current

nding and internship models they are not able to accommodate all potential JCU graduates. Preliminary work conducted in the Northern Zone:
  - has not considered the impact of additional graduates from other Queensland universities
  - has not considered the possibility of alternative models for internship in order to increase the number of interns able to be employed in Queensland (not just Northern Zone)
  - indicates additional funding will be required for each additional intern employed
  - suggests all JCU graduates should be employed in North Queensland
    - it is likely that not all JCU graduates will want to stay in North Queensland
    - it is likely that graduates from other Queensland universities will have come from and/or will want to relocate to North Queensland on graduation.

- Additional medical graduates will enter the workforce from 2006. Queensland Health is currently exploring the options for managing the additional medical graduates. Stakeholders involved with this work will include representatives from each Queensland Health Zone, Medical Superintendents, Medical Board of Queensland, and the Postgraduate Medical Education Foundation of Queensland.

- Staff from the James Cook University School of Medicine have approached the Premier, local Members and the Minister for Health to express concerns for the future of the School of Medicine, the main one being that The Townsville Hospital was constructed as a teaching hospital but was not being funded as such.
  - the Townsville Hospital was a teaching hospital before James Cook University established a medical school
  - the current benchmarking model used to fund Queensland Health hospitals, sets benchmarks for specific peer groups. This model considers infrastructure differences including teaching requirements. The Townsville Hospital is in the same peer group as other teaching hospitals such as the Princess Alexandra, Royal Brisbane and Women's, and The Prince Charles Hospital
  - the Premier's office was advised that Queensland Health, through the Northern Zone Management Unit, is willing to work with JCU on the issues raised by Professor Wronski, to develop a strategic understanding of the issues and a plan to manage them
    - this work could include a joint planning exercise to assess the impact of increased medical graduates on public health services in North Queensland.

MEDICAL INDEMNITY (General Issues)

Background

- The collapse of the United Medical Protection (UMP), one of Australia's major medical defence organisations, in early 2002 lead to a range of significant events relating to medical indemnity arrangements at the state and federal level.

- On a state level, Queensland was proactive and undertook the following:
  - implementation of extended indemnity cover for Queensland Health medical practitioners;
  - indemnity support for visiting medical officers (VMO);
  - Tort Law Reform (Implementation of Justice Ipp Review Recommendations);
  - representations to the Commonwealth concerning the Incurred But Not Reported (IBNR) Indemnity contribution scheme on behalf of affected employees.

- From a Federal perspective, a Medical Indemnity Policy Review Panel was chaired by the Federal Minister for Health and provided a report to the Prime Minister 10 December 2003.

Key Issues

- The Medical Indemnity Policy Review Report included a range of recommendations that have now been adopted by the Federal Government pertaining to indemnity arrangements for private patients. Key changes include:

- **Lower Threshold for High Cost Claims Scheme (HCCS)**
The new claims threshold to cover 50% of the cost of all claims against doctors over $300,000 will not be available for claims related to the treatment of public patients treated in public hospitals.

Queensland Health is aware that UMP will no longer provide insurance cover to a doctor who treats public patients in public hospitals due to the inability to access the HCCS. This has potential to affect those medical companies that are contracted to supply services to public hospitals eg radiological services.

While UMP is one of the major medical defence organisations, Queensland Health is aware that that other MDOs will provide cover for the treatment of public patients in cases where the state does not indemnify the doctor.

- **Premium Support Scheme (PSS)**
The Federal Government will pay premium support to medical insurers to ensure that doctors are supported for 80 per cent of the amount their premiums exceed 7.5 per cent of gross private medical income. It is unclear the level of impact that this will have on Queensland Health employed doctors.

- **IBNR Scheme**
The Federal Government has altered the IBNR scheme to reduce the financial impact on doctors.

Queensland Health has advocated that various categories of Queensland Health doctors should be exempt from the scheme and is awaiting confirmation from the Commonwealth Department of Health and Ageing regarding application of the *Medical Indemnity Amendment Regulation 2003* in relation to this issue.

