COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# HOUSE OF REPRESENTATIVES

## STANDING COMMITTEE ON HEALTH AND AGEING

**Reference: Health funding**

THURSDAY, 16 MARCH 2006

BRISBANE

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**HOUSE OF REPRESENTATIVES**

**STANDING COMMITTEE ON HEALTH AND AGEING**

**Thursday, 16 March 2006**

**Members:** Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Entsch, Mr Georganas, Mr Johnson, Ms King and Mr Vasta

**Members in attendance:** Mrs Elson, Mr Entsch, Mr Johnson, Mr Somlyay and Mr Vasta

**Terms of reference for the inquiry:**

To inquire into and report on:

How the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c) considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d) how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e) while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior’s Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

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**Committee met at 9.26 am**

**CHAIR (Mr Somlyay)**—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into health funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. Although Australia has one of the best health systems in the world, members of parliament are only too aware of the need for improvements. We all receive a steady stream of complaints from our constituents concerning the health system, often about private health insurance premiums, gap payments and public hospital waiting lists.

The road to this public hearing in Queensland has been long and arduous. It is the first time in my memory of 16 years on parliamentary committees that the Premier of Queensland has banned his officials from giving information or evidence to the federal parliament. This, in my opinion, is a reflection of the Queensland culture of lack of accountability and parliamentary scrutiny of the executive.

At the federal level, the Auditor-General has the power and the duty to conduct performance audits of government programs on behalf of the parliament. The Auditor-General currently is auditing the performance of the Australian health care agreements and will report to the federal parliament shortly. But the Commonwealth Auditor-General cannot examine the performance of the administration of the health care agreements by Queensland. Tragically, neither can the Auditor-General of Queensland, because he does not have the power to conduct performance audits, only financial audits. Perhaps the power to conduct performance audits would have prevented the events in Bundaberg—the worst example of maladministration, I believe, in Queensland's history.

The Premier's reason for non-cooperation with this committee is that a COAG process of review of the health system is under way and a committee of officials is working on that review. Our inquiry is giving others the opportunity to have a say in the COAG process, as the senior officials referred to by the Premier seem to be the problem, not the solution. Having said that, I guarantee the full protection of the federal parliament to any witness from the public sector in Queensland who feels bound by their conscience to give evidence to this committee but who is prevented from doing so under threat.

At today's public hearing, the committee will hear from Mr Tony Morris QC, the former commissioner of inquiry into events involving Bundaberg base hospital, We will also take evidence from Professor Wronski of James Cook University, the Australian College of Rural and Remote Medicine and representatives of the visiting medical officers, local GPs and the Queensland branch of the AMA.

Before we start, I would like to thank Mr Phil Sheedy and the Mount Olivet Hospital for very generously allowing us to have use of this room today. I would prefer to have public hearings on the health system within the confines of a health facility, rather than the sterile atmosphere of, say, Parliament House or another government office. This hearing is open to the public and a transcript of what is said will be made available via the committee's website.

[9.30 am]

**MORRIS, Mr Anthony John Hunter, QC, Private capacity**

**CHAIR**—I thank you, Mr Morris, for making your submission to this committee at my suggestion. You are a very well-respected Queenslander for the work that you did on behalf of the people of Queensland. I and a number of other members of the committee felt that your work should not disappear and that you should be given the opportunity to table it and speak to it under parliamentary privilege. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement to the committee.

**Mr Morris**—As you noted, I have provided a written submission to this inquiry. I really do not wish to add anything to what is in writing, because I put a lot of thought and care into it. It outlines, albeit in a fairly summary way, the issues that I think are important for ensuring that the problems that existed at Bundaberg not only are addressed in a quick-fix way but also are prevented from occurring again at any time in the future. Frankly, that is what all of us want to see regardless of politics, regardless of whether we are oriented to the state or federal system and regardless of whether we are in the health system, the legal profession or any other walk of life. Having the world's best health care has to be a priority for all Australians. I cannot pretend that I have all the answers; I am sure I do not. But my experience of hearing evidence over 50 days gives me some insights, and I hope that sharing those with this committee will be of some assistance.

**CHAIR**—Under the health care agreements, the Commonwealth funds about 50 per cent of the cost of public hospitals and the states fund the other 50 per cent. Through the tax sharing arrangements and the GST which Queensland received, about half of all expenditure in Queensland is from Commonwealth revenue. We have a vested interest as about 75 per cent of the cost of public hospitals is funded from the Commonwealth. So for us to be told, 'Mind your own business; public hospitals belong to us,' whether it is by Queensland or any other state, is really not acceptable to the Commonwealth. The minister for health, Tony Abbott, has already foreshadowed that the Commonwealth will be examining the health care agreements, next time they are renegotiated, as to whether or not there should be strings attached to the funding given to the states for public hospitals in order to achieve national standards. Do you have a view on that?

**Mr Morris**—I would be very disappointed if this fundamentally important issue descended either into a brawl between politicians of one side and the other or between state and federal levels. Frankly, no-one can say that they have a totally clean slate in health care. Looking at the federal level, for a start, the Keating government in 1995 cut the number of medical students from 1,200 to 1,100 per year throughout Australia. That was a silly decision, but since then we have had 10 years of Liberal government, which has done nothing about it.

Similarly, at a state level, during the last 15 years or so, all of the major tertiary referral hospitals in Queensland have been rebuilt, and a lot of the major provincial ones. Every time, the

number of hospital beds has been reduced—the Royal Brisbane Hospital, Princess Alexandra Hospital, Townsville Hospital, Cairns hospital and Bundaberg Hospital—all of them have been reduced, often with a 30 or 40 per cent reduction in the number of beds. You cannot say that is Mr Beattie's fault. I am not here to defend Mr Beattie or his government, but the problems which are now emerging are long-term problems that cannot be attributed to one side of politics or the other or to one level of government or the other. We are in a crisis and we all have to work together to find a way to solve that crisis.

**CHAIR**—The committee could not agree with you more, Mr Morris. In fact, one of the motivations for this inquiry was that members of parliament, at least at the federal level, are very tired of the blame game played by the federal government and the state government. We have had suggestions, not concrete evidence, that as little as 20c in the dollar gets through to the patient in the public system, which is totally inadequate. We want to achieve a better result than that.

**Mr Morris**—Frankly, those suggestions do not surprise me. I have not been able to get hard figures either. Indeed, I have not even been able to get hard figures on the number of employees within Queensland Health. The best figures that I do have suggest that there are close to 10,000 clerical staff employed by Queensland Health. That is 2½ or three times the number of doctors. That is more than there are hospital beds throughout the state. So to say that only 20c in the dollar is getting through to health care does not surprise me at all.

**Mrs ELSON**—I was just reading some figures that state only 20 per cent of Queensland Health's 64,000 employees are actually doctors or nurses. So it is not a monetary problem, is it? If it were, you would not have that many bureaucrats or public servants in jobs while doctors and nurses jobs were only 20 per cent of the jobs on the ground. Logic tells me it is not a monetary problem.

**Mr Morris**—That is absolutely right. It is a problem of ensuring that the money gets spent where it is needed. As one example, one figure that I have—and this comes from Mr Peter Forster's report, so it can be regarded as fairly reliable—has over 4½ thousand public servants operating out of Queensland Health's headquarters in Charlotte Street. The only patients that ever feature at the Charlotte Street headquarters are the occasional public servants who scald themselves on the tea trolley, yet taxpayer funds, both federal and state, are being channelled into health care and are being spent on running a massive bureaucracy in the middle of Brisbane rather than going out to the hospitals in the suburbs and throughout the rest of the state. That is what needs to be addressed.

**Mrs ELSON**—Publicly, we hear that doctors leave Queensland because they are not being paid the substantial amounts that our southern doctors are paid. Did you pick up that through the course of your inquiry?

**Mr Morris**—Definitely. It is beyond doubt that at least until quite recently both Queensland doctors and, more importantly, Queensland nurses were the worst paid in Australia on average. I give credit to the Beattie government, which has addressed the situation with visiting medical officers, VMOs, which is an important category of health care professionals. But it is just not good enough to say that Queenslanders are not as important as the rest of Australians, because

the people who provide primary health care—the doctors and nurses who treat Queenslanders—should not be paid as much as their colleagues in the southern states. That is a disgrace.

**Mrs ELSON**—We would lose doctors at a faster rate in Queensland if they were under pressure, wouldn't we? It would be easy for them to move to another state to work, wouldn't it?

**Mr Morris**—What you say is obviously right, but I do not want to lose sight of the fact that we have wonderful people working in our state's hospitals—magnificent nursing staff and doctors who are of the highest standard that you will find anywhere in the world including amongst them, combining the public and private sector for the moment, some 1,700 overseas trained doctors. One of the tragedies of Bundaberg is that the Patel experience has cast a cloud over so many outstanding overseas trained doctors who are providing magnificent service to Queenslanders.

What you say is perfectly right: the pay and other conditions are not conducive to keeping the best people in Queensland. But we all have to be thankful that there are so many doctors and nurses who care more about their patients than how much they get paid. If it was not for the self-sacrifice, the situation would be far worse than it is at the moment.

**Mrs ELSON**—I agree with you. Thank you.

**Mr ENTSCH**—I want to continue on in relation to the bureaucracy versus the health providers. A lot of the hearsay evidence we get suggests that this is where one of the major problems is. The layers of bureaucracy are overburdening the health providers. You made a comment that in fact there is more than one bureaucrat for every bed that is available in this state. You would almost expect every patient in hospital to have a bureaucrat standing beside them offering services.

This is taking it away from the south-east corner, but in Cairns, for example—and you may or may not be able to answer this—if one of the bureaucrats takes leave or for some reason is not available to work there is no difficulty in finding replacements. Basically, that job is filled for that period of time; the bureaucratic void is always filled. However, if one of the health providers—be they a member of the senior nursing staff or a doctor or whatever—has to for some reason or other take a leave of absence, there is a tendency to shut down beds rather than replace them. Do you have any evidence of that?

**Mr Morris**—That is certainly the anecdotal evidence that we received during the course of the inquiry. It is interesting that you have raised the example of Cairns, because just before my phase of the inquiry was closed down we were examining the situation in Cairns. I want to emphasise that this is only an allegation—we were closed down before we could fully explore it, get to the bottom of it and find out the truth. One of the allegations that came to our attention was that while doctors placed patients on waiting lists in particular categories—one category is those who have to be treated in 30 days; another category is those who have to be treated within six months; and so on—a junior clerk in the manager's office had the job of taking patients out of the category that a doctor had put them into and putting them into a lower category so that at the end of 12 months their waiting list figures looked better than they really were. A person without any medical qualification—a person who had never even seen the patient—was saying, 'This doctor thinks you need treatment within 30 days but I am going to put you on the list of

people who need treatment within six months.' That is the sort of thing we have to address with bureaucracy. As I say, I do not know if that particular allegation is true, but it fits in with the anecdotal evidence we received about what is going on in, frankly, every regional hospital throughout the state.

**Mr ENTSCH**—That is very much in line with concerns that have been raised about people who have come to the top of the list and, either the morning of or the day before their operation was due, have been told that they have now been slid back and to come back in a month or two. I have examples of that happening four and five times over a period of months.

**Mr Morris**—Apart from obtaining replacements when someone is absent, the other great imbalance between bureaucrats and clinicians is in their conditions of employment. I take as the best example of this the visiting medical officers, who are, frankly, the backbone of our hospital system. I do not detract in any way from the great work done by staff doctors, but VMOs are often very senior specialists in particular fields and people who command huge incomes in the private sector. They make themselves available to work in public hospitals as an act of charity. When I say 'an act of charity', the hourly rates that they are paid at a public hospital do not even cover the rent of their rooms on Wickham Terrace for the period that they are performing operations, so it is genuinely an act of charity.

When a VMO arrives at a public hospital, you would think, for example, that he or she would have a car park that they could use which was near the lift so they can get in and out quickly. But, of course, they are all taken up by the district managers, area managers and so on. You would think that there would be a coffee room where, for example, a surgeon could sit down and talk with the anaesthetists and the other medical referring staff and so on about the problem. But that is elitist. You cannot have a doctors' common room like you did in the old days. If you have a doctors' common room, then you would have to have a nurses' common room, a wards persons' common room, a gardeners' common room and a tea-trolley operators' common room. Doctors are not allowed to have common rooms like that.

I know that this committee is very interested in the process of auditing performance within hospitals. A major part of that is what is known to the initiates as M and M committees—mortality and morbidity committees—where a doctor who has performed an operation sits down with other people in the same area of specialisation and talks about the operations they have had over the last week or the last month. They talk about the patients who have died to find out what went wrong. They talk about the patients who have had infections or other unacceptable outcomes. That is a tremendously valuable part of the continuing improvement in our medical system. But VMOs are not paid for attending meetings like that. They are paid to arrive at the hospital, to operate for a number of hours and then to leave, without any allowance for participating in those sorts of auditing or similar processes.

The other fundamental problem that so many VMOs come up against is that within the public system everything has to work to a schedule. You might have a surgeon arrive to do an operating session where there are six patients lined up, and it is expected that those patients will be finished within a certain number of hours. But the first patient has unexpected complications and the operation takes longer than anyone expected. If that happened in the private system, if that happened at Wesley, at St Andrew's or here at Mount Olivet or somewhere like that, the hospital administration would bend over backwards to make sure that those patients were not

disadvantaged and that the ones who were on the end of the list were rescheduled later that day or the next day—in any event, as soon as possible.

But within Queensland Health there are strict guidelines that the staff have to work for a number of hours and then they have to leave. Even if they volunteered their own time to stay on and finish the operating list, they would not be allowed to. It is so frustrating for VMOs, who are giving up their own time, as I say, practically as an act of charity, to help out, frankly, the more disadvantaged members of the community who need to rely on the public system. Every day they see patients being turned away without treatment because the managerial systems within Queensland Health do not allow that treatment to be carried out efficiently, as it would be in the private sector. It is just a tragedy.

**Mr ENTSCH**—On staff resourcing, tomorrow we are going to Caboolture, where there is a real issue. Again, talking parochially, in the south-east corner there is a crisis and a political commitment has been made to get a service up and operating within a very short period of time, because the area is so under-resourced in relation to staff. Do you have any evidence at all in relation to where they have drawn those staff from to meet that political commitment? There have been suggestions that some of those staff have been drawn from other remote and regional areas where there are also critical shortages. They have basically been drawn to an area because of a political commitment to get something up and running and, in doing so, chronic shortages have been created in those other areas. It is robbing Peter to pay Paul, if you like.

**Mr Morris**—Mr Entsch, I think you have really hit on one of the biggest problems at the moment. Queensland Health is in damage-control mode. Caboolture is either the best or the worst example of where we now have a contract to private enterprise to provide the emergency services at Caboolture because Queensland Health could not provide the doctors that were necessary and the government had made a commitment to the people of Caboolture that they would resolve it.

It reminds me of the old saying, ‘The squeaky wheel is the one that gets the oil.’ If your local community complains loudly and has the support of its local member of parliament and the support of the media, the government can suddenly find money to put in private contractors to provide essential services. But if you live at Biloela or Cunnamulla, where you just do not have the sort of political clout that you need, the problems can be ignored and allowed to go away.

In one sense I have to give credit to the health minister, Mr Robertson, and to Mr Beattie for coming through on their promise. They told the people of Caboolture that they would address the situation and they have done. But in another sense it is a sign of a quick-fix solution that will do nothing either for Caboolture or for anyone else in the state.

**Mr JOHNSON**—And creates a crisis in another region.

**Mr Morris**—It creates a crisis in another region. It is a bandaid solution. It is a very expensive bandaid but a bandaid nonetheless, and we need to look at addressing the real structural problems within Queensland Health. These are all long-term matters. Perhaps I can illustrate with one example. Mr Beattie—and, again, he deserves credit for this—has negotiated with the federal government 80 extra training places for doctors in Queensland. That is a start, and no-one should take that away from Mr Beattie. But the reality of the situation is that, at this

moment, we have 1,700 overseas trained doctors working in Queensland. Under Queensland law, they would not be working here unless there was a genuine shortage. There has to be an area of need or something of that sort. So we can work on the premise that 1,700 is the absolute minimum shortfall that is in existence at the present time. It is probably a lot more than 1,700 but let us say that it is 1,700.

We have 80 extra places. It normally takes a minimum of about eight years for a student to start off at med school and end up as a fully qualified doctor. So those 80 extra places will come on stream by about the year 2016. To fill up the current shortfall of 1,700, by producing 80 extra a year, is going to take 22 years. So we are looking at something like the year 2038 as being the time we have simply addressed the current shortfall—which will be great for me, as I will be 78 then and I will probably need all the health care I can get!—but that is just assuming that the population does not continue to increase and the population does not continue to age and that we do not have improvements in health care that mean that conditions which currently are not treatable will be treatable and so no. So whilst 80 extra places is a great achievement—and all credit should go for that—it is not enough. It is far short of being enough.

**CHAIR**—Can you understand now why I was so critical of the state government not appearing before this committee to give us information such as you are giving us in order for this committee to make recommendations to the government about training places?

**Mr Morris**—I understand your viewpoint but, frankly, I do not want to be drawn into controversy.

**CHAIR**—It was not a question.

**Mr ENTSCH**—In your submission you made a comment about the economic rationalist culture within the department of health and the feudal hierarchy that you have there. I put to you that the fact remains that it does not matter whether there are 80 doctors coming on by 2016 or 800 or 8,000 doctors coming on by 2016; the reality is that, unless that attitude changes significantly, the benefactors are going to be other states that are providing a far more attractive employment situation for those trained professionals.

**Mr Morris**—You are undoubtedly right, but I think three things have to change. You have identified one of them—that is, that the bureaucratic hierarchical structure has to change. The second thing that has to change is having actual clinicians, people who are trained in medicine, deciding what goes on in our hospitals. As I said earlier, you do not found a school with the principal being a bean counter or a bureaucrat; you have an educator in charge because they know what they are doing. You do not send an accountant to head the police station at Mount Isa, Longreach or Townsville. You do not run any other branch of government or any branch of private industry on the basis of having people in charge other than those who actually know what the operation is all about.

Yet, throughout Queensland, we have hospitals run by people who do not even require a St John’s ambulance first aid certificate to get those jobs. So that does have to be addressed. We need to have the clinicians not running the bureaucracy—it would be a scandalous waste to have trained doctors actually writing the cheques or ordering the pharmaceuticals or whatever—but in decision-making positions so that people who know what they are talking about can say: ‘We

need more funding here for endoscopies, because if we don't have more funding here for endoscopies we're going to have more cancer patients and that's going to cost more money down the track. Spending $500 today, giving a person an endoscopy and detecting a cancer, is not only go to save that person's life but also going to save the Treasury tens of thousands, perhaps hundreds of thousands, of dollars over a five-year period.' That is why you need to have clinicians making the decisions and not bureaucrats.

The third thing—and I am sorry this is such a long answer—is communities have to be given ownership of their own hospitals. We had a system in Queensland until the late 1980s of hospitals being run by local boards. That became a bit of a scandal mainly because hospital boards tended to resemble the local branch of the National Party. What happened then is that we threw out the baby with the bathwater. We now have a system where hospitals are run solely by bureaucrats appointed from Charlotte Street, with so-called advisory councils that have no role at all. We heard evidence at the Bundaberg inquiry from the chairman of the advisory council, who was a very distinguished local government servant of the people, a man who knew his community and so on, and he had not even heard about the problems with Dr Patel until he read about them in the local newspaper. No-one told him what was going on. Two days after Patel left, he wrote a glowing reference thanking Patel for his contribution to the hospital because no-one had told him what was happening. The Patel situation just could not have happened if we had the old hospital board system, where members of the local community could tap someone on the shoulder and say: 'We seem to have a bit of a problem with that doctor. Can you find out what's going on?'

