

Submission to the Senate Education, Employment and Workplace Relations
References Committee

This submission is not confidential and my name can appear on the Committee website.

I am a medical practitioner and public health physician who has worked in Aboriginal and Torres Strait Islander health in NSW, in Queensland and in Canberra (as medical adviser to OATSIH) since 1982. I was substantively employed in a permanent full time senior medical officer position by Queensland Health from 1992 until January 2013.

I held the position of public health physician – sexual health in the Cairns Public Health Unit (CPHU) from 2005 to 2013. This position was given the brief to work with remote communities and health districts (Cape York and the Torres & Northern Peninsula Area (T&NPA)) to address the entrenched high rates of the common bacterial sexually transmitted infections (STI), that is, gonorrhoea, chlamydia, trichomoniasis and syphilis, and to prevent an outbreak of HIV/AIDS. The position also worked to improve the management of STI in the broader north Queensland population.

The sexual health program in CPHU (which my position led) grew out of the real and persisting concern that far north Queensland remote populations are at significant risk from HIV/AIDS. The proximity and interaction with Papua New Guinea (PNG) populations living in remote Western Province, and the ever increasing mobility of remote living young people to and from regional mainland Australian cities (with significant HIV burdens) combined with the existing burden of other STI place remote populations at ever increasing risk of an outbreak of HIV that would affect young men and women of reproductive age equally.

The sexual health program (SHP) in CPHU developed slowly. Over time, it built community engagement mechanisms and (for the first time in north Queensland) significant sexual health promotion capacity. For example, we have recently published in the Australian Health Promotion Journal (December 2012) an article outlining the development and evaluation of community groups called Youth and Relationship Networks or YARN groups that inform and guide our work in the T&NPA District. The YARN groups provided oversight for research (knowledge, attitudes and practices surveys of young people in relation to STI, HIV and safe sex), for the development of sexual health communications projects (two series of an educational radio drama called Kasa Por Yarn, and the conduct of Indigenous Hip Hop projects). The YARN groups also provided community support for the development of a high participation population STI testing and treatment strategy (called the Young Person Check or YPC). Academic articles describing these initiatives are currently being finalized for publication in various peer-reviewed journals.

In addition to community engagement, sexual health communications projects and effective high coverage STI testing and treatment strategies, the CPHU SHP worked hard to improve condom access throughout the remote region of north Queensland. This work and the continuing challenge posed by the need to continue to improve condom access for remote living young people has recently been published in an editorial (in December 2012) in the Australian and New Zealand Journal of Public Health. Another critical area of work has been a collaborative project with Education Queensland that aims to embed, again for the first time in north Queensland continuous, age appropriate sexuality and relationships (S&R) education in Indigenous majority schools in the region.

In addition, the CPHU SHP conducted communicable disease enhanced surveillance for gonorrhoea and for syphilis and assists with workforce development for remote practitioners.

This was all “a work in progress”. We had developed some traction, but progress in addressing sensitive health issues in remote Indigenous populations is always slow and arduous and requires a long-term investment. Sadly, this investment has now been largely wiped out – and with no consultation, no evaluation, and no discussion of how emerging gaps could be filled.

In 2005 the SHP comprised two positions – mine and the public health nurse (PHN), syphilis surveillance, for north Queensland. These positions were both permanent and full-time. The program had grown to include a second full-time PHN coordinating the YPC (Australian government (AG) funded), three sexual health promotion positions including a permanent state funded senior coordinator, a senior public health officer, a temporary position working to embed S&R curricula in schools, and administrative support. Funding came from both QH and Australian Government sources though most of the project funding was ultimately federal in origin (from national partnership agreements: both Closing the Gap and Indigenous Early Childhood).

Despite being fully funded within the allocations attached to the SHP positions, approval for work travel became very difficult from April / May 2012. This, we were informed, was to be short term due to QH budgetary shortfalls in the 2011-12 financial year. But approval for work travel continued to be withheld after June 2012 and in fact was never restored. We had received funding for another PHN position in early 2012 because the staff in the SHP had become very busy – a situation exacerbated by an on-going syphilis outbreak in remote north west Queensland - but we were not allowed to recruit to this AG funded position.

We were told that an organizational re-structure was imminent and that this would entail the loss of some positions from the Division (the Health Services and Clinical Innovation Division) within which the public health service network across the state was situated. Email comments on the overall approach to this re-structure were invited by Brisbane but no details were given on options for particular programs or positions. No requests were made for information that might inform such a re-structure, no evaluations of the work being done were requested. No consultation meetings were held. Possible outcomes – such as

the abolition of the key positions that drove the work of the SHP – were never discussed with me nor with my SHP colleagues.

In early September, while I was on three weeks leave, the new organizational structure was announced by videoconference from Brisbane. Approximately 40% of the 100 or so positions in the north Queensland public health service network were gone. The new structure abolished most health promotion and all public health nutrition positions across the network and no longer included a public health physician – sexual health, nor the senior sexual health promotion coordinator position. The public health officer position had also gone, temporary positions were ceased at the end of their contracts and approval to recruit to the new funded position was never allowed.

It is pertinent to note that this cost-cutting restructure of QH has disproportionately affected the most disadvantaged and least influential populations in the north Queensland region.

It still remains unclear what the remaining CPHU SHP staff are meant to be doing and the work of the SHP has all but ceased (with the exception of syphilis surveillance).

I was not given any forewarning of this outcome. My immediate supervisor has since told me that he was disallowed the option of discussing possible outcomes with me or of informing me of the eventual outcome before I had left for my overseas holiday. My immediate supervisor (senior director of CPHU) contacted me by telephone while I was on leave (and travelling in Europe) to let me know that my position no longer existed after twenty years of public service.

Despite repeated requests for a rationale, explanation, justification for the abolition of the three (two permanent and one temporary) most senior positions in the SHP – I have not received any explanation. My email to senior QH staff members commenting on the problems with the new arrangements and the challenges posed by the loss of the SHP, remained unanswered. The work we (in the SHP) were doing was effective and progress was being made. The work still needs to be done and it is not possible to do it at a district (now HHS) level as it requires expertise and public health knowledge and experience that is not found in the remote HHS setting.

I returned from leave in mid September and on October 8, 2012, I received a letter confirming that my position had been abolished and that they (the Chief Health Officer Branch) had been “unable to identify an alternative suitable role to place (me) in within the Division”. I was therefore designated as a “surplus employee”. I was not offered any kind of support from the QH hierarchy, and I was not encouraged to seek re-deployment. QH decision-makers made no attempt to find an alternative position for me within the organisation. I was not given the opportunity to apply for QH positions in Brisbane or elsewhere.

I waited a further two months to receive the so-called “offer of voluntary redundancy”. It was made clear to me that to refuse the redundancy would

result in retrenchment soon thereafter (without the financial sweetener that accompanies redundancy). My last day of work was January 11, 2013.

The manner in which the SHP program has been treated indicates to me that the work we were doing was not valued by decision-makers and is clearly not considered a priority. The manner in which I personally have been treated by my public health physician colleagues and by decision-makers in Brisbane is at the least dismissive, offensive and lacking in respect. I do not hold any hard feelings for the senior director of CPHU as he was placed in an impossible position and had been very supportive of our work over the years. Since leaving QH I have been awarded a national consultancy in my area of expertise – it is not the work I would have chosen to do at this point but it does indicate that my skills were appropriate to my position in QH.

The outcome is personally difficult but the loss is mainly to be felt by remote area youth in far north Queensland in coming years.