- **Tort Law Reform**
The Federal Government supported a recommendation for states and territories to continue the process of tort law reform and the work on developing a scheme for the long-term care of the catastrophically injured. The Queensland Government has already enacted relevant legislation by adopting all of the Justice Ipp recommendations. Furthermore, Queensland Health is represented by the Deputy Director-General Policy and Outcomes on the national review of long-term care costs.

- **Review Panel**
The Federal Government will convene a new working group to consider the effectiveness of the recommendations – including further tort law reform – and, if necessary, the feasibility of a doctor-owned monopoly medical insurer (within 18 months).

- **Medical Assessment Panels**
The Panel called on the States and Territories to examine the option of Medical Assessment Panels to analyse cases on a clinical basis before they become part of the legal process and enable such panels to refer matters to Medical Boards where appropriate.

MEDICAL INDEMNITY (Visiting Medical Officers – VMO)

Background

- While Queensland Health provides VMOs with indemnity cover for the treatment of public patients and for "failure to warn" claims, the Department also implemented the Indemnity

surance Reimbursement Scheme to 'compensate' VMOs for a proportion of their private medical indemnity insurance costs (as per the VMO Agreement 2001).

Key Issue

- The implementation of both Federal and State initiatives are intended to ensure that the medical indemnity system is stable, equitable, and affordable. VMOs will significantly benefit from the Commonwealth Government injecting $181 million to adopt the Indemnity Panel recommendations (in addition to previous commitments of $438 million over the next four years).

VOCATIONAL TRAINING

Background

- Medical Specialist (vocational) training is the responsibility of Specialist Medical Colleges. Queensland Health employs the trainees, as Registrars, while they are "in training".
- The Australian Medical Workforce Advisory Committee (AMWAC) was established in 1995 to assist with the development of a more strategic focus on medical workforce planning in Australia and advise on national medical workforce matters, including workforce supply, distribution and future requirements. This includes present and future medical workforce training needs.
- Queensland has 16.5% of national training positions for 18.7% of the Australian population. Each year, in consideration of the AMWAC recommendations, Queensland Health, in consultation with hospitals and specialist Colleges, identifies specialty areas which are a funding priority for additional Registrar training positions.

Key Issues

- The Australian Competition and Consumer Commission (ACCC) considered an application by the Royal Australasian College of Surgeons for authorisation to engage in anti-competitive conduct. The ACCC imposed a range of reforms aimed at finding an appropriate balance between the need for the College to remain substantially involved in the setting of surgical training and assessment standards and the need for concerns about the College's processes to be addressed. The process for the review of other medical specialist colleges is still to be determined.
- Queensland Health has concerns about College processes for the selection of trainees and is continuing to meet with the College in relation to those concerns.
- The remaining medical Colleges are to be reviewed by the ACCC. The Australian Health Workforce Officials Committee (AHWOC) is currently examining how this process will proceed in consultation with other stakeholders.

FEES PAID BY RETIRED DOCTORS

Background

- A "non-practising" registration category was introduced into the *Medical Practitioners Registration Act 2001* in 2003 to allow retired doctors who no longer intend to practise medicine to continue to use the title "doctor".

Key Issues

- The AMAQ and numerous retired doctors have expressed concerns about the registration fees payable by retired doctors who elect to retain "full" registration so they can practise in a limited way.

- These concerns were discussed at a recent meeting convened by the Chief Health Officer, involving AMAQ and Medical Board representatives. The parties agreed that the issues could be resolved by the *Medical Practitioners Registration Regulation 2002* being amended to allow the Board to waive the registration fee for retired doctors who earn no income from practice. Retired doctors would also be exempted from payment of the application fee for non-practising registration if they are already registered in another category of registration.
- The Board's endorsement of this proposal is being sought after which a Ministerial Submission will be forwarded seeking approval for the relevant amendments.