**Mr ENTSCH**—It could not possibly have happened either if staff were encouraged to raise concerns, and were protected when raising those concerns, about activities of individuals or processes in hospitals. This is one of the areas where you were very critical in your report, with regard to Queensland Health's approach to dealing with staff who raise concerns about activities within hospitals. Could you expand on that? Have you any views on how we could look at ways of encouraging and protecting those people who are prepared to stand up and make a difference?

**Mr Morris**—Let me begin by paying the tribute to where it belongs—to Toni Hoffman. What a wonderful person: to put her career, her friends and everything on the line for the sake of protecting the patients. I read in the paper that she was down in Canberra earlier in the week shaking hands with the Queen. I have shaken hands with the lady who has shaken hands with the Queen, and I am proud that I have. She is a wonderful person.

But for every Toni Hoffman in Queensland Health, there are probably another 19 Toni Hoffmans who have attempted to blow the whistle and have not succeeded. Toni Hoffman was, in a sense, lucky not only because she is a very articulate, forceful and clear-thinking person but also because she had support of a local member of parliament, Mr Rob Messenger, the National Party member for Burnett, and, ultimately, the support of the *Courier Mail* and the other press and media. Without that, it would have fallen on deaf ears.

I can give one specific example. I would prefer not to name names, but during our inquiry we received evidence about a situation at the Gold Coast involving a dental practitioner working for Queensland Health who would be the Jayant Patel of dentistry. The whistleblower who blew the whistle on that particular dentist was another dental practitioner. He had the support of nursing and other clinical staff. He made his complaint. As a result of that, he got sacked and the district

manager of the Gold Coast Hospital got promoted. Nothing has been done to redress or remedy that situation. That is just one example.

Earlier this week, another example arose. An employee of Queensland Health—I will not say where from or what branch or practice that person is involved in—has very grave concerns that Queensland Health is ripping off the federal government's Medicare structure: overcharging, bulk-billing patients without having proper referrals and without filling in the forms, having blank referrals signed or sent through on the fax machine—the most scandalous stuff. Fortunately, I was able to tell that particular whistleblower about the existence of this committee and I understand—and I thank the committee secretariat for doing this—that every appropriate step has been taken to ensure that that person can provide information to this committee with protection against any adverse consequences. But it should not have to be like that.

It is great that this committee is here to provide that resource, but it should not have to happen that way. We need to address it from two directions. On one hand, we need to make the administration in Queensland Health more acculturated towards supporting people who blow the whistle, rather than vilifying them. On the other hand, we need to have the legal protections in place so that a whistleblower does not have to go the people whom he or she is blowing the whistle against, which is the current system.

The whistleblower should have a mechanism where they can raise their concerns in a formal way within the department and if nothing is done within a limited period of time, say three months, then they have the right to go to their trade union if they are, for example, a nurse or a member of another union organisation, to their professional body if they are a member of, say, the AMA or another professional association, to their member of parliament, either state or federal, to raise their concerns and, in the ultimate resort, if they still cannot achieve satisfaction after, say, another three months, to the press and media.

Throughout my long career in the legal profession, I have had mixed relations with the press and media, but we have to face the fact that they are the ultimate protection of our liberties in this country. One can say all one likes about the great institutions of parliament, but unless we have a powerful, courageous, and independent media then things like Jayant Patel can happen and no-one gets to hear about them.

**Mr VASTA**—What would you like to see happen out of the inquiry that really has not been achieved yet?

**Mr Morris**—I think we have lost a great opportunity to have genuine systemic reform. I do not wish to belittle what has been achieved. Mr Davies has produced a magnificent report. He has given closure to the people of Bundaberg. He has highlighted and exemplified the problems with Jayant Patel. I think we can be fairly confident that that specific scenario is not going to arise again. But it is all wasted unless we have the structural reform that is necessary to put Queensland Health into a situation where it can handle the demands of a state which has the quickest growing population in Australia, a population which is rapidly ageing, particularly because of the effect of retirement refugees from the southern states. We have our own unusual mix of medical problems, from tropical diseases in the far north of the state to the diseases that come from working on the land, the skin cancers and so on that we all know about, to the diseases involved with urban living, the heart and arterial diseases, diabetes and all of those sorts

of urban diseases—that unusual combination that I do not think any other state in Australia really has. We have the most diverse population in Australia. We are the only mainland state where more than half of the population lives outside the capital city. We have all of these challenges. To address those, it is not enough to let a contract for private enterprise to run the emergency department at Caboolture. I would prefer to see a contract go to private enterprise to run the administration of Queensland Health, and then we would see some real reform.

**CHAIR**—That might become recommendation 1!

**Mr Morris**—We do need to address the structural problems. We do need to address, as I have said, having clinicians given a genuine role in decision making, having local communities given a genuine role in running their local hospitals, and having this imbalance between administration or bureaucracy on one hand and clinical services on the other hand redressed to the point where we do not have—as seems to be the case—something like 80c in the dollar being spent on non-clinical services. So those I think are the challenges.

I do not doubt for a moment Mr Beattie's commitment to solve this problem. I give him every credit for that. But unless something is done, and done quickly, to address those structural problems, just putting out the bushfires when they arise at Caboolture, Maryborough, Bundaberg, Cairns or anywhere else is not going to correct the problems.

**Mr JOHNSON**—Mr Morris, thank you for coming before us this morning. I read your submission with great interest, having a brother who is a neurosurgeon and a sister who is soon going to graduate from medical school. It was very compelling and very instructive. I will just ask you a series of general questions initially and then lead to some specific ones. Obviously, many months have passed since you were first appointed to the commission. When you first took on that role, could you foresee or imagine the kinds of evidence and submissions that you would hear?

**Mr Morris**—That is a very interesting question. I have not even reflected on that.

**Mr JOHNSON**—Obviously there was a context for your appointment in the first place, but then going into the more deep and substantive—

**Mr Morris**—The answer is, probably not. I think two things surprised me more than anything else. Firstly, when I read in the *Courier Mail* about Jayant Patel—although I am not saying for a moment that I discount everything I read in the *Courier Mail*—it did come across as a bit of a beat-up, a bit of a storm in a teacup. In fact, the *Courier Mail*, despite all the tremendous work done by Hedley Thomas, had only scratched the surface. We had the most awful evidence of just how bad this man was. A very distinguished Australian-trained surgeon who saw a lot of Patel's patients, a guy called Geoff de Lacy, said it was not at the lower end of competent; I think he described it as something like 10 times worse than anything he had seen with any other—

**Mr JOHNSON**—A hundred times. I wanted to take you to that quote:

They're not 10 times what you might expect. They're more like 100 times what you might expect.

**Mr Morris**—That was a genuine shock. The other thing I found quite surprising was the extraordinary culture of difference—the them and us attitude—between administration and clinicians. I do not know whether anyone on the committee has noticed that for years it has been a staple of television medical dramas that you have the bureaucrat at daggers drawn with the clinician. In fact, while the inquiry was going on, Channel 7 brought out that new program with Hugh Laurie called *House MD*. It demonstrated very well the brilliant clinician fighting against the bureaucrat who saw things through bureaucratic eyes. I thought that was all fiction; I thought that was something that scriptwriters made up out of their fertile imaginations because it made a good story. But, no. It is going on every day in every town and city throughout Queensland. It is mind-boggling that the 64,000 people, or however many there are working for Queensland Health, are not all on the same team trying to do good for the patients. They are fighting with one another over what money gets spent on what, and whether Queensland Health should fund projects to establish systems for which there is then no funding to implement. There are mad debates that go on rather than everyone focusing on how they can make life better for the patients. Yes, those were two genuine surprises.

**Mr JOHNSON**—In your introductory remarks you said that we should be ‘world-class’. This issue over the state of Queensland Health has certainly become a bit of a barbecue stopper. My Queensland colleagues and I are often ribbed by our colleagues in Canberra about the state of our health system. My own view is that we are not world-class. I would like your thoughts on that. When you say ‘world-class’, what is your reference point?

**Mr Morris**—Our interstate colleagues who rib you should bear in mind that Queensland led not only Australia but also the entire world in having universal free hospital care. We were the first state in Australia and we beat the British National Health Service by about 15 years. The world’s most wealthy country, the United States, still has people dying in the gutter because they cannot afford medical insurance. I think that we, as Queenslanders, should be tremendously proud that we have led the way in ensuring that every citizen has the right to a standard of medical care that is, in my belief, world-class.

One of the witnesses who came before the inquiry was an American neurosurgeon who had worked in some of the most prestigious hospitals in the United States. At the time, he was working at the Townsville Hospital. He said that what he found at Townsville was as good as anything that he had seen anywhere in the United States. I think that is a great tribute. As I said, we have that despite the fact that our doctors are the worst paid, that VMOs are treated so badly and that our nurses are the worst paid, because those people have such a commitment to the system.

Mr Johnson, I agree entirely that there is room for improvement. There is always room for improvement, but I do not take away one iota from the quality of the clinical care provided by clinicians throughout the state. I would just like to see them given the support they need to improve on that.

**Mr JOHNSON**—Can I just interrupt before I lose my train of thought. So our professional doctors and skilled clinicians are world-class?

**Mr Morris**—Yes.

**Mr JOHNSON**—But are you saying that the system and the culture are far from world-class? Is that what needs to be addressed?

**Mr Morris**—Absolutely. It is medieval—this idea that you can have the lord of the manor based in Charlotte Street in Brisbane telling his minions 1,500 or 2,000 kilometres away how to run a hospital, based on bureaucratic models. Humanity is not like that. Humanity is infinitely diverse. You cannot say, 'You are budgeted to perform a laparoscopic cholecystectomy in 20 minutes' because one patient will take 10 minutes and another patient will take three hours. You cannot run hospitals with that sort of bureaucratic mind-set. You have got to have people who understand patients running them.

**Mr JOHNSON**—Maybe rather than being medieval it is prehistoric!

**Mr Morris**—Perhaps I am excessively generous!

**Mr JOHNSON**—Perhaps so. I just want to continue on my general questions. Since the termination of your commission, no doubt professional colleagues and friends have talked to you about this issue. Can you give us a sense of their input or their thoughts on this issue—being closer to you than many of our fellow Queenslanders?

**Mr Morris**—Actually, the response has not been so much from my professional colleagues. Barristers are funny people. They are a bit like taxi drivers. We are all fiercely independent. We are all in competition with one another. But the reaction I have had from the public has been wonderful and overwhelming. People have written to me, emailed me and telephoned me, saying that they have never made contact with a public figure in their lives but they just wanted to write and say, 'Thank you for what you did.'

**Mr JOHNSON**—Sounds like some of my constituents!

**Mr Morris**—Exactly.

**Mr JOHNSON**—They had never made contact with me before.

**Mr Morris**—And of course that makes me feel tremendously proud but it also makes me feel very sad that those people feel that something is necessary to make their medical system better and it has not happened. I feel, to some extent, that I have let those people down because I set out to achieve a result and I did not achieve it.

**Mr JOHNSON**—You mentioned earlier as well that this is going to be a long journey to repair, or you gave the inference that it is not an overnight fix.

**Mr Morris**—Absolutely.

**Mr JOHNSON**—The Queensland Premier has indicated that he intends to fix it and he would resign otherwise. I just wonder if you might like to comment on that in a very generic sense. The inference, of course, is that it is fixable before the next state election.

**Mr Morris**—I would actually be sad to see Mr Beattie resign. I think he is the best premier we have had in living memory in this state, and that is from someone who has traditionally been associated with the other side of politics. I think that there is a bit of unnecessary martyrdom in his comment because the problem existed before the Beattie government came to office and I am sure will exist well after the Beattie government is only remembered from the history books. I interpret Mr Beattie's remarks to mean that he will fix the immediate problems, the immediate crisis—as he has done, for example, in Caboolture. I do not think Mr Beattie or anyone else thinks that the long-term problem can be fixed in one year or three years or 10 years. I think that has got to be a much longer-term solution.

Governments have to do both. There are people who need emergency services in Caboolture and, while the solution is not the ideal one, at least he has come up with a solution, which is something. What concerns me is that there is too much focus on the short-term solution and not enough focus on what is needed to make Queensland Health viable—not just this year or next year but in 10, 20 or 30 years time.

**Mr JOHNSON**—One of the points you made in your submission to us was your concern about the business model. I think you use the phrase 'business model'. Reading that, it gave me the impression that Bundaberg Hospital was almost a commercial profit-making entity, rather than an institution or a physical location to service the health needs of Queenslanders and Bundaberg residents. Can you comment on that?

**Mr Morris**—I think the use of some of these expressions is more significant because it is evidence of a mind-set. It is common within Queensland Health to refer to their headquarters in Charlotte Street as 'corporate office'. They have got to understand that it is not a corporation. Corporations exist to provide profits to their shareholders. Queensland Health exists to take taxpayer funds and use those funds to provide the best possible services they can to the community and using that corporate concept is totally out of place.

You see it again and again—for example, when clinicians have great ideas. A doctor in Bundaberg wanted to have a kidney day as part of a national kidney awareness week. It seemed like a very sensible, intelligent thing to do, but the instructions from Queensland Health were that they had to have a business plan before they could examine that kind of thing. Bureaucrats have to understand that they exist to facilitate the provision of clinical services—that the bean counters are there to let the doctors do their jobs, not the other way round.

And then there is the terminology that is used. How offensive it is to describe patients as 'clients'. How offensive it is to treat someone in a hospital bed as if they were just a client rather than a patient. How offensive it is to talk about corporate office and business plans and to call people executive directors rather than superintendents and so on. It is all part of this culture that sees balancing the budget as more important than providing world-class services.

**Mr JOHNSON**—So we effectively need a brick-by-brick restructure of our health system?

**Mr Morris**—I think so. There is always the risk of throwing the baby out with the bathwater. There are some wonderful things in Queensland Health, and I have touched on some of those; but, in a structural sense, in the design of how Queensland Health functions as an overall entity, yes, I think we have to throw out the existing model and start again.

**Mrs ELSON**—On your facts and figures, you are saying that we cannot fix the problem just by taking in extra trainees in Australia so we are going to rely a lot on doctors from overseas. At one of the committee's hearings, we heard that there were resource constraints at base hospitals in Queensland, which means that some specialists are forced to undertake procedures that are beyond their experience and to do so without the critical equipment. Who would be the best people to screen these doctors when they come into Australia? It seems that they go through a process, fall through the cracks and come into Australia saying they can do things. Is it the bureaucrats putting pressure on them to operate beyond their capacity which ends up creating cases like Dr Patel in our base hospital system?

**Mr Morris**—We should not confuse the situation which existed when Patel slipped through the cracks with the situation that exists now. One thing I pay tribute to the Queensland government for, particularly the Medical Board, is that it moved very quickly to address those problems to ensure that we do not have any more Jayant Patels slipping through the system. Having said that, you are perfectly right that both overseas trained doctors and Australian trained doctors are being put in very awkward positions whereby they are being asked to do things which are beyond their level of competence or beyond the facilities of the hospital or institution at which they work. That is a particular problem for the overseas trained doctors because they are not in a position to stand up to their managers or bureaucrats. At least an Australian trained doctor can say, 'I don't like this and, if you insist on it, I'll go and get a job in the private sector and make three or four times the income I am currently making.' They have that option, while the overseas doctors have to put up or shut up.

**Mr ENTSCH**—That is a point I was going to make. I can understand the nursing staff—again, in the Patel case—being intimidated by the bureaucracy and being reluctant to go past their bureaucratic managers, but we are talking about the professionalism of our doctors. Surely to goodness the warning bells would have rung for some of Patel's colleagues who would have been fixing up the messes he made, because it happened over a considerable period of time. It gets back to the individual doctors who would have been involved in it, through the Queensland Medical Board for example, bypassing the bureaucracy and saying, 'This is inappropriate.'

**Mr Morris**—I would not want to be critical of the doctors involved, because the only mistake they really made was going through the right channels. They followed the handbook. It said that if you have a problem you report it to the district manager or to your immediate superior. They did things the right way. It just proves that the system in place then was not good enough and the system in place now is not good enough. The problem only emerged because Toni Hoffman cut the Gordian knot and said, 'I've tried approaching it the right way and nothing happened, so now I am going to approach it the wrong way and go to my local member of parliament and to the press and the media and get the story out there.'

Protecting patients from people like Jayant Patel should not depend on individual clinicians having to choose between their own careers and doing what they think is the right thing. As a society, we should not be putting doctors, nurses, dentists or any other health-care professionals in a situation where the individual is called upon to make that sort of decision. The only way we can redress that, as I said, is firstly by changing the culture in Queensland Health but also by changing the legal protections so that those doctors who were aware of what was going on with Patel were entitled to go to the AMA and those who worked full time within the hospital were

entitled to go to their union, to their local member of parliament and, if necessary, to the media to authorise them to do the things that Toni Hoffman did without authority.

**Mr ENTSCH**—You said that since then the Queensland Medical Board has made changes that will help to deal with that issue?

**Mr Morris**—Absolutely. Some people have assumed that the Medical Board were to blame because they gave Patel the ticket to work in Bundaberg. But that was just the beginning of the problem. They did let him through the cracks—they have acknowledged that and apologised for it, and good on them—but it just went on from there. The Medical Board said, ‘Yes, he can work in Queensland as long as he is in a position of being a surgeon who is under a director of surgery.’ Queensland Health just ignored that and made Patel director of surgery at Bundaberg without anyone over the top of him. You cannot say the blame is with the Medical Board when they put the protection in place and Queensland Health just ignored it—not just by making him director of surgery but by not having proper auditing procedures and by not having a functioning M&M committee. Every step of the way Queensland Health allowed this man to get away with killing his patients; there is no other way you can put it. Yes, the Queensland Medical Board opened the door but Queensland Health showed him the way.

**CHAIR**—Can I digress from Dr Patel for a moment. There is another half to the story of health in Australia, and that is the private sector. At present all specialists are trained in the public system. Do you think that the public system, as it is in Queensland, has the capacity to train adequate specialists and should the private hospitals assume a role in the training of future specialists?

**Mr Morris**—I am afraid that is a little out of my exposure or expertise as a result of the inquiry. I think the point that needs to be made is this: for public hospitals to continue that important role, they need to encourage the top specialists to continue working in the public hospitals as VMOs. The difficulty as I see it is that, without having the best neurosurgeons, the best vascular surgeons, the best urologists, the best dermatologists and the best psychiatrists working at hospitals like the RBH and the Princess Alexandra, you are not going to provide the right level of training. The first step has to be to provide the best possible facilities, in terms not only of salary but also of all the other terms and conditions to encourage the top people to work at those hospitals. But I agree: I think there is a lot of scope for major private hospitals such as St Andrews and the Wesley in Queensland to support the public sector by training their own specialists. There is a lot of value in that for the private hospitals as well. I sincerely think that should be pursued.

**CHAIR**—Are the systemic problems in Queensland hindering the capacity to train these specialists?

**Mr Morris**—I think so. You would need a computer model to keep track of the shortages of particular specialists in particular areas from day to day and week to week. One week there may be a shortage of anaesthetists at the PA hospital. That was a situation that existed, I can assure you, for a lot more than one week. If that is the situation at the PA, then obviously the interns, anaesthetics registrars and so on of the PA are not receiving the level of supervision and training that they need. So you have got to fix the system first, and the simplest fix is to look at what is needed to attract VMOs back into the system and make sure that the top Queensland specialists

are welcomed with open arms and encouraged to be in the public hospitals—not only to care for patients and provide patients with the benefit of their skill, but also to assist the training of the junior staff.

**Mr JOHNSON**—I just have one final question, Mr Morris, about the reference you made to community ownership. You would have to get that model right, wouldn't you, because it could be abused or it might not fulfil its function? I have concerns and reservations about a community element to it that is perhaps not a professional community. Could you define that element a bit more?

**Mr Morris**—I will answer you in two ways. One is to say, 'I don't think we need to reinvent the wheel on this.' A lot of other states and a lot of overseas jurisdictions, including the National Health Service in England, already have systems in place to ensure community involvement in operating hospitals at regional level. You do not have to start with a blank sheet of paper and devise an entirely new scheme; you look at what is working elsewhere.

The second answer is that the starting point has to be that within a local community the local board of management—whatever you call it: trustees, managers, directors or whatever—has day-to-day functional and financial control. Of course the central office can give it directives and say, 'It's our directive that you have to have a coronary care unit, whether you think that's a good idea or not.' But the local board is told: 'You've got, say, $80 million; you work out how to spend it. If you want to pay someone more to have a top-flight neurosurgeon at this hospital, then that is your choice. If you want to have more GPs or more junior doctors at the hospital, that is your choice.' To make that decision making effective, you need a chair who is a genuine clinician, a practising doctor—whether a specialist or a GP—a practising nurse or even someone from the allied professions: a dentist, a pharmacist or whatever. The top of the tree has to be a clinician who is exposed to patients. You need representatives from the highest echelons. I do not mean that in an offensive sense, I mean the highest echelons of the local community: the professions, the business world, people in local government and so on. So you are really drawing on both local expertise and local connections, if you like. As I understand it, that is in rough terms how it is done in Victoria, for example. I do not say that is perfect, but I think it is better than what we have got here at the moment.

**CHAIR**—As there are no further questions from committee members, thank you very much for appearing before us, Mr Morris. You have given a very balanced view to the committee. As I said at the outset, we have had difficulty getting a view from Queensland Health or the state government. We appreciate the time you have taken to come before us. We consider what you have said to be a very balanced view, and I am sure what you have said will help us in our deliberations.

**Mr Morris**—Thank you, Mr Chairman, and I thank members of the committee.

**Proceedings suspended from 10.35 am to 10.56 am**

**WRONSKI, Professor Ian, Pro-Vice-Chancellor, Faculty of Medicine, Health and Molecular Sciences, James Cook University**

**CHAIR**—Welcome.

**Prof. Wronski**—Thank you for the invitation to appear. It is a pleasure to do so.

**CHAIR**—Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement to the committee.

**Prof. Wronski**—I would like to make a couple of observations. I will not take too long in doing that. Fundamentally, much inside the health system crisis at the moment is actually a crisis of the health workforce. The health workforce is a predominant part of the health system's budget and the supply and the quality of that workforce is really the reason that there is so much fundamental angst about the sector at the moment. The tide has gone out in the health and medical workforce in the last 25 years. In the seventies and the eighties, I remember talking about the lack of workforce supply in Indigenous communities. Then there was a lack of workforce supply in remote communities, a lack of workforce supply in rural and regional communities and now we have a lack of workforce supply in many of the metropolitan areas as well. It is just a feature of shortages spreading throughout the country. It means that we need to give particular attention to the systems that support workforce development.

The key elements in the system of education and training for the health system's workforce and its specialities are issues relating to clinical training facilities and the type of clinical training we actually want. Australia actually has a great tradition of having a lot of clinical training in its training programs, as opposed to the experience in, say, some European countries where people graduate as a professional but do not have any clinical experience. They do that later on. There are issues about whether we will be able to maintain that system. There is a significant issue in relation to the culture of the health systems in which we bring up our health workforce professionals at undergraduate, postgraduate and specialist levels and the culture of that workforce in relation to its attitude to its role in education, research and training, and whether that is seen to be a core activity of the state health facilities. We have had health ministers in the past stating that it was not.

Fortunately that has changed now, but there is clearly still a cultural element in how the health system accommodates the education, training and research responsibilities. It is a very significant part of the quality and safety agenda in Australian hospitals. There is the big health system's relationship to university medical schools, nursing schools and those sorts of things. The fact that there are professors of surgery and professors of medicine wandering around the wards being paid quite often by a separate agency has a very important, implicit and explicit function in the quality and safety systems of our health system.

The emergency measures trying to keep tottering parts of the health system up have tended to create an environment of moving from crisis to crisis, and short-term measures have created

some tremendous instabilities in the education systems. That has led to probably what will amount to a price war between the states and between Australia and overseas countries without significantly addressing the production of the health workforce, which is at the base of it. We are now seeing unsustainable gaps in remuneration between public sector practitioners and those doing the same job but working for universities. They both operate together. They both see patients together. The gaps are astounding, and I leave it at that for this moment.

**CHAIR**—Could you give us an example?

**Prof. Wronski**—$150,000 to $200,000 difference, not counting overtime. It is not to say that anyone is being underpaid or overpaid, but the gap creates a system of instability. For instance, in the various inquiries in Queensland in the last year or so, Townsville has come out relatively unscathed, and much of that is related to the level of federal investment in new medical schools and new health facilities. In the last eight years or so, there has been a very significant roll-out of health professionals from James Cook University. We were the first of the new medical schools, and we benefited a little by picking the workforce crisis a little earlier than many others and positioning ourselves. Nonetheless, North Queensland has been a beneficiary of that. But, in a sense, one of the reasons Townsville came out relatively unscathed was the fact that there are many professors of medicine and surgery, nursing schools and allied health professional schools that help populate the health system. That creates a group of people who stand back and are committed to standards. It creates a different culture.

Another significant issue in relation to the health workforce and being able to run an efficient health system in the future is going to be health workforce variety. The Productivity Commission’s report tried to come to terms with parts of that, particularly in relation to what we are going to do about first-contact health care. Is that only going to be medical practitioners? I do not think that can possibly be the case, because we just cannot produce enough, and we have to look at how we are going to free up the types of ways people can get access into the health system and at least some of those costs being borne under Medicare arrangements or whatever.

There is going to be an issue about new professions, because the current range of professions is not going to be enough to sustain our needs. We will need to look at a delegation model for medical practitioners. The Americans have had that for 40 years now, called physician assistants. Britain and Canada have now adopted it too. I do not think we will be able to avoid anything like that—a group of practitioners who function under delegated authority of medical practitioners, quite often in their own practices, who are supervised by them and whose standards are guaranteed by them.

There will need to be new professions, and there will need to be new roles for current professions. I think we will have to look at the role of, say, physiotherapists referring directly to orthopaedic specialists and various others in the health care system. We will see the expanded role of nurses. We will see the development of physician assistants, I think.

In terms of the specialties, it is a fact that Australia does tend to have a more siloed set of medical specialties than many other countries have. That means that it can be hard to develop new areas of specialisation as important health patterns emerge. In a sense, postwar medical specialisation has all been about knowing more and more about less and less—a sort of vertical specialisation. What is clear now is that many of the ways patients present are no longer in that

measure. We are able to do a vertical specialisation because it was based on the big metropolitan cities, particularly Boston and New York. It worked in Sydney and Melbourne and could work in Brisbane. The problem is that Australia has a quite dispersed population. Where you have workforce shortages, super-specialisation does not work and we have needed to find ways of developing horizontal specialisations where people establish sets of clinical skills relevant to how people present. The most obvious of these is emergency medicine, which became a specialty in the early nineties, but really—and emergency physicians might come after me for this—emergency medicine is essentially physicianship, surgery, anaesthetics and some critical care things all pulled together.

Rural medicine is the most obvious example at the moment. In many ways it has really failed to become a specialty even though rural medicine being recognised as a medical specialty will have immense implications for the way we run our health system outside metropolitan areas. Related to that is what relationship the state and federal governments would have in the allocation of funds to encourage specialisation at what locations on the basis that we know, particularly in relation to the rural and remote workforce, that the capacity to train locally people who are from local areas is a key way of making sure regional areas have a health workforce.

**CHAIR**—Before we go to questioning, can I say that I think the decision to put a medical school in Townsville was a very good one. It was at a time when we had a very perceptive minister for regional development. One of the reasons for putting it in Townsville was the perception that if you train doctors in the bush they will tend to stay in the bush, which is something that we need desperately. Are you finding that to be the case?

**Prof. Wronski**—Yes, and it is not only with medicine. We have followed it quite closely in pharmacy and occupational therapy, and we have now started it in physio and speech pathology. We have had one graduation of medical students. Thirty-seven of the incoming cohort of medical students came from North Queensland and seven were from interstate. In terms of internship positions, 51 of 58 have stayed in Queensland, 31 are working in North Queensland and seven have gone interstate. There is no doubt that rural origin as well as where you train are the most significant predictors of where you are likely to work. Of the students who went interstate, at least half have gone to undertake specialties that were not easily available in Queensland and their intention is to come back in one of those specialties. Many of them have families in North Queensland. We have also seen it in pharmacy, where we know that about 75 per cent of rural kids coming into our pharmacy program go rural, compared with about 25 per cent of rural kids going rural in metropolitan pharmacy programs—so it is where you are from and where you train.

**CHAIR**—Is there much interstate migration in as well as out?

**Prof. Wronski**—About 60 per cent of the medical school applications come from interstate. But the medical school system is a national one and when all the offers are made from all the various programs—and we do have a system that is independent of the usual national systems for medical selection—we do target rural kids from all over Australia. Because Queensland is a quite dispersed and rural state, a significant number of rural Queenslanders do get in. A significant number of rural kids from other states do get in too, and there is still a lot of metropolitan kids who are interested in rural, remote, Indigenous, tropical—which is what we

shape ourselves as. To be honest, many of the metropolitan kids who come to us really want to do tropical medicine, so we are pleased with that. The scale of it is astounding, though.

Through the Queensland Tertiary Admissions Centre, medicine this year had 1,183 applications, and I think we have a funded load of 81. So the capacity to expand medical training in Australia, and certainly in North Queensland, is significant. The other important issue in the expansion of health workforce training is that the health system is strangulated by lack of workforce supply. It is actually very hard to get it to expand. We have seen that, once we have got four or five years of graduates out of pharmacy, occupational therapy and now medicine, the health system suddenly expands and its capacity to do much more supervision expands dramatically. For instance, when we started our pharmacy program we had about 60 preceptors across all of North Queensland—that is people who do clinical supervision. We did an audit last year after four or five years of graduation, and we have got 300 preceptors. So systems do expand based on workforce provision, and that is going to be important financial issue, too.

**CHAIR**—Incidentally, during the week, when I went to an ophthalmologist, he told me that the number of students who get OP1 scores and choose to be optometrists rather than go into medicine is surprising. Is that because of the unavailability of places, or are people choosing these other professions over medicine? Medicine used to be the number one choice of anybody who achieved the required academic results. Has that changed?

**Prof. Wronski**—Probably. For a start, most medical schools now use criteria in addition to academic scores. There is usually an interview system or some other exam system, like UMAT—Undergraduate Medicine and Health Sciences Admission Test—or GAMSAT for postgraduate schools. So there are issues beyond your year 12 results that are taken into account. I think there is also a change in the student population's attitudes, and quite often kids who are doing OP1s decide that they want to be aviation engineers. I guess medical training these days looks long. There is a lot of public disquiet about the quality of life associated with that. Nonetheless, I would have to say that the numbers applying to a medical school increase every year.

**CHAIR**—The tendency is for academic achievers to be women. To some extent the government has programs to encourage male students. Are you finding the medical workforce has problems because of the increasing number of women who become doctors, and who then later in life have children and leave the workforce?

**Prof. Wronski**—The Australian Medical Work Force Advisory Committee looked at that. More women do go part time, for obvious reasons, and there are enough jobs in the health workforce, broadly, to accommodate part-time practice. But it is becoming a bigger feature of the Australian health workforce scene. It will create some—

**CHAIR**—How is it affecting the public system?

**Prof. Wronski**—I think the numbers are something like this: there has been a reduction in hours worked by males in general practice of about four per cent over the last few years, and of about five per cent by women over the last few years. So it is true that more women are working part time. It is also true that the men involved are starting to work fewer hours, too. Mind you, the hours used to be very long and there are possibly safety and quality issues with that.

Undoubtedly, we want a balanced workforce—on gender grounds, on ethnic grounds and for a whole range of things. In the way that in the seventies and early eighties these programs were dominated by males, they are now dominated by females. I understand that in the state education systems they are looking again at how these subjects are taught and what is emphasised. I also understand that when curriculums are changed the performance of males and females changes too. For instance, there is some initial anecdotal evidence out of New South Wales that the percentages seem to have been changing since the curriculum changes of the last couple of years. Nonetheless, our aim ought to be to have a balanced workforce in relation to gender, ethnicity and a whole range of other things.

**Mrs ELSON**—From your intake of medical students at the moment, what are the percentages of women and men?

**Prof. Wronski**—Probably 65 and 35—something like that.

**Mrs ELSON**—Sixty-five per cent women?

**Prof. Wronski**—Yes.

**Mrs ELSON**—I think that is a concern. I was on another committee where figures showed that, once women have a family, the majority go back to work in a private practice on an average of only one to two days a week. They will not enter the hospital system because it is difficult to get that small amount of work per week. I think that if we are looking at the figures going in there now and expecting they are going to be servicing a community another 10 years down the line when the ageing population is going to put a lot of pressure on our health system, it has to be a concern at the beginning to know that we are not getting the males in there that have a better chance of staying within the system at a full-time rate.

**Mr Morris**—Yes. I think the health system will have to accommodate some of those things.

**Mrs ELSON**—What can we do to encourage women? I think there has to be a lot of support, maybe with child care or hospitals building child-care centres to look after the children of doctors.

**CHAIR**—And nurses.

**Mrs ELSON**—Yes, and nurses especially.

**Prof. Wronski**—Across the health workforce, the fact is that women still are the predominant caregivers and if the health system wants to be able to recruit women—and in the current cohorts they are the biggest group coming through—they need to find ways of making sure that women are enabled to get access to that job. Looking after kids, and those sorts of services, are going to be part of what is needed. A lot of that work is already being done. Many hospitals do have some of those things already. It will not just involve medicine though.

**Mrs ELSON**—You have to look at the tax side of it too. A couple of female doctors that I know keep the work down because they only have to pay their HECS if they earn above a certain amount. I think we may have to look at that side of the issue too.

**Prof. Wronski**—Yes. I guess the other thing that might be important is that in the funding of the education system there are some significant challenges for the workforce in relation to clinical hours. For instance, I am not convinced at the moment that the funds universities receive are enough to do the sort of quality of clinical placements in any of the health professions that is required. That will be an issue for what level of clinical experience people will have when they graduate. That will be really important for the health system to be involved in.

The other side of the full fee paying local arrangements is that many of the students will come out of university with very significant debts of $200,000 or more. Whether those students will stay in Australia or migrate to countries where the salaries are much higher is yet to be seen. It is really important to align the incentives in our education funding systems with what we want to have come out of the health system.

**Mrs ELSON**—I was interested and very pleased to hear of the retaining of doctors in rural areas once they have finished their education. We have changed the provisions and the provider number if they stay in rural towns. Would that be some basis for it or is there a financial incentive? I was on another inquiry a few years back where I went to a university in a rural area and talked to the young doctors who were about to graduate. When I said to them, ‘Are you going to stay in your rural town?’ They said, ‘No. Why can’t I be a North Shore doctor? Why should you expect me to stay here?’ I am just wondering why the mindset has changed so that you have a larger percentage of your university staying in the rural area.

**Prof. Wronski**—I think it is the selection system. We have only had our first graduation; we are just following them, so the provider number legislation does not have an impact. Although, I think all those things have added up. I think it is because of who we recruit. You can see it across the medical schools. You can see in the young doctors who come from different universities their attitudes to things.

A Cairns doctor at Cairns hospital recently acknowledged that although he thought there was a rhetoric reality gap in the talk about rural kids going rural, for the first time that they could remember they have had people applying for rural rotations out of Cairns hospital. Where you go has a lot to do with where you are comfortable. It has a lot to do with which schools you went to, and where you train has a lot to do with where you meet your significant others. If it is in the metro area, the significant others usually have family connections and things that make it quite hard to move. All those things build up.

**Mrs ELSON**—Congratulations on retaining all those rural doctors.

**Prof. Wronski**—Let us hope it continues.

**Mr VASTA**—What role could private hospitals play in training medical staff?

**Prof. Wronski**—A much bigger role. We need to look at how a training system works across the private and public sector. Both sectors receive public funds anyway. The private sector has generally expressed a willingness to do it but to be fair they do not always come up to the plate. Nonetheless, it is going to be really important to involve them if we want to train more specialists in places like North Queensland. For instance, there is a feeling amongst senior people at Townsville hospital that they could double their specialist production out of Townsville

hospital. The question is: how are the registrar positions created? If many of the Australian trained fellows work in the private sector, what are the incentives to encourage them to oversee training in the public sector? We need to think about that. We need to think about tagging registrar specialist training positions to areas in Australia if we want to build this sort of workforce as opposed to encouraging a situation where most of them are targeted in capital cities everywhere.

**Mr VASTA**—Have you looked into any overseas models? Is there an American model that we could look at?

**Prof. Wronski**—The American model is almost entirely private. Predominantly there, though, the medical schools actually run the hospitals and there is a myriad of relationships in the American health care system, including health maintenance organisations. There are endless numbers of agreements. The key thing about the American training system is that there is a hospital quite often owned by the university attached to the medical school and a lot of the training happens there. That is a slightly different system from Australia. In the United Kingdom it is the really the health sector that funds the health sector of the universities. In that sense they have been able to equilibrate remuneration in the education sector and the health sector more easily. That is another way of doing it.

**Mr ENTSCH**—Retention was touched on a moment ago by my colleague. JCU is bringing in young people who have a commitment to working in regional and rural areas. The figures you quote for those young ones leaving university and going out into the workforce are very impressive, but it will count for nought unless we retain them not only within the regional areas but also within the state—I am being a bit parochial for Queensland. Clearly, there have to be incentives. You gave an example of university professionals who are working in the public health system with disparities in salaries upwards of $150,000. That is a great disincentive for somebody to maintain their involvement in the public health system.

The other issue which is critical to maintaining these people in the public system rather than the private system is the fact that we require these skills in the public system in order to get out into the remote communities. You do not get private practices in remote communities. You would be aware of the crisis situation we have in places like Weipa and other areas where we are flat out getting a doctor let alone any trained nursing staff. In all the training that you do you are focusing on these regional areas. I congratulate you for the first locally trained Torres Strait Islanders on the Thursday Island campus. But it will account for nought unless there is a way we can hold them. Do you have a view on that?

**Prof. Wronski**—There are a couple of issues there and they are really important ones. The Indigenous health workforce is something we pay a lot of attention to because it is our backyard, too. We have about 100 Indigenous kids enrolled in the faculty at the moment. About 50 of those are in nursing; the rest are scattered through medicine and various other professions. When I look at the postcodes as to where they are coming from, it is quite clear that most of them are from provincial centres. What I read from that over the years is that there is a bit of an economic boom going on in resources and various other things that affect places like Queensland, and there is some effect of trickle-down economics. We are seeing Indigenous families recognising that university education and becoming a professional is an important career choice. So in a sense some of those things are happening.