RECENCY OF PRACTICE

Background

- All of the Health Practitioner Registration Acts (enacted in 2001) include a "head of power" to prescribe a regulation to enable the boards to consider an applicant's 'recency of practice' in renewing registration. The regulations have yet to be made.

Key Issue

- The Office of Health Practitioner Registration Boards has commenced a project to determine the Boards' policy on this issue. The AMAQ is being consulted as part of this project. A Regulatory Impact Statement for any proposed regulation will need to be prepared, which will be managed by the Legislative Projects Unit.

BENEFITS AND COSTS:

ACTIONS TAKEN/ REQUIRED:

Note the above information.

ATTACHMENTS:

nil

DRAFT MEDIA RELEASE:

[ ] ATTACHED

[X] NOT ATTACHED

[redacted]

Queensland Government
Queensland Health

MINISTERIAL BRIEFING

Number BR020647

For Noting

DEADLINE 25 May 2004

SUBJECT:

Meeting with AMAQ

PURPOSE:

To advise the Minister on areas of concern identified by the AMAQ.

DEPARTMENTAL OFFICER ATTENDING THE MEETING / EVENT: (Optional)

The information is required for a meeting the Minister will be attending with the AMAQ. The meeting is scheduled for Tuesday, 1 June 2004.

BACKGROUND:

The information requested relates to concerns with the provision of health services in Queensland raised for discussion by the AMAQ.

1. Concerns raised by the Australian Society of Anaesthetists in their letters dated 8 March 2004 (MI 118209) and 16 April 2004 (MI 119664).
2. Introduction of Telephone Triage into Queensland.
3. Bulk Billing Clinics in Public Hospitals.
4. Waiting Lists for Elective Surgery.

KEY ISSUES:

1. **Concerns raised by Australian Society of Anaesthetists.**

- MI118209 (8 March'04), MI119313 (27 March'04) and MI119664 (16 April'04) refer.
- In addition to the above correspondence, the A/General Manager Health Services and Principal Medical Adviser have met with members of the Australian Society of Anaesthetists – Queensland Committee on 28 November 2003, 22 January 2004 and 5 March 2004.
- A briefing (MI119664) has been requested and is being prepared on the concerns raised by the Australian Society of Anaesthetists.

- Concerns raised by the Australian Society of Anaesthetists are:
  - a high level of dissatisfaction of Specialist Anaesthetists working full time for Queensland Health (QH)
  - remuneration and conditions of employment for anaesthetists
  - the number of overseas trained doctors employed by QH
  - variations in the application of the award across QH facilities resulting in some specialists receiving different remuneration or working under different conditions.
- Another issue raised in the latest correspondence (MI119664) which is not specifically related to anaesthetists is indemnity:
  - lack of support for a medical employee by QH
  - in relation to aeromedical retrievals – anaesthetists do not undertake aeromedical retrievals.
- Information provided from LATTICE indicates there were 118.75 approved full time specialist anaesthetist positions across QH as at 25 April 2004; 2.7 of these positions were vacant. This is an acceptable vacancy level.
- The Anaesthetists from the Princess Alexandra and Royal Brisbane and Women's Hospitals have indicated a need for a 100% pay rise for anaesthetists working at those two hospitals:
  - QH is not able to match remuneration available in the private sector
  - full time specialists employed by QH have access to private practice options whereby they can engage in private practice and increase their salary by up to 100%
  - the A/General Manager Health Services has employed a project officer, to commence 1 June 2004, whose role will include examination of the terms and conditions of employment of Queensland Health medical practitioners across the State
  - this request from PAH and RBWH anaesthetists for increased remuneration was related only to tertiary hospitals in Queensland. No consideration was given to practitioners in other specialty areas or other hospitals.
- Approximately 30% of Queensland Health's medical workforce is trained overseas. There is a limited supply of Australian graduates, with vocational training places to be filled (1489 in 2003) exceeding Medical School output (~1250 per annum). The Australian Government has increased the number of medical student places with the additional medical graduates over the next 5-10 years, the reliance on overseas trained doctors will decrease.
- Some facilities have reportedly offered incentives (including financial) outside award entitlements to interstate anaesthetists. It is planned that the project officer being employed by the A/General Manager Health Services will consider examination of this issue.
- Indemnity
  - <u>Perceived lack of support for QH medical employee working at Caloundra Hospital</u>
    - this issue is being managed directly between the Office of the Director-General, the Sunshine Coast Health Service District and the doctor concerned
    - the Medical Board of Queensland has referred the doctor concerned to the Health Practitioner's Tribunal
    - under the current IRM policy related to indemnity, QH is not able to grant indemnity to enable legal representation before the Health Practitioner's Tribunal
    - the IRM policy related to indemnity is currently being reviewed.
  - <u>Indemnity during aeromedical retrievals</u>
    - anaesthetists are not involved with aeromedical retrievals
    - the point raised is an insurance, not indemnity issue – it is not related to indemnity of the doctor should an adverse event occur during the flight but the amount paid to the family in the event of an accident