What worries me, though—and this is the reason for the Torres Strait experiment and the Mount Isa experiment—is that I do not see postcodes from remote communities. That is possibly because those communities have not benefited from the economic developments of the last few years. The issue for the federal government, the communities and us, jointly, is whether we are going to allow that to continue. Does that mean that if you are not in an area of economic growth your kids do not get access to professional training programs and to the economic change that can bring to families and communities? So we need to think again about how we are going to do this.

Brendan Nelson agreed to fund the Torres Strait Islander experiment at levels that make it doable. The Mount Isa nursing program is funded by a mixture of state health funds, federal funds and the university department of rural health funds. We know enough about what it costs to put one of these programs in a smaller community. It is not cost effective in the sense that you are taking 100 people into a program and producing large numbers.

We know that for start-up costs of around $1 million and then about $650,000 to $700,000 recurrent costs we can maintain a nursing science program integrated with enrolled nursing at TAFE, a sports science program and probably an Aboriginal health worker program and provide that in a community and make it available—on the condition that someone agrees to do that for a decade. We have made the undertaking that we will do that at named locations. So we understand the finances of it. The $650,000 sounds a lot, and for the first year it may be just one or two people. Ultimately they have to see successes in others and you have to do it for long enough. That is the way to create a belief in communities that they can have access to these sorts of things.

**Mr ENTSCH**—You also have to be able to recognise their training through remuneration and other incentives to keep them there. You mentioned the postcodes and the students coming from provincial areas. There are 8,500 Torres Strait Islanders living in the Torres Strait; there are 27,000 Torres Strait Islanders living in mainland Australia in provincial and metropolitan areas. The ones in the provincial areas have a better chance from an education perspective of getting through the system quicker than those in the remote communities. The challenge, once you have trained them, is to get them to go back to their home communities rather than stay and practice in the metropolitan areas.

**Prof. Wronski**—The Torres Strait model and the Mt Isa model are not bad for that. The nursing program in Torres Strait teaches them in the Torres Strait, and they stay there nearly the entire time, apart from clinical placements. Ultimately I think many of those people, if they do go away to get further levels of training—which I think they will also do—will come back. Their family connections are there. I think over time there will be significant cohorts of people who are well trained who can staff the facilities. I cannot help but think back to the West Kimberley in the 1980s when Aboriginal health worker models were first investigated by Aboriginal medical services there. In 1982-83, when all that started, we found it almost impossible to find Indigenous staff in the health services there. It is quite nice to go back to the West Kimberley now and notice that many of the family of the people who went into Aboriginal health worker training in 1982-83 are working around health facilities. Quite often it is the family and relatives of the people who did the early training who are then taking it up. There is this generational move, but you have to be prepared to do it and to stick at it.

**Mr JOHNSON**—I have a couple of questions. I think you made a reference to delegated practice. Can you just expand on that? It is an area that I am quite interested in. If I can give you a reference point in terms of my interest, a lot of psychologists live in my electorate. They have contacted me about how they can help in terms of this big problem we have in the country of mental health. That would play a part in relaxing some of the stresses we have on the system. It is that the sort of thing you are talking about, where the allied health professionals can play a role in the overall medical profession?

**Prof. Wronski**—Yes, I think there are two elements. One is the expanded role of current professions. The next is—and psychologists could be part of this—mobilising all the current professions to be able to do a one- or two-year program that would create something similar to the American physician assistant system. Most of the states in the US just have a phrase in the legislation that says, 'Doctors may delegate.' So you will find significant areas in the US—operating theatres and emergency rooms in major hospitals—populated not just by doctors but by physician assistants who work on the technical side of medical practice. Psychologists could be part of that, but so could ambos, Aboriginal health workers and pharmacists, all of whom could be mobilised to participate in first contact health care. It is not just that psychologists could already work in mental health—I think that is a definite—but how could you expand that role into diagnostic activity?

**Mr JOHNSON**—But is your view now that a psychologist, currently trained and qualified, would not have sufficient competence to go into the area of mental health?

**Prof. Wronski**—I think they already function in mental health, if they are a registered psychologist. I suspect that they could play a bigger role and that, as they become more senior, they could play more senior roles. I think that is true of all the professions, not just psychology: it is true of physiotherapy and occupational therapy. There are much more senior clinical roles that all those professions could play. That is a definite. In addition, we need another way of mobilising people from various professions who want a bit of a career change and who are able to do a one- or two-year program that would enable them to assist in first contact health care. The attractive bit of that is that, in the United States, many international medical graduates who do not get to practise medicine in the United States may be able to practise in delegated roles, so you are able to mobilise that part of the workforce too. It is the expansion—and this is your point—of current clinical roles and expanding them so that the professions can be autonomous and do more. In addition, it is the mobilisation of current practitioners so they can get involved in first contact health care.

For instance, when you go to a pharmacy the pharmacist may have a range of things they can do. In the United States, Manitoba or many parts of the United Kingdom now there are programs whereby that person can do a year or two training and be able to do diagnostic care in a range of conditions, which then means that that person does not have to see a medico. But they operate in association with practices that guarantee standards and have a collegiate relationship. That will dramatically improve the access points into the health system.

**Mr JOHNSON**—So would it follow that a Medicare system, and a Medicare rebate, would then allow scope for acknowledgement of that?

**Prof. Wronski**—Sure. For instance, why wouldn't the Medicare rebate go to the practice rather than the practitioner? If the Medicare rebate, or the payment, went to the practice then the practice could decide on the appropriate allocation of resources and they might make decisions about what level of person ought to see what level of condition. For instance, taking blood pressure, and the routine pre-examination stuff that occurs in medical practice, might be further expanded. It is an expansion of the practice in this model, I guess. But some relatively small changes to the reimbursement system could allow a whole lot of economic forces that normally operate.

**Mr JOHNSON**—I am thinking of midwives, for example—there is a group in my electorate of Ryan. They are outside the scope of Medicare and that affects the take-up rate.

**Prof. Wronski**—Yes, I think there is a whole range of professions that could expand their role or play a bigger role at least in first-contact health care.

**Mr JOHNSON**—Would that ease some of the pressures on our health system across the country?

**Prof. Wronski**—Absolutely.

**Mr JOHNSON**—Can you quantify that?

**Prof. Wronski**—I cannot quantify it, but I can give you some examples. Look at ambulance officers. Just about every second rural town has ambulance officers. They do have training programs. But in Queensland we do not have a paramedic scheme. They are probably the only underutilised health resource in the country. They could become much more effective by being able to have access to programs that let them work in association with medical practices that allow them to do a standard set of diagnostics.

**Mr ENTSCH**—Years ago, particularly in regional areas, you could go to the ambulance if you had minor injuries, or something like that, for treatment and they would use sutures and a whole range of things.

**CHAIR**—You still can.

**Mr ENTSCH**—Could I quickly follow up on what Michael was saying in relation to the psychology issue. There is a big issue in our area, and in remote and regional areas, where psychiatrists are fairly endangered—you never see them; they are very rare. Yet we have quite a significant number of psychologists who work right through those remote areas. So we are talking about primary preventative health issues in dealing with some of these conditions—particularly mental health issues—before they become major issues. One of the things that has been raised with me is access to Medicare and recognition of those issues. My understanding, not being a medical person, is that trained psychologists certainly have the qualifications to be able to identify, if you like, and refer if necessary.

**Prof. Wronski**—Yes, and you can take it further than that. For instance, in Britain—or in England at least—occupational therapists do most of the mental health work in hospitals. Why not expand the roles of other practitioners as well? There are occupational therapists out there

who are doing a great job, but we could expand the role that they can have in relation to mental health—and the role of Aboriginal health workers. I think we need to get beyond the guild mentality.

**Mr JOHNSON**—That was my next point before my senior colleague very politely interrupted me and took the lead.

**Prof. Wronski**—In a sense I have most of those groups in my faculty, so I can sort of sit back. But that guild mentality affects all the professions.

**Mr JOHNSON**—You yourself are a former guild boss, if I could use that term. My understanding of the colleges is that they are very protective and conservative. As I mentioned in my questions and comments to Mr Morris previously, my brother is a neurosurgeon. Some of the tales he tells me would make for a good book. Can you comment on that? Are they too much of a closed shop? Are they overly protective? You could count the number of neurosurgeons on one or two hands. Would they be resistant to this idea?

**Prof. Wronski**—I think that is changing with time. A decade ago, even five or six years ago, there was intense resistance, but in many of the colleges now you can really see the rise of people who are more future oriented. I think there is the capacity to involve the medical colleges and the other guilds in a dialogue along the lines of what the Productivity Commission has suggested. I personally believe in the autonomy of the professions because I think it is quite important in a democracy. I would not like the British experience, where they essentially just created a national board and put one member from each profession on it to decide about these things. The autonomy of the professions is an important barometer for the health of the health system. The professions are able to squawk if they do not like stuff. Quite often it is just about quality and safety. Queensland has had some experiences of that. The independence of the profession has actually been quite important in that. At the same time, you can take it too far.

The economic incentives with the shortages of workforce supply and the comfortableness of the range of hospital or health facilities—where you can train people with not enough capacity to broaden a teaching role beyond the institute that you are most comfortable with so it takes a regional basis—are things that have to be explored. For instance, specialist training will surely have to be at least district based. You may have someone at a private hospital who is an experienced Australian trained fellow but who does not want to do that much work in the public sector. We need to look at the idea of training VMO positions so that they can supervise registrars in the public sector so you can have viable training programs that cover a district. In a sense, that is already possible but you have to create the economic streams to make those things work.

**Mr JOHNSON**—I do not want to labour this point but I am not sure I share your optimism that these guilds are—what was your phrase—forward-looking or progressive—

**Prof. Wronski**—Future oriented.

**Mr JOHNSON**—We all know that the AMA of course has its focus on issues of standards, safety and health care, but we also know that they are a very influential group. Take the

midwives, for example. Overwhelmingly, we know that doctors are very reluctant about the expansion of the role of midwives in hospitals.

**Prof. Wronski**—I think they are happy about the expansion of the role of midwives in hospitals. They are probably less comfortable outside of them. But I also make the other point that practitioners, like physician assistants, working under the delegated authority of medical practitioners have no such political problem. Part of the thing would be to create similar models in Australia to overseas so that there is a range of comfort zones that medical practitioners work with to expand the effective health workforce. There is a range of medicos. Some are happy working with independent practitioners and other professions and maybe some are less so. But the absence of a delegated group is a very great impedance to the development of the Australian health system.

**Mr JOHNSON**—I want to put on the record that I am very supportive of that expansion as well.

**CHAIR**—I want to finish on this note. Mr Morris mentioned to us this morning that we have 1,400 overseas trained doctors in Queensland. That really is indicative of how many places we are short in Queensland.

**Prof. Wronski**—Medical places?

**CHAIR**—Yes. COAG recently announced new places for Queensland. Is Townsville going to benefit from that? Do you have the capacity to train additional doctors if you have the places?

**Prof. Wronski**—Yes.

**CHAIR**—And do other medical schools in Queensland have the capacity? Has the public sector got the capacity to accommodate them?

**Prof. Wronski**—I was hoping to see more from COAG. I think the allocation of fee-paying places will do little for the problems in the health system. They are fee-paying places, and although the government increased the loans to $80,000, degrees will cost in the order of $200K. My guess is that most of those students will try to pay off their loans very fast, probably by going to the United States. So I do not think the expansion of fee paying actually does that much. As to whether we should create more medical student places on a HECS basis, absolutely. I know the numbers for North Queensland really well. We believe, as does the health system, that could easily go from 81 or so funded places to 150 now that we have graduates. Part of what we have learnt is what happens once you have some graduates out there, how the health system expands to accommodate greater training. It expands dramatically.

Even the health system is now quite comfortable with, really, a doubling of medical intakes in North Queensland. The Forster inquiry suggested several numbers for the workforce shortage in Queensland. The one that I believe more is the one in the body based on doctors per capita, which is a figure of around 1,800 as opposed to the figure that was in the executive summary, which is more like 200 or something.

**CHAIR**—Mr Johnson has pointed out to me that it was 1,700.

**Prof. Wronski**—Yes, in the order of that. I think you can tell on the ground by whether anyone can take holidays or get affordable locums. That is a pretty important thing. In terms of Queensland broadly, once there are graduates out of Griffith University, which is the new medical school, the Gold Coast and Sunshine Coast will be able to take more trainees too because, once there are intern positions, you have people to supervise the medical students. But you do need the consultants and the registrars, who will supervise the training docs. In a sense, North Queensland is a bit of an encapsulated thing so it is easier to understand. We have produced a bolus of kids. We have now graduated them and they now want specialties to do. So far Australia has not recognised rural medicine as a medical specialty. It actually really needs to because these are rurally focused kids who want to be specialists in that sort of medicine. I think the health systems will need to accommodate those realities. But the capacity is there, and I think mostly the goodwill is there too. But there are some significant cultural changes that the Queensland health system, certainly, will need to embrace. My guess is the health systems of most of the other states are going to need to embrace them as well.

**CHAIR**—The importance is, of course, time lines for all of these things. We would like to see that achieved before Mr Morris reaches 78. Thank you for appearing before us. If need be, which I think is quite possible before this inquiry is finished, we may contact you again.

[11.48 am]

**CHATER, Associate Professor Alan Bruce, Immediate Past President, Australian College of Rural and Remote Medicine**

**COWIE, Ms Marita Louise, Chief Executive Officer and Company Secretary, Australian College of Rural and Remote Medicine**

**CHAIR**—Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Would you like to make an introductory statement to the committee?

**Prof. Chater**—I am here obviously on behalf of our current president, David Campbell, who is from Victoria and is unable to attend, so he sends his apologies. I am a rural doctor 600 kilometres north-west of here in a small town called Theodore. I live and breathe the issues that as president I have led the college on and also bring to the discipline of rural and remote medicine at the University of Queensland. I really want to give you a little background to our college so that you can understand where we are coming from and a little about rural practice, and then I want to look at where the health system has been and where it is going. If you will allow me a moment to do that, we can then certainly follow up some issues that you raised with Ian Wronski and some issues that Ian raised.

Our college has almost 2,000 members. It was established in 1997, and it really evolved from a grassroots desire to get rural and remote medicine onto the agenda, if you like. Those 2,000 members have been very loyal, despite having no legislative recognition. So they have paid their dues each year, despite having that lack of legislative recognition. We have developed courses and curriculum for rural and remote medicine, and that recognises the breadth of practice. There is often a concept that you need to do extra things in rural practice; in fact, those extra things are rural practice, and we need to acknowledge that. It is not just city based practice with a bit added on. You really need to understand what it means to treat somebody with a snakebite or with a heart attack in your town. You cannot learn that at the Royal Brisbane Hospital; you have to learn it in practice. We teach that sort of stuff, and we teach it in our curriculum. We have established a women’s group. I know you mentioned before the gender issues, and women in rural practice was one of our first committees and actually has a board member. They bring some good perspectives that way, and they are important perspectives to our college so that we can understand some of the issues and try to address them.

ACRRM really is a world leader in this. No other country has yet established a college of rural and remote medicine. We are the first one, and that always makes it a bit tough when you are trying to advocate for it because people say, ‘What are the precedents?’ There are not any precedents; we are it. Rural practice is different. As I said before, it is not just an add-on. If you want an analogy, it is the SAS. They are the people who are right on the front line, having to have all the skills, without the tanks and without the support necessarily being right there. They have to deal with it: package it and send it out sometimes; deal with it sometimes. That is what I see and our college sees rural practice is about.

What do we need, if you like, to fix up rural practice? There are two things really. One is rural infrastructure. The hospitals need to be there. Thank heavens, most of them have stayed, although some of them are run down quite considerably, and that does fall at the feet of the states in lots of ways. They have not kept them going as well as they possibly could have. But, to be fair to them, they have not been sure what their workforce is and what the skills of their workforce are. So there is a tendency at times for rural to be—and I use the words emotively—'a dumping ground'; there is a sense that you could send anyone there. In fact, it should be the SAS version rather than send anyone there, as those of you who live in rural communities know.

We need to get doctors who have a good attitude to the bush, and we need doctors who are trained for the bush. We have worked very hard with the Commonwealth government, in particular, about this, and so we have a range of things in place that you guys have been a part of. In relation to rural recruitments, we have a 25 per cent rural intake; we have rural scholarships now, the RAMUS scholarships; we have James Cook University; and we have rural clinical schools.

In my own rural clinical school, the four sites of Rockhampton, Toowoomba, Hervey Bay and even Bundaberg, in the present crisis, are oversubscribed this year with medical students. We had to go through a process of saying, 'Sorry fellers, you are going to have to go back to Brisbane.' That is the first year that has happened. We brought them out first and now they are oversubscribed. The medical rural bonded scholars—there are 100 a year—are about to graduate, so we need to do something with them. We need to get them going. We have procedural medicine grants, which are getting doctors back in and keeping those that are already there doing obstetrics, anaesthetics and surgery. The big gap has been vocational training. There has been this myth that vocational training could be done in a general practice environment, so you could teach them anywhere in a general practice or you could teach them in a big Brisbane hospital. Neither of those things works. Our program is designed to overcome that.

I will give you a progress report. Ian has touched on it. Through an AMC process, Minister Wooldridge encouraged us to apply for recognition of rural and remote medicine. On reflection, talking to him a little while back, he thought he had given us a pretty tough call really and did not expect us to do as well as we have done in it. It was a process where the AMC, the Australian Medical Council, struggled to cope with the diversity of general practice. It is what Ian said before about silos. They could cope with that quite nicely. Palliative care and pain medicine were approved like that. With rural and remote medicine, they said, 'It looks a little bit like general practice; it is a bit too close,' and that was the problem. Basically our bid for specialist recognition was turned down, but in doing that they did acknowledge the positive impact of ACRRM and the skills required in our practice. So they acknowledged it but they just could not bring themselves to fit us in to the system as it now stands. As Ian said, that needs to change in some ways.

The minister has now given us a commitment of a million dollars in funding to expedite a process to support accreditation of our pathway through the Specialist Education Accreditation Committee, known as SEAC. He has acknowledged the discipline of rural and remote medicine and he tells us that he intends to establish a register within the broad church of general practice to say 'generalist practice' if you like. This will allow some streamlined training to rural practice, and that is what we feel is needed. You need to get the SAS trained quickly, easily and efficiently. So we are confident that, with a bit of bipartisan support, the minister can achieve

this solution and get registrars into flexible arrangements. We want to get them out into rural practice straight away and teach them in rural communities.

I have a registrar with me who is in his third year. He is in a very small pilot program which is called the Remote Vocational Training Stream. In his second year he did his first caesarean section with me. He has done another caesarean section this year. He helped me with the snake bite yesterday and with the person in hospital who had a heart attack. He was really right into it from his first day of training, not sitting and waiting in a city area saying, ‘Oh, I don’t know if I will be able to cope with that.’ That is the sort of program we are looking at. We are confident that if the minister can deliver on those things we can certainly have our own training program working with registrars next year who can get past all the other barriers, if you like, and get people out into rural practice. In that way they become like my registrar—a very useful part of the practice. He is actually working with me all the time to achieve those aims.

I will give you a very quick Queensland overview. We are pleased to say that, as a result of all the inquiries et cetera, the Queensland government is working with us on a rural generalist pathway to help deliver those things. Without federal recognition those doctors cannot work in private practice. That is our problem at the moment. We actually cannot go that final step with the Queensland government until they have got that ability. The *Rebirthing* report is changing the outlook about small maternity units. We have got more remuneration and more accommodation now in Queensland. The infrastructure certainly needs to be beefed up somewhat. That is a progress report on Queensland. Sorry for such a long opening statement.

**CHAIR**—You do not leave us much questioning capacity! Can you describe the size, gender balance and age profile of your membership? It seems to be a young person’s game.

**Prof. Chater**—A lot of the age profile of rural practice generally—unfortunately in lots of ways—is my age group, the 45 to 55 age group. The gender balance is still very much male. It is changing. It is tough for the 45- and 50-year-olds if they do not have younger people coming through. Specialists survive in large hospitals through having keen registrars who in the middle of the night will cope with the first bit of it and then say, ‘Boss, I think you should come in because I don’t know what to do at this juncture.’ I am sure that is the way your brother, Mr Johnson, would survive as a neurosurgeon. That is what they need. It is changing. I think women in rural practice are very keen to be part of providing services in rural areas, but we do need the child-care stuff addressed. I think they get sick of being stereotyped as non-procedural, non-gutsy doctors. The Women in Rural Practice director on our board does caesarean sections and delivers babies generally down in Victoria.

**CHAIR**—How long does the average doctor last in the bush? Have you had a career in the bush?

**Prof. Chater**—Yes, I have been there 25 years, but I am not typical. Certainly there is a large group who have been there a while, and they are in the 45- to 50-year age group. We see it as necessary for it to be marketed to doctors that they can go out and get superb training in rural areas and then, if they want to come back, they can come back. Some of them only go for a few years, particularly in the Northern Territory. You find that in the more remote communities they find it difficult to stay longer than that. Many of my colleagues around my age stay quite a considerable time. There is a mixture.

**Ms Cowie**—I understand that, looking at the cross-section of general practice and those that practice in rural areas—not necessarily those that practice the broader skill set that we describe as rural and remote medicine—over recent years five years has been the average period for them to stay in rural areas. I qualify that again by saying that those that stay for that length of time are not the people that have really shown enthusiasm and passion and have been trained to do a broader and perhaps more challenging form of practice.

**Mr ENTSCH**—Would it be possible, as we were talking about earlier on with Professor Wronski, to have a broader recognition of some of the allied health workers? I would suggest that five years as an average time frame would be really pushing the envelope given the calls that would be on you as probably in many cases the only medico. You would have no backup; whatever happened, you would have to deal with it 24/7. You have mentioned the issue of locums, which are as rare as rocking horse teeth in some areas.

**CHAIR**—That is a good expression.

**Mr ENTSCH**—That is the reality, and it would be very unusual if most of the rural and remote doctors were still there in 25 years. Most of them leave not because they want to leave but because there is no backup, no support, and they burn out. Would recognition of allied health professionals—we are talking about primary care psychologists and professionals in other areas—for example, on Medicare, as a support for you as a medico benefit you?

**Prof. Chater**—I will make a couple of points. I think single doctor towns will die if they do not have two doctors. There has been a big push to have two doctors. You need at least two to share that load. That is the important thing. Regarding delegation, it is interesting to look at the Medicare item numbers with the practice nurse item numbers—

**Mr ENTSCH**—Which we are doing now.

**Prof. Chater**—which are now immunisations, dressings, smear tests and midwifery. They have been accepted wholeheartedly by the rural groups. The Rural Doctors Association and ACRRM have said, ‘Let’s do it.’

**CHAIR**—What about the communities?

**Prof. Chater**—The communities accept it. As Ian said before, I think there is a need to take things a bit slowly sometimes. Having them as a delegated authority certainly helps. In my practice I have nurses, visiting psychologists, a social worker and a diabetic educator. All of those people work within my practice. They do that very well. They are well accepted by the community and they take a lot of load off. I think that is what we need. We need to let the doctors work at the level they really need and want to work at and have a lot of good supports in those areas too.

I think there is less tension sometimes between the various professions in the bush. When things go pear-shaped in a delivery in the bush, midwives do not say, ‘Oh, God, the doctor is here,’ they say, ‘Thank God the doctor is here.’ I have talked it over with them lots of times. They know not to get me in a situation that is unsustainable and I know not to drop them in one either. A friend of mine was saying that we have integration but no services. In the city they have

services but no integration. I think there is a big element of truth in that. There are certainly some areas where it does not work quite that well, but it is generally better.

**Mrs ELSON**—You touched very lightly on the idea that there is progress made in the maternity units in rural hospitals. I and a couple of other colleagues have had our rural hospital wings closed because of not being able to get support or workers out into rural areas to do work in those sections or deliver. We had local GPs who were assisting, but the state government more or less cut the funding to have them assisting. I just wondered what that progress you mentioned was because I would be very keen to know.

**Prof. Chater**—A report commissioned by the Queensland government by Cheryl Hirst, an independent report called 'Rebirthing', is certainly worthwhile getting. I think it is one of the best reports on obstetric services anywhere in Australia. Her recommendation was to try and re-establish units. I am on the implementation committee for that. The committee is very keen to see where appropriately that can be put forward. I think you do need the right staff. We do have a bit of a problem with midwifery. A problem all through rural areas is trying to grow your own staff. I think you were talking about that before. You need people who can actually train out in rural areas. One of the big problems with midwives at the moment is that they have to spend a considerable time in the city.

**Mrs ELSON**—Queensland Health said they could not afford to put a specialist or an anaesthetist in every rural hospital.

**Prof. Chater**—They do not need one. All of our fellows have generalist qualifications which allow them then to deal with motor vehicle accidents and things like that. Then we expect all of our fellows to have one extra skill. That would be obstetrics or anaesthetics or surgery or mental health.

**Mrs ELSON**—So they do not need the specialists sitting there constantly?

**Prof. Chater**—No. You need a team of generalists who have the skills. That is what we want to see happening now. Certainly the rural generalist pathway agreement with the Queensland government is part way to that in that they certainly want to see training with us in places like Stanthorpe and Roma and so on. Those should be teaching centres. They should not just be service centres. We can take that down a lot further than people have felt in the past. The barrier is probably getting the recognition of rural and remote medicine. Unfortunately, the AMC put us in a difficult situation that way. But I think with goodwill from the minister and with your support, obviously, we can get that up. But I think that is vital now.

**CHAIR**—Can you give us some figures on how many doctors we are talking about?

**Prof. Chater**—How many doctors?

**CHAIR**—Within the college.

**Prof. Chater**—There are about 2,000 in our college. As I said, that is without any recognition legislatively. Australia-wide, there are about 1,000 proceduralists left. There are about 4,000 rural doctors altogether. So there are 4,000 in rural areas and a thousand doing procedures. At

least 2,000 of the 4,000 attend hospital in emergencies and things. The majority of our membership would be involved with their local hospital. A large number of them would be involved in procedures.

**CHAIR**—How many short are you?

**Prof. Chater**—There have been various estimates of that. With some innovation as to the workforce and with getting registrars and training out there, I think we are probably at least 500 short. If only we could get some registrars attracted to go out there to practices. As Ian said before, if you get them out there and get the teaching happening, all of a sudden other people will come. There is nothing like a sinking ship to make people hop off.

**CHAIR**—To learn to swim.

**Prof. Chater**—Yes, to learn to swim.

**Mr ENTSCH**—I refer to what Kay was mentioning about the removal of birthing facilities in small provincial areas and to your comment that small provincial centres should really be training grounds rather than having their services taken away. The other area, and this would relate specifically to you as rural and remote doctors, is that in many communities there has been a tendency over time to take away any capacity to be able to give birth in them. Since native title came in it has become a major issue in so much as there is a very strong desire—almost a requirement—by people to be born in their home country. In the case of those that are being forcibly removed from their home area and taken to provincial centres to have their children, their children are then ostracised in the community and challenges are made that they are not of that country because they were born somewhere else. That is an interesting one that needs to be addressed. I would be interested to hear your views on that, because one of the problems you have is that in most of those communities there are no doctors, although they do have some midwives. The problem you have is that the health issues relating to many of those in those communities are much greater than those in provincial centres, so the risks of having a birth with an unsupported midwife is much greater. I would be interested to hear your views.

**Prof. Chater**—It is a matter of balancing risk and it is a matter of trying to look at what those things are. I think people do not mind if they know that it is done on a reasonable basis, even if they have got a great attachment to land and things like that. I see that even in our local community people would prefer—

**Mr ENTSCH**—to be born on country.

**Prof. Chater**—Yes. They would much prefer to be born where their family are, because to give birth away means they have to go away for quite a long time to ensure that. That is a quite significant issue. If there are reasonable grounds on which to transfer someone, I do not ever get any problems. But we do need to make it reasonable. We need to try to get appropriate staff to be able to do a lot of these things in appropriate places. As I said, I would encourage you to read Cheryl Hirst's report because it explores that issue in probably one of the most sympathetic ways that we have ever seen. Great credit should go to her for the quality of that report.

**CHAIR**—From the point of view of funding—and we are concerned with funding—what else could the Commonwealth do over and above what it does now? That would be in cooperation with the states.

**Prof. Chater**—I think there is a need to address the recognition issue. That will have a small funding effect. We are not absolutely sure of the quantity of that, but certainly the AMC said it was small. I think they were taking probably a fairly negative view of it, but they were still saying it was a fairly small effect funding wise. One of the big barriers, particularly in Queensland, is the barrier between private doctors and rural hospitals. At the moment private doctors can only admit people who are privately insured or willing to pay the private fees. You end up with a fairly ridiculous situation sometimes where the doctors who are the most experienced are sitting there twiddling their thumbs during an emergency because they are not employed by the public hospitals.

There is a need, maybe, to look at some mixed funding models that way so that there is not that barrier between the two. When you look at the shortfall in the use of private health insurance in rural areas then you see that that is really only equitable and just. There are other funding areas that are important. Traditionally we have looked at teaching sites being big city based hospitals. There has been very little funding out to rural areas for infrastructure. There is some funding for remote placements of students in private practices, but there is very little infrastructure out there sometimes in those areas. The infrastructure area would be a really important one. I think it can be done in partnership with the state in most states.

**CHAIR**—What about partnerships between private health and public health? We saw the example in Sydney. The North Shore Private Hospital has two or three cath labs located within the Royal North Shore Hospital, the public hospital. To us that looked like a very efficient model where there was cooperation between the state system and the private system. Could this happen in rural and remote Australia? The level of private health insurance in rural Australia is quite low, obviously, because they do not have access.

**Prof. Chater**—There are two issues here. One is that in the truly rural and remote areas there are very few private hospitals. I think it is a matter of making sure that there is an allowable mix of private and public within the state hospitals in rural and remote areas. When it comes to regional areas, it is a bit different. I must say that our university, interestingly, has moved its office into the Mater Hospital. Our clinical director in Rockhampton is appointed half the time by the Mater and half the time by the university. We are moving a lot of our teaching into the private sector, as well as the public sector. Certainly, in private, rural and general practice, there is quite a commitment to students being taught there. That is certainly possible. In regional centres there does need to be more clinical cooperation between the two.

**Mr ENTSCH**—I have a question on the lack of infrastructure in regional centres. You are somebody who has practised in a bush setting for 25 years. Going back a few years, we had all these little bush hospitals. In my own area there were small hospitals like Mareeba, which almost closed down recently. They had a training program there. They trained all their nurses and staff in the hospital. Of course, there has been a change now in that, to be qualified, you have to be university trained, which, I would assume, drains away the capacity for teaching in those hospitals. It sends them all down to places like Townsville and Cairns and thereby creates a huge

vacuum of skills within the hospital system. Have you experienced that? Is that what is happening out there?

**Prof. Chater**—There are a couple of aspects to that. The first is that they are useful hands when they are training in a rural hospital, so you have lost that. The second thing is that you send them to Townsville or Brisbane and they marry a city spouse, so you lose them that way. You just do not get them back. It is interesting that medicine has gone full circle that way. Now, with rural clinical skills, we are getting people from rural areas and trying to keep them in rural areas.

Would you bear with me for just one anecdote? We did a trial last year. It has just been evaluated and we will probably go back to it in the university. We did a trial of having a student learn the whole of his third year of medicine in basically a two-doctor practice—my practice. He was an interesting fellow. He was a shearer for 10 years and then decided that he would do psychology. He did psychology at the University of Southern Queensland. When he went to Brisbane for his first two clinical years, he told me that he had to learn meditation to cope with Brisbane. He got back to Theodore, spent the whole third year learning at Theodore and said that after a couple of months he did not have to do his meditation any more. He then went to Rockhampton for four theories and is in Cairns at the moment. Even though they are regional centres, I think he copes with those quite nicely, but he does enjoy the bush and we need more people like that.

He actually learnt medicine, surgery, psychiatry, general practice and rural medicine with us during the year in what I call the 'live-in, fly-out service'. You actually live in the community and become a useful member of the team, as you were saying about the nurses. Then, if you want to do a week of surgery, you go to Rockhampton and do a week of surgery; if you want to go to the psychiatric unit, you go to the psychiatric unit; if you want to do some learning with the physician for a week, you do that. It is turning the whole system around and I think that is really important. At the moment we have a very metrocentric model that says that all the knowledge is in the city and then you send people out to experience the bush.

**Mr ENTSCH**—So you see a very positive outcome by reversing that a little bit and bringing it back into those centres?

**Prof. Chater**—You have to look the other way. I always say that Brisbane is really the rural fringe.

**CHAIR**—Is there anything at the federal or state level which impedes this process?

**Ms Cowie**—I could respond to that question and follow on from the question before as well, in a sense, using the example of nursing. In our primary field, which is medical training, the experience over recent years is that the federal government has really shown a lot of leadership in regionalising general practice training through the general practice education and training structure. There are now 22 regional training providers, mostly regionally and rurally based, training their doctors locally within what are still quite large districts but districts that offer a lot of opportunities for training. That has been remarkable in the sense of shifting the mindset and training people more locally. The early indications are that it is very successful. That has been a major step in the right direction.

What our college feels at the moment is that we need to build on that and then recognise: now that we have them there, what skills do they need to be able to serve their communities and meet the needs of their patients? We need to look at the skill-set model a little bit, which is very much based on, I guess, a more metrocentric view of general practice as it operates in a larger centre. At this point in time, it does not recognise the skills and experience that you need to run a local hospital and it does not actually credit that towards your qualifications and your ticket to practise. That is where ACRRM comes from, from the point of view that hospital practice, private practice and everything in between is what you need to be able to care competently for your patients. That is why our fellowship, our curricula and our processes are different. We come from that other perspective, I guess.

**Prof. Chater**—It is looking at it from a rural perspective.

**CHAIR**—You have probably gathered that the rural and regional members of this committee are on this side and the city boys are on that side.

**Prof. Chater**—We will educate you fellows, but it was nice to see the balance.

**Mr JOHNSON**—Bruce, I would like your comments about the training that we have in this country in terms of medicine as a graduate degree versus an undergraduate degree. In this country it is not yet across the board that medicine is a graduate degree, but my thinking is that that will end up being the case. Can we make a judgment on that? Is it a good thing, a bad thing or neither here nor there?

**Prof. Chater**—It is always interesting to reflect on these things. The university I am involved with, the University of Queensland, has a graduate rather than undergraduate program. I have seen both sets of students come through, and there are good sides and downsides. Learning everything all together, which is what the graduate program does—you learn anatomy together with physiology together with clinical skills—does integrate them better, and the students are normally a bit more mature because they have had another career beforehand. You may get a student who was a physiotherapist, and you could tell she knew how to deal with patients because of the way she dealt with them the moment she was in the practice. She knew how to hold the arm of the old fellow, ease him into the room and say, ‘Let’s talk about things.’ There are some big advantages that way. The other side of the coin is a very structured program where you build from the base up, which has stood the test of time over a long time. In the end you probably end up with a similar output. It is just two different ways of building a car, if you like.

**Mr JOHNSON**—I assume that when you make these sorts of changes you make them because they are going to produce a better system or a better output, because in the ordinary course of events and logic you do not implement change to have a detrimental result.

**Prof. Chater**—The change was probably brought in to look at people with more life skills. Also, there was a fair bit of evidence that an integrated method of learning was more effective—that, if you learnt your anatomy of the wrist when you were in year 1, by the time you got to be a surgeon, you had to go and learn it again, to some extent anyhow.

**Mr JOHNSON**—I have a question about mature students—older Australians doing medicine. In the real world, as opposed to, say, Mr Morris coming from the legal world into politics, is it

more difficult for someone who is an engineer or in some other profession to have a second or third career in medicine and then go into the rural and regional parts of our country because they have an interest, although the system does not currently encourage that or offer incentives to do that?

**Prof. Chater**—Our shearer who did psychology was a good example.

**Mr JOHNSON**—You and I would soon be very rare exceptions.

**Prof. Chater**—We are getting more people from rural backgrounds. We are getting more people who have done other things. It means that you have to have a very tight training program, and that is certainly our view. You need to quickly give them the base skills and get them into an area where they can learn on the job, because then they are useful in that site and, as I said, you are immersing them in the culture of what you want to do. One of the things I find with the more mature students is that they are hungry to get to work. They have not been a student all their life, and some students get quite comfortable—

**Mr JOHNSON**—Or they have that gap between student life and going back to it.

**Mr ENTSCH**—It was a Vietnam vet who took out top honours at the first JCU graduation.

**Mr JOHNSON**—That is exactly the sort of example I am thinking of. Someone who might be 40 or 45—

**Mr ENTSCH**—50!

**Mr JOHNSON**—They may or may not be comfortable financially in their current profession or work, but they are intellectually capable and challenged to do it.

**Prof. Chater**—I think that is part of the frustration of the present system. The present system is very bureaucratic, if you like. With all due respect to bureaucrats, it is unnecessarily bureaucratic.

**Mr JOHNSON**—It is lucky I am not one!

**Prof. Chater**—There are a few. It is unnecessarily so. Instead of saying, ‘Get out into practice and learn with someone out there,’ it says, ‘You’ve got to do this term or that structure or whatever.’ There is too much unnecessary structure to it instead of saying: ‘You’re a mature adult. You’ve got four years to learn this curriculum. Let’s get on with it.’ Instead of being focused on outcomes and skills, it is saying, ‘You should do this term or that term or whatever.’ Then, unfortunately, our fellows who want to do it have to go through the impositions of that structure. So they say to us, ‘We really want to do your program but we’ve got to do all this other stuff too, and it’s just all too hard.’

**Mr JOHNSON**—This goes back to my earlier reference to the colleges and their very closed thinking and closed shop mentality.

**Prof. Chater**—I would like to think that we are a reasonably young and innovative college. As Ian said, having a group of peers gives you a lot of strength when you want to influence doctors and get the right outcomes. It is important in any profession to have that, but it needs to be useful. Our college comes from what is useful for my community. The nice thing about ACRRM is that those people actually live in rural communities. We are bushies, and we want the best for our community. That is where we come from.

**Mr JOHNSON**—Mr Entsch is going to go into the medical world following his time in politics.

**Mr ENTSCH**—It is nice to hear you referring to your patients as patients and not clients.

**CHAIR**—Thank you very much for appearing before us today. We value your words a lot. If we need to contact you again in the preparation of our report or other evidence we receive, we will. Thank you again.