- QH is currently preparing a cabinet submission in relation to insurance cover for medical officers who participate in aeromedical services.

Key Messages

- It would be inappropriate for QH to consider the salary increase requested, which is for one group of specialists and limited to 3 hospitals in Queensland. There would be major industrial implications in relation to anaesthetists working in other hospitals and to medical practitioners in other specialties.
- The A/General Manager Health Services has a project officer commencing 1 June 2004 whose duties will include an examination of the issues raised in relation to employment conditions.

2. Introduction of Telephone Triage into Queensland.

In the recent Queensland Government election Premier Beattie announced the establishment of a 24-hour, seven-day-a-week, statewide health hotline to give easy access to health advice and information about the most appropriate and accessible services. The election commitment included a triage service operated by fully trained nurses and backed up by specialist doctors. The health hotline, known within the health sector generally as a health contact centre (HCC), is expected to be operating by December 2005.

To commence the development and implementation of the election commitment Queensland Health has established a project team and will shortly be issuing a tender for a three month consultancy to determine the preferred HCC business model for Queensland. During this phase consultation with internal and external stakeholders will be undertaken to ensure that the model will be sustainable and accepted by health consumers.

The election commitment allocated $25M over three years, $10M capital and $10M recurrent once fully operational ($0.5M for half year operational costs in 05/06). The adequacy of this allocation will be assessed by the HCC project team during the development of the preferred business model in terms of split between capital and recurrent and the on-going operational budget.

In a letter from AMAQ dated 28April 2004 they raised concerns regarding telephone triage systems in terms of consistency in advice, potential medication errors and compliance of callers to advice given. These are legitimate concerns for any health service and, as such, are the foundations of most evaluations of a HCC. Due to the information collections associated with HCCs, it is relatively easy to benchmark in regards to these health outcomes. The difficulty is benchmarking HCCs to other health services, which generally do not have the same level of data.

AMAQ stated that the only telephone triage service they support is one based on an after hours model and staffed by General Practitioners. The Queensland Government and QH hold a different view as they consider a society that is increasingly becoming 24x7 for work and personal activities requires the services of a HCC beyond just the after hours period. International and Australian trends clearly indicate that Registered Nurses are the most common call-takers for HCCs. Add this to the result, as stated by the AMAQ, that overall information provided by HCCs has not seen a significant proportion of adverse events, QH considers nurses as an appropriate profession to staff a HCC.

Key Messages:

- QH has commenced the work to implement the election commitment of a health hotline.
- The first phase of work for the HCC project team will include consultation with internal and external stakeholders. QH is keen to work in partnership with such organisations as AMAQ.
- The AMAQ's concerns regarding health outcomes of telephone triage services are concerns of any health service. HCCs proactively evaluate themselves against such measures as advice consistency, compliance rates, clinical errors and service cost which forms their framework for continuous improvement.
- The election commitment reassured health consumers and professionals that callers would remain free at all times to use the doctor or service they choose and that quality of care would be upheld as the service will give advice based on strict and proven clinical protocols.