[12.35 pm]

**SHEEDY, Mr Philip, General Manager, Mount Olivet Hospital**

**CHAIR**—It is my pleasure to call Mr Sheedy of Mount Olivet Hospital to give evidence. We did acknowledge early on our appreciation of the hospitality of your hospital in allowing us to use this facility. We really like to have our inquiries in a setting that is more conducive to the inquiry than the other sterile rooms that were available to us. I will now say what I said to all the other witnesses—please do not take it personally. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the federal parliament. Giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. I invite you to make an opening statement to the committee.

**Mr Sheedy**—I suppose I need to declare, in light of Mr Morris's comments, that I am a professional hospital administrator. I do not hold a nursing or medical qualification or a first aid certificate, but I have been engaged as a hospital administrator—not an accountant or bureaucrat—in my profession for 37 years. It gives me great pleasure to welcome the committee to Mount Olivet. It is a great source of pride for us to have members of the House of Representatives hold a hearing in our hospital.

Mount Olivet is not your ordinary hospital: we have no operating theatres, emergency room or midwifery service. We offer a rehabilitation service where patients will come for three or four weeks for a rehabilitation program and are then discharged home. We provide interim care for patients who have been in an acute hospital to come here while they are waiting for a nursing home placement. The other service that is well known to all Queenslanders is our palliative care service. In that service we accommodate 28 inpatients and have about another 130 patients being cared for at home in the community.

So, excluding rehabilitation, we are a hospital that looks after those in the winter of their years and, for a number of them, who are at the end of their life. We would average about 120 patients in hospital, so we are not a very large hospital. We are a private hospital. We are part of a group: the Sisters of Charity and Holy Spirit Health Service. We operate other acute hospitals in Brisbane, a range of nursing home facilities in Gympie, one under contract in Toowoomba and a number in northern Brisbane. Our mission here is to bring the healing ministry of Christ to all we serve. While we are a private hospital, here at Mount Olivet we do provide services to public patients through a contract with the state of Queensland.

But all of our contracts, whether they are to serve public patients, private patients or veterans, are on the basis of a fee for service. We have no grants to provide inpatient services. So we are just like every other private hospital in that regard. We do have a grant for our palliative home care service with the state and, as a private hospital, we do have one medical officer in training here, so we have a grant for that from the state. We also provide an outreach to Wynnum Hospital, which is a public hospital.

The current issues facing this hospital are much the same as those of most other private hospitals in Queensland irrespective of the service profile: things like nurse recruitment, other

skills shortages and exceptionally tight margins. Perhaps the most significant topical issue for us as I speak is how we will deal with the 23½ per cent wage package with additional benefits that has been offered to Queensland public sector nurses. I suppose it is an issue associated with your brief concerning the sustainability of a strong private health sector into the future and also the Commonwealth's responsibilities for health insurance and veterans affairs.

I would qualify that by saying that this hospital and the sector generally does not have a difficulty at all in ensuring that nurses are appropriately remunerated—they are the backbone of our hospitals, and we have a vested interest in looking after their interests. The issue for the sector with this offer is that is very front-end loaded. Private hospitals derive about 86 per cent of revenues from health insurers. Contracts are negotiated on the basis of fixed prices for a given period and insurers in turn submit applications to the federal government for premium increases based on anticipated cost increases. They then in turn fund health care services for their contributors from that premium income.

The 3½ year wage offer, which contains almost 50 per cent in the first 12 months, exceeds the budget expectations of the private hospital sector and also the funders and purchasers of private hospital services. The Private Hospitals Association of Queensland is currently conducting an industry impact analysis relating to the potential implications of the package. Once that is collated the association will be briefing all parties who purchase private hospital services to determine what options are available to ensure our highly skilled and valued clinical workforce is appropriately remunerated and that the private sector continues to provide the choice, access and high quality of care available today.

In Queensland the sector employs about 11,500 equivalent full-time nurses and we are operating about 6,000 beds. Were a number of nurses to shift from the private to the public sector, it would likely be accompanied by a diminution in capacity in the private sector which, in turn, could lead to a consequential increase in demand in the public system. It certainly carries risks of other unintended consequences and could well compound problems and not ease them in the public sector. These risks might have been minimised had the public package being phased in with a time frame more manageable for private hospital funders.

Private hospitals need nurses to operate and they need a reasonable margin to reinvest in capital, maintain standards and keep abreast of technology to provide for the needs of the growing population of south-east Queensland. Exposing the sector to financial shocks of this magnitude and its associated risks is not really in the interests of the overall community. So we, along with other hospitals in the sector, hope the PHAQ and the purchasers of private hospital services are able to develop a resolution to this most testing issue.

In making these comments, and as they are so typical, I have drawn information from a press release issued last week by the association. I have that available for the committee, if you are interested. This and other industry issues aside, Mount Olivet continues its 50 year tradition of care to patients who come to us. I look forward to showing you our facility at the conclusion of your hearings this afternoon.

**CHAIR**—Thank you very much. Of the five per cent recent increase in private health insurance premiums, how much of that will flow to the private hospital sector?

**Mr Sheedy**—Traditionally, it is less than 50 per cent. That is what we have experienced in the past.

**CHAIR**—I understand your concern about how the private sector is going to respond to the state government's package. Are you going to compete with it, and, if you do not, will there be a flow of people to the public sector?

**Mr Sheedy**—We have to compete if we are to retain our staff. However, we cannot compete unless we are supported by the funders. They are the people that pay us. If the funders are not able to, yes, there is a significant risk that we will lose valuable, scarce resources to the public sector.

**Mr VASTA**—What is the mix of state, Commonwealth and private patients?

**Mr Sheedy**—In very general terms across the country, about 56 per cent of surgery and about 46 per cent of all separations are done in the private sector. So it is very significant. If there is a diminution in the capacity of the private sector to provide that surgery, they have only got one place to go.

**Mr VASTA**—Yes, that puts enormous pressure on the others.

**Mrs ELSON**—You said before that you are on fixed price terms with the private health providers. If you have to carry that 23½ per cent it would be an awful strain on your budget, but if you could not carry it you would have nurses leaving and you would be in a worse position, wouldn't you, if they go to public hospitals?

**Mr Sheedy**—That is right. One would hope that we will be able to work a solution through with the funders, and that we are able to graduate an increase. The difficulty for the funds is that, apart from DVA, at this time we are basically locked in for about another year under current funds. Certainly this hospital is.

**Mrs ELSON**—In the past, were your nursing staff being poached by the public sector?

**Mr Sheedy**—Yes, but there has always been a margin. Very generally, there are few private hospitals that would be paying exactly what the public system pays. There have always been other attractions in the private sector. We do not have the bureaucracy that the Queensland public hospitals have. We are more flexible and we try very hard to accommodate people's family needs. That is part of being nice to your staff, but it is also a commercial reality. If you do not, you will not have staff. So we have always been very flexible and we have tried to pay as much as our fund contracts allow us to.

**CHAIR**—Do you use agency nurses as much as the public sector does?

**Mr Sheedy**—It varies, but at times up to 18 per cent of our staff have been agency staff. It is not quite as high as that at the moment, but it frequently gets to double digits.

**Mr ENTSCH**—You said you had one doctor training here. What about aged and palliative care nursing staff—do you train them here?

**Mr Sheedy**—From time to time we will have relationships. We have had a relationship with RSL Aged Care that has seen some of their staff coming here for training. But, no, there are very few private hospitals that have the old-style nurse training. We will have clinical placements of first-year graduates, and again that is common for private hospitals. Periodically within a group of hospitals, rather than specifically Mount Olivet, we may conduct some particular training for nurses.

**Mr ENTSCH**—Often the public sector has made comments about parking aged care patients in beds in public hospitals because there have been no appropriate aged care facilities available for them in specific aged care facilities. Do you have any experience of that or any problems here?

**Mr Sheedy**—Not recently. My bailiwick is Mount Olivet Hospital rather than the nursing homes. At the present time we have 41 public patients in the hospital who are here under what we call the interim care program. They are patients who have come from public hospitals and are awaiting nursing home placement. On average, they would stay in our hospital for about 30 days before they find a place.

**Mr ENTSCH**—So there is no backlog on them. You are able to find a clear path through.

**Mr Sheedy**—Yes, but I need to qualify that. They are assessed as high care, so they are attractive placements for nursing homes. We do not provide low care in our hospital as a transition program.

**CHAIR**—Part of the terms of reference of this committee looks at cost shifting, and the Commonwealth and the states blame each other from time to time—or all the time. Do you see evidence of cost shifting in the operation of this hospital from the public sector? The state government would argue that placing high-care patients with you here, in the absence of nursing homes beds, would be an example of cost shifting by the Commonwealth, which is not providing sufficient beds to take those people who are unkindly called ‘bed blockers’. Do you have a comment on that?

**Mr Sheedy**—Yes, they may have that opinion. We are very happy to provide services for those people—they may be public patients under our state contract, and we certainly look after a lot of others, such as veterans, who are in the same category. However, privately insured patients have a very strong financial incentive to find a nursing home place very quickly, because as soon as their acute care certificate runs out—

**CHAIR**—How long does that take?

**Mr Sheedy**—Normally it is a period of 35 days. It can be extended.

**CHAIR**—Depending on your fund?

**Mr Sheedy**—No. It depends on the doctor’s certificate. But the people who would come here for transitional care or interim care would not have an acute care certificate. They have been assessed as high care, ready for placement. The debate about cost shifting has certainly gone on

all of my career, and I think many people would just like to see a decision on it made and it go to Canberra.

**CHAIR**—Mr Sheedy, we will see you and ask you more questions during our inspection tour later on. I thank you again on behalf of the committee for appearing and for the facilities.

**Proceedings suspended from 12.52 pm to 1.07 pm**

**LINDEBERG, Mr Kevin, Member, Whistleblowers Australia and Whistleblowers Action Group**

**SENEWIRATNE, Dr Brian, Member, Whistleblowers Action Group (Queensland)**

**CHAIR**—I am required to tell you, as I have told all other witnesses—so do not take this personally—that the committee does not require you to speak under oath. You should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Do you have any comments to make on the capacity in which you appear?

**Dr Senewiratne**—I was a senior specialist visiting physician at Princess Alexandra Hospital and I was one of the initial whistleblowers in 1994. I am currently out of the public sector: I was eased out because of blowing the whistle.

**CHAIR**—Do either or both of you wish to make a brief introductory statement before we proceed to questions?

**Mr Lindeberg**—Yes, I would like to. Mr Chairman and committee members, on behalf of Whistleblowers Australia, I wish to thank the committee for the invitation, albeit at short notice, to speak to our submission No.93 of 22 November 2005. It has suddenly fallen on me to address the committee because our national director, Mr Greg McMahon, is in Sydney and therefore cannot attend this hearing. I am aware of the contents of our submission because I assisted in its construction and recommendations.

Our submission finds its origins firstly in the Bundaberg hospital commission of inquiry chaired by Commissioner Tony Morris QC until it was closed by court order on a finding of apprehended bias against him; and then in the new commission of inquiry into the Bundaberg hospital chaired by former Court of Appeal Justice, Hon. Geoff Davies QC. The committee will see that both our submissions to commissioners Morris QC and Davies QC dated 18 August and 16 September 2005 respectively are attachments to our submission of 22 November 2005.

I believe I am obliged to inform you that one of Dr Patel's alleged victims was my first cousin. My cousin, who was my age, died shortly after Dr Patel performed the operation, which we now know he was not qualified to perform nor the hospital resourced to cope with. I knew nothing of Dr Patel at the time I attended his funeral in Bundaberg.

Whistleblowers Australia comes to this national inquiry under term of reference (c), which says:

> c. considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

We have concentrated on the word 'accountability'. We have attempted to define what accountability ought to mean for government and its employees and what the Australian

community, in a democracy governed by the rule of law, are entitled to expect as users of its health system, which is resourced through their taxes.

Our submission finds its validity flowing out of the conduct of rogue surgeon Dr Jayant Patel at the Bundaberg Base Hospital. Its force comes from how long it took his rogue prima facie unlawful conduct to come to public attention in post-Fitzgerald Queensland, with all its so-called checks and balances guaranteeing greater accountability; its claims of being an open and accountable government; its whistleblower protection; its public sector ethics legislation on the statute books; its Medical Board functioning under law; its Crime and Misconduct Commission functioning to eradicate official misconduct, and doing so without fear or favour to none; and its oaths of office sworn by doctors and nurses as well as politicians and law-enforcement officers before taking up their duties.

In simple terms, how could such harm inflicted on unsuspecting, trusting patients in a civilised society like Queensland come to pass? Where was accountability to law, professionalism and the public interest when it was so desperately needed? Where were the public officials, both elected and appointed, when Dr Patel was acting like a rogue doctor? Why didn’t someone stand in front of him and simply say, ‘No more’?

While we all want justice for the victims and the families harmed by Dr Patel and the health system which failed them, the critical unanswered question remains—and, if we are to learn from the experience, it must be answered honestly—why wasn’t the whistle at Bundaberg Hospital blown sooner? Why did it take someone like nurse Toni Hoffman to risk everything to get her employers, the state of Queensland and the Crown, and her fellow public servants to obey and uphold the law and to be accountable instead of allowing Dr Patel to wreak havoc for several years?

Fear undoubtedly permeates Queensland’s public service, and fear of speaking out to avoid a reprisal puts accountability at risk. Queensland’s public servants do not trust their system of government. They know it is highly politicised and toxic. We believe that bullying and intimidation starts from the top. We have illustrated in our submission what the system does to people who blow the whistle in Queensland. It cites the unresolved corruption surrounding the Heiner affair, which effectively set the unacceptable template for all that has followed in post-Fitzgerald Queensland. It cites the reprisal against key Fitzgerald inquiry whistleblower police officer Col Dillon; the forcing out of the health system of Dr Brian Senewiratne after he dared expose unacceptable working conditions of and for staff and patients at the Princess Alexandra and QEII hospitals; the treatment of ICU nurse Wendy Erglis by the system, including abuse under parliamentary privilege; and Mr Greg McMahon trying to hold the system to account.

Our submission exposes what is called ‘regulatory capture’ of our law-enforcement and accountability arms of government in our unicameral system. It also highlights, in the public interest, serious concerns about the suitability of the current state coroner, Mr Michael Barnes, to hold his position against his handling of the Heiner affair when at the CJC. It is especially concerning because his coronial duties now include investigating reportable and questionable deaths in hospitals, workplaces, prisons and detention centres, which may from time to time have the potential to adversely impact on government. As coroner, his duty is to be impartial and act according to law. Whether he complies with this is in doubt. An indicator of his unacceptable deferential attitude towards government and Crown law advice occurred as recently as 18

September 2004 before the Senate Select Committee on the Lindeberg Grievance, which related to the Heiner affair, when he said:

Surely governments must be free to take and act on such—

Crown solicitor's—

advice. Even if Mr Lindberg's claim that the shredding was unlawful has any substance how could action be taken against the Goss Government for acting in accordance with its legal advice?

Such an attitude presupposes that executive government, Crown law advice and public officials are above the law. They are not. Such an attitude breaches the doctrine of the separation of powers, the very doctrine which preserves his own judicial independence and function.

Equality before the law is the one common feature that motivates whistleblowers and is deeply cherished by the community. It is the democratic principle for which I have fought for 16 years in the Heiner affair despite suffering hardship and ridicule from those in authority. When double standards are applied to use the law to advantage executive government and public officials by law enforcement authorities like the Crime and Misconduct Commission or our state coroner, would-be whistleblowers simply have nowhere to go. Trust is destroyed. Everyone is left in no-man's land. Public safety is thus put at risk.

One disclosure route is through a politician who is prepared to exercise the constitutional right of parliamentary privilege and air the disclosure on the floor of parliament. Nurse Hoffman chose this course. Another course is through the media. The media must be prepared to report the alleged wrongdoing fearlessly and, importantly, stay the course. It is not unknown in the affairs of men for cover-ups in government to occur, and therefore, in a modern world of 20-second media grabs, the media may quickly lose interest and leave a whistleblower stranded and isolated simply because the issue, unless resolved quickly, becomes old hat.

This is why we have recommended the establishment of an independent whistleblowers protection authority in federal and state jurisdictions. It is our sword and shield policy. Such an authority's prime task would be to shield the whistleblower from reprisal because the sword—which in Queensland's case is the CMC, possibly the police or the Ombudsman—simply cannot both investigate and protect, let alone be trusted to investigate properly as our whistleblower case studies show.

We have also recommended that legislation governing the employment conditions of public servants be amended. For instance, in dealing with federal legislation, section 10(j) of the Public Service Act 1999, which refers to the Public Service values underpinning accountability, ought to include the following binding provision of a 'corruption-free workplace.' So it should read: 'a fair, flexible, corruption-free and rewarding workplace'.

Constitutional government requires that government obey and uphold the law. Elected and appointed officials are in some cases required to swear an oath before taking up their duties, or seat in parliament. The public expects these oaths to be respected to prevent abuse of office. Public officials must not advantage themselves or another when applying the law.

It is open to suggest that those who became aware of Dr Patel's conduct—which reasonably would have raised more than just the suspicion of incompetence but would have raised the suspicion of official misconduct—had a duty to refer such conduct to a proper authority, and, providing the public interest disclosure was genuinely held and not motivated by malice, basic contract of employment law ought to have protected them. Failure to report and refer Dr Patel advantaged him to the disadvantage of others.

It is perverse in the extreme in a society governed by the rule of law and where the law is enforced in the name of the Crown that a Crown public servant should be afraid to see that the law is upheld, let alone the Crown itself—or the public, for that matter—needing or relying on one lowly public servant within its ranks to risk everything to get the Crown to do what it is obliged to do.

In that sense, any public servant—from nurse, doctor, health administrator, childcare officer, legal officer, teacher, police officer, archivist to administration officer—ought to have the statutory democratic guarantee that not only will the Crown provide a work environment free from health and safety concerns but free from corruption. If not, an action in damages ought to be open to anyone who had to risk career and health by blowing the whistle to bring the Crown back into line regarding obedience to the law.

All contracts of employment are two-way streets. We have recommended that the whistleblowers protection authority be permitted at law to assist, through access to public funds, a properly accredited whistleblower to take such an action against the Crown in damages for breach of contract in respect of having to restore lawfulness in the workplace—just as the Crown can, at law, bring criminal charges, sack or discipline any public servant who engages in lawlessness in the workplace. It is about time governments throughout Australia guaranteed their workers a corruption-free work environment, because in doing so it would better protect them and the public from harm and restore confidence in government.

Finally, we acknowledge that the overwhelming majority of public officials working in our health system throughout Australia are honest and motivated to serve the public to the best of their ability, but corruption in the workplace can erode everything. It can destroy trust between work colleagues, in superiors and, worst of all, it can destroy everyone's trust in government because it undermines the rule of law.

Queensland is the sick man of Australian politics. It needs radical surgery. We have put forward recommendations in good faith which we hope will put Queensland back on the road to recovery. The shame is that submissions put to the Morris and Davies inquiries in good faith remained concealed and could only see the light of day and be made privileged public documents by the federal government. Now history and the public may judge their worth.

This malaise goes beyond throwing more money at it, although money is needed. It is about confidence in government and its institutions, let alone eternal vigilance. There is always a glimmer of hope, however, so long as we have nurses like Wendy Erglis and Toni Hoffman and senior doctors like Brian Senewiratne and Con Aroney who put the public interest first and not self-interest when lack of accountability affecting others comes to their attention.

We must, however, broaden and strengthen that dissent base to underpin accountability. As we all grow older and our health invariably declines and either hospital or aged care homes loom large, or when our children or grandchildren require surgery, we simply cannot afford to live our lives when using our health system anywhere in Australia by hoping that harm will not come our way by relying on sheer good luck that some one who sees abuse at a particular institution will speak out. The reality coming out of the Bundaberg Base Hospital experience, and now seen in the emerging aged care home abuse situation, is that few working in the system will speak out because most live in fear of doing so. Our duty is to do all we can to drive away that fear for the good of us all. Thank you.

**CHAIR**—Thank you, Mr Lindeberg. You were a witness at a previous inquiry that I was on. It was the Legal and Constitutional Affairs Committee inquiry into another Queensland matter—the Heiner affair. I know that you are a dedicated advocate of the rights of whistleblowers. How much success have you had with your proposal for a whistleblower protection authority to be established at the state and federal level? What avenues have you used to put that up as a policy?

**Mr Lindeberg**—We appeared some years ago, in 1994, before the Senate Select Committee on Public Interest Whistleblowing chaired by then Senator Jocelyn Newman. We put that forward then. There was another committee that followed up on that—the 1995 Senate Select Committee on Unresolved Whistleblower Cases—and that proposal was part of the general thrust. Our understanding is that whistleblower legislation in the federal parliament has not moved anywhere. In Queensland, it is not moving other than from the Davies inquiry into the Bundaberg Base Hospital. They recommended that whistleblowers fall under the control of the Ombudsman in Queensland. We do not agree with that. So we are not really having any success in introducing this particular body whose sole duty is to protect whistleblowers from reprisal.

**CHAIR**—Do you wish to make any comments, Dr Senewiratne?

**Dr Senewiratne**—Yes. I first make a plea of guilty to being lazy. I submitted a 70-page submission to the Morris commission. A lot of your questions to him today that I sat through were really directed to the wrong person because, with due respect to Mr Morris, he was not in a position to answer them. They should have been directed to someone like me. That is where I find myself guilty in not submitting a submission to you despite many pleas from your colleagues in parliament that I do so. I would be glad to send you a late submission outlining the problems in the health service—not just whistleblowing but also the whole gamut of what you have been dealing with today. I have been an associate professor of medicine. I have taught medical students for the last 45 years. I have that experience and I can tell you that medical training needs a bigger royal commission than health, because we are in a state of crisis. I will put that to you in a submission.

I have only just got off the plane from addressing the European parliament, because I have another skeleton in the closet: I am a human rights activist. With no insult to your inquiry, my top priority is to prevent a civil war in the country of my birth and I am flying back to Geneva for that. I have had to prepare a massive submission there because the Sri Lankan government has challenged every word of what I have said because they want to indulge in another war, which would be the end of that country. However, on my way back from Geneva, I will try to give this matter some thought.

Very briefly, I have come here for three reasons: firstly, to tell you of my personal experience as a whistleblower because there are some lessons to be learnt from that; secondly, to bring you up to date on what has happened since the Morris and Davies inquiry; and, thirdly, to make one or two suggestions regarding the future.

I was the first whistleblower, that I know of, in 1994 when I blew the whistle on what was going on at Princess Alexandra Hospital. It was an outrageous situation. It is not that people before me had not tried but that they had not got anywhere with the administration. I addressed my colleagues, mind you—not the media, not the public. It was not a publicity exercise; it was talking to my colleagues about what we should do. At the next meeting, the doors were closed and I was kicked out. I remind you that I was senior physician of over 20 years standing in that hospital, and I had to get to the gardens outside the hospital. Five minutes after I started addressing nearly 800 of my colleagues from all levels—doctors, nurses, gardeners, labourers, the lot—I was thrown out of the hospital grounds and I had to get to the streets. It is not my style as an associate professor of medicine and a senior consultant to have a public brawl outside, but I had no option.

That was picked up by the media and the next thing I knew I was defamed in parliament by the then Premier, Mr Goss. You will find it in the Queensland *Hansard* for 30 May 1995. I tell you, if those statements had been made outside parliament, I would not be trying to put bread on the table; I would have sued him for defamation. I think that some control has to be introduced. Free speech is not the freedom to say anything to anyone, parliamentary privilege notwithstanding. I think it is time we moved beyond all that. I was there in parliament when I was defamed. I had no way of salvaging my reputation or saying exactly what happened: I blew the whistle and then nothing happened. I was defamed, bingo.

About four years later, I went to see my sister in England who had had a stroke. I had permission to do so—a 10-day visit. When I came back, I did not realise that my name had been taken off the admissions roster. This is the busiest medical unit in the whole hospital, and the about 35 beds that I looked after dropped to 30, 20, 10, five, three, two and then one. I was in the absurd situation where I was coming to the hospital and seeing one patient. I asked why that should be and they said, ‘Your name has been taken off the roster.’

I then went and asked the general manager, ‘Can my name please be put back on the roster?’ He said, ‘Well, you know, we were just wondering about a retirement party.’ I said: ‘I am not retiring. If you want my resignation, that is another story. But I am not retiring.’ He said, ‘If you choose to retire.’ I said, ‘I am not choosing to retire; I am being forced into resigning.’ I think I made the biggest mistake of my life by, in a fit of temper, grabbing a piece of paper, and writing that I resigned from the hospital. But there comes a time, I think you will all appreciate, when you come to the end of your tether. You say, ‘God, I’ve had it; I’m quitting.’ And that is what happened to me—not that I regret it; I am doing pretty well in the private sector, thanks. I do not need to work in the public hospital sector.

To bring you up to date, before the questions, which I am happy to answer, nothing has changed. You can have Tony Morris, Davies—the lot. Even after I returned from Brussels two days ago, I have had calls saying, ‘Can you please blow the whistle on this, that or the other.’ My daughter, who is a plastic surgeon, came to me yesterday and said: ‘Can you bring to light the fact that I’ve got a huge waiting list to see me, but I’m not allowed to operate. I’m happy to

operate. I don’t get any more payment for operating. I’m just being prevented from working. The result of which is my waiting times having gone up.’ They are afraid. It is a culture of fear—Fitzgerald, Davies and everyone notwithstanding. My recommendation is that you can have whatever act you pass, but unless the penalties are a deterrent—I would even suggest a jail sentence for those who intimidate those who blow the whistle—you are not going to get anywhere. If you are going to have this whistleblower protection in the hands of the Queensland government, the health service or anything other than a very independent commission like what Tony Morris recommended, nothing is going to work and nothing is going to change.

**CHAIR**—You said you were going to prepare a submission to give to the committee. When we receive that, we will obviously examine it very closely and I think we can give you another opportunity to appear before the committee and speak to that submission. It is in your hands to provide that for us.

**Dr Senewiratne**—In that submission, I will deal with not just whistle blowing but the whole spectrum of health as I see it. I did not train in this country; I was trained in Cambridge and London, and I returned to Sri Lanka as an associate professor of medicine. I left the country because the Sri Lankan government said that they did not want a black Englishman such as me in the country and asked me to get out. I had the option of returning to England or coming to Australia. This is important: I had equal opportunities to go to the United States at a salary 2½ times what Princess Alexandra Hospital paid me. I opted to come to Australia. When I came here, I had job offers from the south which were double the salary of what I was earning. I still opted to come to Queensland, and the reason is the type of lifestyle you have in Queensland. That is a big attraction. I still believe it is possible to retain a number of very good doctors in this state just because you are blessed with a fantastic climate, apart from anything else. Also, my colleagues here have been some of the best that I have ever met in the world.

I will deal with that problem of public hospitals and then I will deal with the question of the training of medical students, which is critical. You are not going to get adequate staff by just increasing medical school places. If your training system is up the chute, which it is, you are wasting valuable time in the training process. You do not need a seven-year course to train doctors. That is just nonsense. I have been in the game long enough to know that.

Thirdly, I will deal with the question of training medical students in the private sector. I think you should be a little careful. Training registrars is a different matter, but for training medical students you may need to have added incentives, such as paying people to do so in the private sector. Private medicine is about making money, not about training people, and that would have to be altered by added incentives.

**CHAIR**—Mr Lindeberg, do you want to say anything else?

**Mr Lindeberg**—No.

**CHAIR**—We have your recommendations and we will consider them. We will await your submission, Dr Senewiratne, before we contact you again. Thank you very much.

[1.34 pm]

**CARTMILL, Dr Ross Ashley, Chairman, VMO Committee, and Member of Council, AMA Queensland, and President, Urological Society of Australasia**

**CHAIR**—Welcome, Dr Cartmill. Would you like to elaborate on the capacities in which you appear before us?

**Dr Cartmill**—In addition to my other capacities, I am also President of the Senior Medical Staff Association of Princess Alexandra Hospital. What I would like to say to your committee will probably involve areas within each of my three hats.

**CHAIR**—I have to say the following; it is not for you to take personally: although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the parliament. Giving false or misleading evidence is a serious matter and could be regarded as a contempt of parliament. I am required to say that to all witnesses. I can tell the committee that I had a meeting with Dr Cartmill in Canberra some months ago, in his capacity as President of the Urological Society of Australasia. He gave me a private briefing on the function of that society. At that time I invited him to make a submission to this committee and I am pleased to see that he has. Dr Cartmill, do you have an opening statement for the committee?

**Dr Cartmill**—I would like to concentrate on the training of specialists in a federal system. I use those words carefully to make sure that we all understand what I am talking about. I am talking about a federal system where there is a federal government and state jurisdictions, each having some input into training in a country where we are constantly being told in recent times that there are not enough doctors and we have to import foreign-trained graduates to fulfil the needs of our society. I think this is a serious matter and there are real issues that we as trainers, and I as a VMO and a senior medical staff member at a major teaching hospital, have with a lot of the things that are being said publicly with regard to this whole problem.

As I understand the terms of reference of this inquiry, we need to look at the financing of training as one of the issues of financing because if we are planning for the future to have enough specialists to satisfy the needs of this country then we need to be planning on how we will achieve that. Mr Chairman, my submission to you and your committee is that what we are currently doing is a disaster. What I am now referring to is the fact that we have a training system whereby the federal government, as the responsible level of government for tertiary education, should be taking an active interest in the training of specialists.

A doctor, we understand, starts the process of becoming a graduate in medicine by going to university. University places, we are constantly told by the state jurisdiction in this state, are the responsibility of the federal government, and the federal government has failed on this issue because there are not enough medical students. The problem with that is that medical students alone and medical graduates will not solve the problem. For example, you do not become a urologist—and I use that term simply because I am a urologist—by going to university and graduating in medicine. That is the start of a long process of being trained. The learning and the

training to become a urologist takes place after graduation and it is done in teaching hospitals. You could have thousands of medical graduates, but you will not fit them into our current training program because the hospitals are run by state jurisdictions and there is no planning to accommodate extra trainees in a system that requires trainers to do the training.

The trainers and the trainees are paid by the state jurisdiction, and the state jurisdiction, broadly speaking, is more interested in waiting lists because that is where the political clout applies; the training is something that applies to the future. Unfortunately, in a democratic process most governments do not worry about the long-term future; they worry about the next election. So we are facing the problem that we have an inadequate number of trainees and an inadequate number of trainers. It is said that it is because we do not have enough medical students in universities.

I put to you that that is not the problem. The problem is that we do not have enough trainers—and we do not have enough trainees as a result—because the state jurisdictions are not prepared to put the money in to guarantee enough positions for trainees and enough trainers to do the training. Your own statistics in Canberra should show you, for example, that the number of specialists in this state who work in the public hospital part time has dropped to something like 30 per cent. When I started training as a urologist, my mentors—my trainers—constituted the specialists of the state, the majority of whom spent some time in a public hospital as visiting medical officers.

I am a VMO and have been for a long time. I will stick it out but I will stick it out in a climate of frustration. Many of my colleagues have given it away. We have gone from 80 per cent of people in private practice in this state working in the public sector part time to where we are nearly down to 30 per cent. Why has that dropped? It is because people do not want to work in the public sector in this state, and that also applies in other states. We need as a country, as a nation, to start looking at why this is so and why a federal government is investing money in training and training is not taking place satisfactorily. I want to put to you a solution to what I see is a problem with the federal system: one level of government is responsible for training and another level of government is responsible for paying the salaries of the trainers and trainees, and the approaches of those two levels of government to the same problem are poles apart. They are poles apart because of political aims and aspirations. They are not the same.

People say there are not enough doctors. I am saying to this committee that there are enough doctors but there are just not enough doctors working in the public sector. A good example would be radiology. The state of the specialty of radiology in the major teaching hospital of this state, the Royal Brisbane Hospital, is such that there are scarcely any trainers in the hospital training the trainees to the point that it is looking like radiology is going to be struck off as a training position in a major teaching hospital such as Royal Brisbane. It is going to be struck off—the word is 'disaccredited'—simply because there are not enough trainers to make the situation fall within the definition of a satisfactory arrangement for suitable training. For there to be a suitable trainee in a suitable training post, the post has to be documented by the colleges as meeting standards. The colleges that do the teaching all do so as a voluntary exercise. I and others give up a lot of our time in our capacity to do this training. It was only two weeks ago that I was in Melbourne giving up a whole day out of my professional life to discuss with the college of surgeons how we could restructure training to suit the needs, given the complaints we received from jurisdictions around the country that we are not meeting their requirements.

We fall over backwards to try to find more training positions in this country so that we can get more trainees and so that we can get more specialists. While are giving up our time to do that as a voluntary exercise, we hear of a meeting of state health ministers running off to the ACCC to put pressure on the college of surgeons, and hence on societies such as mine, over complaints that are invalid: that we are trying in some way to stop the number of trainees in this country being increased. We are striving constantly to get more trainees. In urology we are always on the look out for more training posts.

A good example of our problems is at Newcastle. My colleagues have reported to me only in the last week that the public hospital and the private hospital in Newcastle have agreed that they will cooperate to use the private sector in training in urology in Newcastle and that in doing so a new training position in urology will be created. That is the sort of thing that my society is trying to do all the time. Why has it hit a brick wall? Because the state jurisdiction has refused to pay indemnity insurance for a trainee when he enters the private sector. Again, I am putting to you that we have a problem with the federal system where we have got two levels of government that are not working together. One looks after its own interests and the other looks after its own interests and in the end we do not get the training program of increasing numbers and increasing quality that is able to be achieved for this country, this nation.

There is a solution to all this, in my view and in the view of the urology society and the AMA. Firstly, we need to get rid of the federal system of funding of training in medicine in this nation. We put it to you that the federal government should say that tertiary education is your responsibility. Therefore, you should be directly financing training in teaching hospitals. It should not be done through state jurisdictions; you should do it directly. We could make suggestions on precisely how that ought to be done, but that is getting into minutiae. I am just putting to you that to go through state jurisdictions is to go through organisations that historically have not been interested in maintaining standards. Jurisdictions are more interested in service commitments, which is a commitment of we VMOs, but training is an equally serious commitment. For the long-term good of medicine in this country, those of us involved in training must persist with maintaining standards and working to increase the numbers.

The federal government and the whole system in this nation are pushing international graduates upon us. They are saying that we need people in areas of need today and they cannot wait for us to get people properly trained, because we need urologists today. The problem with that is that you then turn to us and say: ‘Here we have Dr Bloggs from some other country. We have assessed that this person is not, under our standards, capable of functioning as a urologist in a solo practice in a provincial town in this country.’ It is then said, ‘You train him up to reach our standards.’ Therefore, we are asked to train this person to reach a standard so that we can then say that he or she is suitable to function as a urologist.

We accept that we have a responsibility to do that, if that is what the nation wants to do, but I put to you: how are we to do that when, at the same time, we are trying to get more training positions for our own born and bred citizens? This is not a statement that is critical of other nations. I am simply saying that there is a limit to the number of training positions, because we have to maintain standards. If we are putting international medical graduates in those positions to train them up then there is a training post gone for the local product. We cannot have it both ways. We cannot create training positions for international graduates and at the same time try to

train our own trainees. The training is being done by the same trainers—those of us giving time to the public sector.

I am saying to the committee that we need to recognise all these problems. We need to say that the federal government is responsible for tertiary education and the federal government should finance training directly. In doing so, we should involve the private sector, because more and more pathology is being evidenced in the private sector that is not being seen by the trainee in the public sector. There are a couple of reasons for that. One is that there has been a limit to the number of patients we have been allowed to treat in the public sector. We are told in the public sector to treat category 1 patients or long-wait category 2. Category 3 patients do not get treated.

In urology, category 3 patients have lifestyle problems, such as prostatic disease and bladder outlet obstruction. Those patients have real symptoms, their quality of life is significantly impaired and they are just not getting treated. But they are being treated in the private sector, and our trainees could be seeing them being treated if they moved to the private sector to see it and in fact even do it. We would have to sort out how that is done legally. But we are saying to you that you must involve the private sector because the trainees are missing out. We can get more training positions if we use the private sector. We need one level of government to bite the bullet and say, 'All these silly obstructions, such as indemnity costs for the trainee, should be met.' They should not be used as an excuse to not let it happen.

The AMA, the urology society and I are saying that the solution is to make tertiary education a federal issue. Let it be a federal issue. Fund it directly. I am happy to talk about ways in which that could be achieved, but you may have your own ideas on how that could be done if you accept the principle that training in the public sector only is failing.

Finally, it is said—and certainly we get criticised for talking about it—that working in the public sector is not something that is encouraged within my profession, and that is simply because in this state for over a decade an attitude has built up that working in the public sector is the source of all the frustration, and more and more people have walked away. We need to recognise, as I said at the outset, the fact that there are enough doctors in this state to do the training, if we get them to come back and be trainers. Recently the state government has made a step towards recognising the truth of that last statement by addressing one of the problems, and that is the salary paid to trainers. We were actually losing money as we spent time in the public sector. It was costing us more to run our rooms than the state jurisdiction was paying us to work in the public sector. That has been partly addressed and now we are almost breaking even, depending on what level of seniority you are in the system. The junior trainer now is probably breaking even. That is not a real encouragement to become a trainer, but there is more than just the money; it is the satisfaction of seeing good quality trainees graduate to be good quality specialists.

You have that goodwill as a nation, and I think the nation is lucky to have that, but we should not depend on it. We should not assume it. We should be working on it to make sure it stays. The federal government has a real opportunity to build on that and to declare that training is its responsibility. It has to grasp the opportunity and ask the state jurisdictions to move away from something that they have handled badly and I do not think are particularly interested in. They will now say they are and, to be fair—and I hope I am always fair—the state jurisdictions since all these inquiries have certainly been making noises and saying things at the very top. That is a

positive thing that has not been said in over a decade. The trouble is that we at the coalface are yet to see evidence that those within the conglomerate called Queensland Health have actually learnt what the top may be saying and putting a change of attitude into effect. There is still clear evidence that that has not been achieved.

We are sometimes accused of talking trivia. If you as a committee want to tour a hospital, come and have a look at Princess Alexandra Hospital, have a look at the tearoom in the theatre complex. I have carried on about this ad nauseam for years, and certainly I get everybody saying: ‘Yes, it’s terrible. We’ll fix it.’ I walked in there this morning to make sure that things had not changed so that I did not say anything to this committee that was untrue and I found that the kitchen in the tearoom in the theatre complex at PA remains disgusting. About four months ago Queensland Health said to me, ‘What can we do of a quick nature to help morale?’ I said, ‘Fix the kitchen in the tearoom in the theatre complex at PA Hospital.’ I get told, ‘Yes, all right, we’ll do that.’ I am still waiting. I am waiting for the change room to be modified to make it even legal in a workplace health and safety sense, but it is so poorly designed that it cannot be achieved.