3. Bulk Billing in Public Hospitals

- The Queensland Government, as part of its 2004 election campaign, committed to pilot four general practice (GP) clinics in or near public hospital emergency departments (EDs) to more appropriately manage and treat the large volume of semi and non-urgent patients seeking treatment in EDs.

- Queensland Health has commenced negotiations with the Australian Government (AG) to pilot the bulk-billing GP clinics and has forwarded a submission to the AG detailing the proposed locations of the GP clinics, proposed service model, infrastructure Queensland will provide, proposed staffing and funding arrangements and hours of operation.

- Proposed sites are Redland, Redcliffe, Toowoomba and the Gold Coast. These sites have been selected based on current activity and anticipated future demand. In the six months to December 2003, these hospitals treated almost 17,000 people categorised as semi and non-urgent during business hours, and almost 24,000 out of hours.

- The Australian Government recently agreed to put in place arrangements so that patients attending a GP clinic located in or near an ED will be bulk-billed under Medicare.

- Under the proposed model, all ED patients will present to a single entry point, where they will be triaged. Based on the triage assessment, patients will be directed to either the GP clinic or the ED practitioner. The GP clinic waiting areas and treatment areas will be separate to the ED areas. The GP clinic and ED will be physically linked to allow easy access/flow of patients from the GP clinic to the ED as required.

- The proposed GP clinics will function as an assessment, management and treatment service for semi and non-urgent presentations. The service will not be directed to the provision of ongoing care or substitute for a patient's usual GP. The purpose of the service is to address a need for more timely access to semi and non-urgent medical care where this cannot be provided by a person's usual GP. Where follow-up appointments are required, the patient will be referred to their usual GP.

- Queensland Health will provide a range of infrastructure to support the establishment and operation of the GP clinics, such as equipped premises, practice nurse services (Queensland Health employees), administrative support and security.

- Queensland Health is keen to collaborate with key stakeholders to facilitate the successful establishment and operation of the GP clinics and will continue to consult extensively with key stakeholders in determining appropriate staffing and funding models for the proposed clinics.

4. Waiting Lists for Elective Surgery

The Queensland Government has committed $110 million over the next three and a half years to treat approximately 18,000 extra elective patients within the times recommended by doctors. $20 million of this funding was made available immediately in February 2004 to address elective surgery backlogs and reduce waiting times by 1 July 2004.

A partnership between the private sector and Queensland Health was created in an effort to reduce elective surgery waiting lists to allow the delivery of more non-urgent procedures such as cataract surgery and joint replacements, as well as maintaining and improving our urgent and semi-urgent performance.

To date more than 2000 patients have had surgery as part of this election commitment.
Around the State:

- 930 patients will receive urgent hip and joint replacement operations;
- 1225 patients will have eye operations - 1000 of those in partnership with the private sector;
- almost 370 people, including 23 children will receive heart procedures that will dramatically change the quality of their life;
- up to 70 children will have ground breaking surgery to correct debilitating spinal conditions;
- another 220 patients will have urgent ear, nose & throat surgery; and
- surgeons will carry out more than 500 general operations.

Over the next three years the initiatives in the $110 million strategy are:

- $7.5 million for an extra 3,000 cataract operations shared with the private sector, and two additional ophthalmology specialist training positions.
- $47 million for public patients across the state, based on the demand for surgery.
- $15 million for an extra 900 joint replacement procedures across the State, including hip replacements and knee reconstructions.
- $3 million for additional orthopaedic surgery, especially joints, on the Sunshine Coast at Noosa Hospital.
- $6 million to commission a second operating theatre at Caloundra Hospital and 10 extra beds. This will mean greater numbers of Sunshine Coast residents receiving their surgery on time.
- $3 million to address the problem of some patients not being fit for surgery causing postponements. Strategies will include weight loss programs, improved cardio vascular fitness, assistance to stop smoking.
- Introduce an independent audit of the State's public hospital waiting lists.
- $2.5 million to employ a specialist ENT surgeon and tackle long wait Ear, Nose and Throat elective procedures at Cairns Hospital.

- $1.5 million to employ six new nurses and open an extra critical care bed at Cairns Hospital taking the number to 16. This will relieve pressure on the emergency department and improve waiting times for elective surgery.
- $4.5 million to establish a full specialist vascular surgery service at Nambour Hospital which will include staff specialists and visiting surgeons, and two dedicated nursing support staff. This will improve waiting times and allow major vein and artery surgery on the Sunshine Coast

This commitment will allow us to further improve on what is already recognised as the best public hospital system in the country with the shortest waiting times. The official Queensland Health figures for the end of the 2002/03 financial year show:

- Only 2.3% of category one (urgent) had waited longer than the 30-day period recommended by doctors, compared to 3.4% at 30 June 2002.
- 5.3% of category two (semi-urgent) patients had waited longer than the 90-day period recommended by doctors, compared to 10.6% at 30 June 2002.

These excellent results are expected to be exceeded at the end of the current financial year.

The official Queensland Health figures for the four quarters of 2003 show:

- 97% of category one (urgent) patients received their operations in the 30-day period recommended by doctors, compared with 96% in 2002; and
- 92% of category two (semi-urgent) patients received their operations in the 90-day period recommended by doctors, compared with 86% in 2002 and the target of 60% set by the National-Liberal Coalition Government of 1998.

These figures are collected in the same manner as that of the previous government, and also in the same way that other Australian governments do.

The 2004 independent Productivity Commission report found that Queensland has the shortest waiting times for elective surgery in the country and that we have the most efficient hospital system. It reported:

- Looking at the time it took for the nation's hospitals to admit half of all patients on waiting lists, Queensland patients were admitted four days earlier than the national average;
- Looking at the time it took for the nation's hospitals to admit 90 per cent of all patients on waiting lists, Queensland patients were admitted 71 days earlier than the national average;
- 3.6% of Queensland patients had to wait longer than a year for an operation in Queensland compared with 4.5% in every 100 nationally.

The latest Australian Institute of Health and Welfare Report (June 2003) for the year 2001-02 says:

- Patients on orthopaedic waiting lists did best in Queensland, with half of them being admitted within 24 days in comparison with 168 days in Tasmania;
- Half the patients requiring an operation on the septum (nose) in Queensland were admitted within 59 days, compared with 228 days in Tasmania and 309 days in the Northern Territory.

MEDIA IMPLICATIONS: N/A

CONSULTATION:

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IS THIS IN ACCORDANCE WITH ANY COMMITMENTS / INITIATIVES:

Responses include information specific to concerns raised by AMAQ.

RECOMMENDATION:

That the Minister not the above information in preparation for a meeting with the AMAQ.

MEDIA RELEASE: (Optional)

[ ] YES [X] NO

COMMUNICATION STRATEGY / SPEECH: (Optional)

[ ] ATTACHED [X] NOT ATTACHED

Section 1 – Concerns raised by Australian Society of Anaesthetists.

Cleared by: Suzanne Huxley
Principal Medical Adviser
Health Advisory Unit

Date: 20/05/ 2004

Cleared by: Jan Phillips
A/State Manager
Organisational Development

Date: 20/05/ 2004

Section 2 – Introduction of Telephone Triage into Queensland

Cleared by: Mr Tony Hayes
Director
Information and Business Management Branch

Date: 27/05/ 2004

Section 3 – Bulk Billing Clinics in Public Hospitals

Cleared by: Ms Anne Turner
Director
Health Strategy and Funding Branch

Date: 24/05/ 2004

Section 4 – Waiting Lists for Elective Surgery

Cleared by: Mr Gary Walker
Manager
Surgical Access Service

Date: 25/05/ 2004

Cleared by: Dr Glenn Cuffe
Manager
Procurement Strategy Unit

Date: 25/05/ 2004

RECOMMENDATION:

BRIEFING

Noted: .....

COMMENTS:

GORDON NUTTALL MP
Minister for Health
Member for Sandgate

/ /