We work under these conditions—conditions that no-one, in my view, would be expected to work in a modern workplace health and safety environment. We still do it. I am growling about it, but I growl about it with a lot of justification. When you fix these things and fix the simple things that fix morale, you will start to get people back into the public sector and improve the number of trainers to fix the training problems. We can do things locally, but my plea and certainly my suggestion to you—and I have said it three times and I will say it a fourth time—is that one level of government looks after training. It is tertiary education; it is the responsibility of the federal government.

**CHAIR**—Thank you for that very comprehensive presentation. How would you compare the facilities in PA with the facilities in a private hospital for specialists? For instance, how would you compare PA with Wesley?

**Dr Cartmill**—It is a public hospital and a private hospital that you are asking me to compare. As a working environment, a public hospital and a private hospital will never be compatible, because a public hospital is a busy place that has far too many patients trying to fit into a system. A lot of negativity permeates the minds of the workers such as me.

When I walk into PA, it is my teaching hospital and I am proud of that. I have worked for that hospital and will continue to do so. But, in my mind, I do not work for Queensland Health; I work for PA Hospital—which is a concept that Queensland Health finds hard to accept. The direct comparison is that one is a busy and almost shambolic place because of the sheer numbers and that the other is a quiet and placid hospital which is maximally efficient because it does not have to deal with the numbers of patients and the consequent bed-block problem that occurs in public hospitals.

If Wesley is having a tight bed problem, that is because of the increasing demand in our community for private sector medicine. In my estimation, the private sector is undergoing a boom in terms of numbers simply because there is so much dissatisfaction and frustration in the public sector. To answer your question, if I go home and feel like kicking the dog or growling at

whoever wants to come across my path, my wife will sit me down, calm me down and say, ‘What’s happened at PA today?’ That is a sad indictment.

I can tell you another story of a colleague I ran into at Wesley Hospital two weeks ago on a Saturday morning when we were doing rounds. He was rather chirpy and gave me a broad smile of greeting. I said to him, ‘You’re looking very happy this morning,’ and he said, ‘Yes, I resigned from PA yesterday.’ He had been a VMO for 20 years and it was sad that he had done that. But, again, he did it through sheer frustration, and his wife encouraged him to do it because she was tired of him expressing that frustration at home. Working in a private hospital has distinct advantages. It is a much more peaceful, structured and efficient environment. In public hospitals, with the numbers and the bureaucrats telling us what to do, the frustration level is so much higher.

And, finally, there is the difference in the operating theatres. In a private hospital, you can operate and get your list done and people do not whinge at you about the time. In a public hospital, come four o’clock in the afternoon, a clipboard nurse will walk in, following instructions, and say, ‘When are you finishing?’ It is a much more time-orientated, watch the clock and do not go over time structure, while in the private sector it is about getting the patients treated. I, for example, delayed some elective surgery to make sure I was here on time. I will go back to the Wesley at six o’clock tonight and finish the list, and there will be no complaints. If I wanted to do that at PA, all hell would have broken loose. They probably would not have let me do it.

**Mr VASTA**—Is the practice of having foreign doctors take the place of VMOs in hospitals becoming more and more prevalent?

**Dr Cartmill**—In a major teaching hospital, no. The foreign graduates are put in places that are called ‘areas of need’. For example, there is a urologist working in a country town in New South Wales—it is best that I do not name the town. As the president of the society, I am very aware of the difficulties that this is creating for us. It is not because there is some problem with the doctor himself. He is well motivated and he is trying his best. The problem we have is in supervising what he is doing and in telegraphing it to the authorities that we are not in a position to say he is reaching the standards that are required. We feel that we have made an undertaking to try to do that, as we are a servant of the College of Surgeons, but if we are not supervising in any close manner then we really do not know what the standards are like. That is of immense concern to us. Are we going to say that this person has reached the standards required and can therefore work in an unsupervised manner or not? We have to make that decision later this year and it is going to be difficult for us. That is in a country town in New South Wales.

We have an overseas trained urologist working in Queensland at the moment. We think he is fine and we are looking like giving him the tick of approval. A lot of that, though, is based on his origin. We are confident about the quality of training in his country of origin. It is when we do not know the quality of training in the country of origin that we have difficulties.

As I said in my submission to you, there is a limit to how much we can supervise our own trainees and these IMGs—international medical graduates. We cannot do it all. We are doing it all in a voluntary capacity. Everybody assumes that we will just keep doing it. We are trying to do it; we do it for the good of the nation. But what frustrates us is that you assume—when I say

'you' I do not mean anybody in particular personally, but the system assumes—that we seem to have unlimited time to do all this. Yet we get criticism from state health ministers conferences turning to the ACCC to criticise us. That has such a negative impact on those of us doing the training that you are in danger of more trainers saying, 'I'm tired of this; the more I try, the more I'm criticised.' The easy option is just to say, 'No thanks,' and move on.

If you talk to the young, that is where it is really tragic. I train young neurologists. The young neurologists say, 'Thank you very much, but no thank you.' They are not going to work in the public sector. The average age of VMOs in this state is now over 50. If that does not impress upon you what I am talking about, I do not know how else I can express it to you. The average age of VMOs is over 50 and going up. If you talk to the young they say: 'We really appreciate the effort you are giving us, but we're not going to put up with what we see you putting up with. You train us and then we'll go into private practice and serve the community in an area of comfort and go to the Wesley and not worry about PA.'

I have a limited time, and so have my colleagues. As the age of trainers is now averaging over 50, if we do not do something soon we are going to find ourselves in a position where this country has no trainers. Yet we have state jurisdictions saying there are not enough doctors. There are enough doctors, but they are not being trainers. We have to get them back to being trainers. We have to get in this country the debate back to honesty, reality and stick to facts. It is very easy for a state jurisdiction to say there are not enough doctors. They are being allowed to say that when, truly, there are enough. There are not enough doctors in the public sector—that is the truth.

**Mr VASTA**—Has there been a turnover of staff of something like 40 per cent in the last two years?

**Dr Cartmill**—The turnover has been going on but steadily worsening over a decade. I cannot give you year-by-year statistics, but Queensland Health should be able to. Interestingly, I think they struggle a bit.

**CHAIR**—Queensland Health will not give evidence to this committee.

**Dr Cartmill**—Hence I am saying to you, Mr Chairman, that one level of government should be looking after this.

**Mrs ELSON**—Can I ask a question on that issue that you brought up before relating to insurance and how the public and private sectors should work together. Is insurance the only block to that happening?

**Dr Cartmill**—The next question is: do state jurisdictions also ask, if the trainee is working in the private hospital, why should they be paying their salary? This is simply because the state jurisdiction says that—and I am not referring to this state in particular when I say this; I am talking about any state—if the trainees are not working in the public hospital, why should they be paying the salaries. They are so focused on service delivery to public patients. They are not focused on training, hence they do not want to pay the salaries. To us this is just two levels of government having another barney. All we are trying to do is get on with the training. If we did

not have two levels of government having an excuse for this, we would be less frustrated in trying to get the training done.

We think there are ways within the federal system of Medicare agreements and so forth that money could be allotted. We think you should be allotting money for a certain percentage of time for training, and if you have to have state jurisdictions still involved—and I do have some understanding of the difficulties of politics but, ideally, the state jurisdictions should be right out of it, in our view—there has to be an agreement of a certain percentage so that what you now ask can be dealt with. But those are the two major obstructions to using the private sector: indemnity insurance and paying the salary—arguments about why we are paying the salary when he or she is working in the private sector, and the patients, it is argued, back at PA are not being treated. I would argue about all that, but those are the two major problems.

**Mr ENTSCH**—From what you said earlier on, there are issues in relation to monitoring the competence of an individual in the hospital system. There are clearly some issues with the competency assessments in relation to the process in place in public hospitals.

**Dr Cartmill**—Are you talking about the trainees or the trained specialist—the person in practice?

**Mr ENTSCH**—You raised an issue of an individual in the New South Wales system.

**Dr Cartmill**—That was an international medical graduate.

**Mr ENTSCH**—There was a difficulty in making an assessment of the competency of that person. There are clearly issues in dealing with those assessment processes.

**Dr Cartmill**—Absolutely. I have said to the federal minister: 'You ask us to assess these people; you put them in an area of need—that means you are not putting them in the middle of Brisbane; you are putting them where there is not a urologist—and then you ask us to supervise their standards. How do you expect us to do that?' It is all very well to import somebody and put them in an area of need and say to the community: 'Aren't we good? We have found a urologist for an area of need.' What you have not said to the committee is: 'We do not really know about the standards of this person.' You are asking the system, us volunteers, to sort that out for you. I am not refusing; I am just pointing out to you that you are asking us to do more and more somehow in our own time.

**Mr ENTSCH**—What about the effectiveness of the medical board in Queensland, for example?

**Dr Cartmill**—I do not think the medical board is in a position to supervise the standards of specialists. There is no urologist on the board in Queensland. How is the board to assess the standards of a person practising in any provincial town in this state or a person in a country town in New South Wales? How can their board assess the standard? All they can do is ask us whether we are happy. I am saying to you that we do not know either. What do you want to do? Do you want to wait for a disaster to happen and then say that he has not met the standards?

Clearly, that is not what you want us to do, and that is not what we want to do. But I am saying that I do not believe that all this has been properly thought through. It is very convenient to say we have plugged a hole and put somebody in an area of need but when you do that with a person whose standards you acknowledge you do not know are satisfactory for our community and you ask us to certify whether he or she is satisfactory, you have to ask whether we are capable of doing that, and what sorts of structures have we put in place to let us do it?

I do not believe that you, the federal government, state jurisdictions or the community have done that. You just hope that it works. I do not think we should be flying by the seat of our pants anymore. That should be fairly obvious after the experiences in this state in recent times. I am flagging that we need to get this far better formalised in a structure. I do not believe you can achieve it using two levels of government.

**CHAIR**—Does this apply to other specialties as well?

**Dr Cartmill**—Absolutely.

**CHAIR**—Right across the board?

**Dr Cartmill**—I use the urology example only because I am very familiar with it, wearing my hat as president of the society. But every specialty has the same problem. I illustrated to you that radiology is a good example right here in Brisbane. That is because there are no trainers. How are you going to get radiologists of the future when your own major teaching hospital is struggling in that department? Pathology is another example. You can look around and see the problems with pathology. My own hospital, PA, was discredited for training in pathology recently. That is the same thing—no trainers. Where are the trainers? They are all in the private sector. They are beavering away, working long hours, but they are not training.

**CHAIR**—What about neurosurgeons and cardiac surgeons?

**Dr Cartmill**—That same thing applies. It will vary from specialty to specialty, but broadly what I am saying to you applies to any specialty. There are fewer and fewer people wanting to be trainers. We have to reverse that. I know that Queensland Health would say, ‘Yes, we agree.’ They would say that now. I am talking about a problem that has been created over 10 years. It is fine for Queensland Health to now say that they are trying to reverse this—and I accept the director-general when she says she is trying to reverse it—but she is working in a state jurisdiction system that I am saying is superfluous. If we are going to get training done and coordinated and structured in a way that we can be confident is going to serve the community in the long term, we need one level of government. Who looks after tertiary education? It is the federal government. I am saying to the federal government: accept it and get on with it. We will work with you. We want to work with one level of government.

If you say you do not want to do it, I would be disappointed. Then say to the state jurisdictions, ‘You do it.’ But you have several jurisdictions and I do not believe, because we change borders from one state to another, we should have a different system. My personal view—and I stress that it is personal—is that state borders have little usefulness in modern Australia. They might be useful for demarcating sporting teams, but that is about it. If I go to Sydney I should be able to practice. Only two days ago I had a patient of mine in Perth phoning

me asking could I do this and this for him. Because he happened to be in Perth I said, 'No, I can't, I'm not registered in Western Australia.' That is nonsense, but that is the legal situation.

**Mr JOHNSON**—Dr Cartmill, thank you for a very compelling presentation. I subscribe very strongly personally to your thoughts. My brother is a neurosurgeon, and the same tale comes to me. I want to clarify something you said. You said that ideally the state jurisdiction should be entirely out of the health sector. Is that correct?

**Dr Cartmill**—Ideally, yes. It is probably not achievable, but certainly in training it should be. We would like to see the federal government say, 'Training is tertiary education,' and you directly fund it. Therefore, we directly communicate with you and we do not have arguments about who we should be talking to and we do not have people blame shifting. If you take it on and do it, then you cannot duck it anymore—I grant you that. You cannot then blame the state jurisdiction if it is your responsibility. It is your responsibility in all other areas of tertiary education. Why is the medical profession any different?

**Mr JOHNSON**—That is the training aspect. What about the formal employment aspect?

**Dr Cartmill**—Ideally I would like to see it one level of government. The problem is that even if you took over looking after training and you directly financed it, the salaries of the trainee and trainer are still being paid by the state jurisdiction. If the salaries or the conditions of employment do not meet expectations and you lose your trainer, that is not your fault. That would be frustrating, I would have thought. If I were the federal government trying to get the best training program running and I did all the work to establish it but the state jurisdiction let me down because they made conditions of employment terrible so I lost my trainers despite all my efforts, that would be frustrating and I would want control of the lot.

**CHAIR**—But the Commonwealth is actually paying for the training.

**Dr Cartmill**—Through the state jurisdictions.

**CHAIR**—Through the health care agreements.

**Dr Cartmill**—How do you know, though, that that money gets into the hospitals for training?

**CHAIR**—We do not know.

**Dr Cartmill**—So I am saying to you: do it directly and you do.

**Mr JOHNSON**—Why is your society not adopting a position extending beyond the points that you have made on the training?

**Dr Cartmill**—Because we think it might not be achievable. We are trying to be practical. We should not be making political judgments, I suppose—that is your role. I would personally not like to be in a position where I am looking after a part of the training and putting some money in it directly but I have somebody else undermining what I am doing by not pulling their weight.

**Mr JOHNSON**—I would have thought that in terms of reform, if you are going to reform this issue, it would be easier to do the entire lot rather than some of it.

**Dr Cartmill**—Then do it.

**Mr JOHNSON**—I support the position personally and I will certainly encourage that view in the committee. On the other point you made about your colleague's resignation from the PA, do you hear sentiments to that effect from colleagues who have not yet taken that path—colleagues thinking about it who have not yet resigned? Do you suspect that that is going to happen more frequently?

**Dr Cartmill**—There have been some changes—and I said I like to be fair—in Queensland Health. Firstly, I negotiated on behalf of the VMOs a salary package which was some significant improvement. That I think will slow the process of some people resigning. But the fellow I told you about, only two weeks ago, despite what I negotiated, still resigned, and resignations are still occurring. Queensland Health tell me that they have employed more doctors in recent times. I do not know where they are. I am not privy to the information as to where these extra doctors are working and what sort of doctors they are. They are not urologists, but still there could be others in some specialties that have been employed.

But there is constantly tearoom talk. It is still much the same. The tearoom talk is still that nothing has changed, despite emails from the director-general to the contrary. I have had a lot of communication with the director-general, which I did not have with her predecessors. Her predecessors would never talk to me in my capacity as the Chairman of the VMO Committee or as president of staff at PA. They ignored me, in fact. When I invited one to come and talk to my colleagues, he even said that he would not come and stand in front of a lot of hotheads. That was a director-general talking about his staff. That was not very long ago. The present director-general has never said anything like that; in fact, she speaks quite differently. I have said I will give a tick when a tick is earned. She says things that I like to hear.

**Mr JOHNSON**—Do you sense a cultural change in recent times?

**Dr Cartmill**—She is striving to achieve a cultural change. I often use the analogy that she is trying to turn around a tanker that is steaming at full steam across Moreton Bay—she is trying to slow it down, stop it and turn it around. That is going to be a difficult task for her. I speak negatively about Queensland Health. I get into strife because that is not the message. To this committee, I speak honestly. I am simply saying that I agree that the director-general is trying to turn things around, but in the people below her, people running the hospitals, there are still clear examples of where attitudes have not changed. At this point, Mr Chairman, if you like, I could just show you a photograph of our tearoom. You may think: why do I keep worrying about a tearoom—such trivia?

**Mr JOHNSON**—You might just send an email about the tearoom!

**Dr Cartmill**—But it is such a morale booster. I will put it another way. If I was running PA Hospital tomorrow and you gave me 24 hours, what would I do? I would probably make Brian Senewiratne an emeritus consultant, because that is what he deserves. The second thing I would do is employ someone in the tearoom to keep it tidy, and I would get a morale boost

straightaway. The third thing I would do, I reckon, is that I would pick on three fellows who are moaning and groaning and go and take them for a game of golf—and then I would probably get sacked. But I reckon, if that was what the new CEO being advertised for actually did, you would stop some resignations.

**CHAIR**—Do you have a picture of the tearoom? If you give it to us, we will compare it with the tearoom here later!

**Mr ENTSCH**—When you say 'if you were able' to do this to the tearoom and engage the emeritus consultant at the back of the room, would you also consider, with regard to recognising the difficulty in being able to assess the competency of overseas doctors—because, as you rightly say, they go into areas of need—looking at bringing them under your wing for a period of time into a hospital such as yours to assess their competency?

**Dr Cartmill**—I will get serious again now. When we invited the federal minister to our Urological Society executive meeting and he came last November, we discussed with him using the private sector in training and he said that this committee was looking at that seriously and he thought it had gone a fair way down the track. I hope it has. Secondly, we put to him that the urology society are prepared to put ourselves up for an opportunity to undertake a pilot study where we actually train—I have not worked out how we would find the time—country general practitioners to have more knowledge about urology, to stop unnecessary referrals to the city. That is not quite answering your question, but I am coming to it. But, if we did this, we would stop a lot of unnecessary referrals. I thought that after training we could give those who volunteer to be trained by us something called a diploma of urology or some sort of ticket to show that they have a specific interest in urology and have a better understanding of urological pathology, and therefore curtail unnecessary referrals and make urological services in the country more efficient.

As to your question, the answer is that we would be prepared to bring the IMGs into our hospital for a period of time, but the problem is that the state jurisdictions would have to agree to that. We would have to find a niche for them to come. Presumably, they have a family and therefore they expect to be paid for the three months while they are at PA being supervised.

**Mr ENTSCH**—It would be a cheap price to pay given what happened in Bundaberg. If he had come there for three months I would suggest that there would have been a lot of lives saved.

**Dr Cartmill**—I am not debating that. I am pointing out to you that the way it works at the moment is that the state jurisdiction pays the salary. We would have to get permission from the state jurisdiction to find the money to do it.

**Mr ENTSCH**—But it would certainly minimise the risk of what happened in Bundaberg.

**Dr Cartmill**—But there is no structure at the moment for us to do that.

**Mr ENTSCH**—Okay. That is the point I was making.

**Dr Cartmill**—But there may be if there was one government looking after it.

**CHAIR**—Thank you for appearing before us. You have been very comprehensive and we have heard your words very clearly. If we need further advice from you we will be in contact. We can either do that in writing or ask you to appear again.

**Dr Cartmill**—I would be happy to do that.

**CHAIR**—Thank you.

[2.28 pm]

**HODGE, Dr Zelle, President Elect, AMA Queensland**

**SMYTH, Ms Colleen, Senior Policy Officer, AMA Queensland**

**CHAIR**—Is it the wish of the committee that the submissions from Caboolture Shire Council and AMA Queensland be accepted as evidence? There being no objection, it is so ordered. I now welcome the representatives of the AMA. Although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceeding of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make a brief introductory statement before we proceed to questions.

**Dr Hodge**—Thank you for giving us the opportunity to speak to you. We know that the federal AMA has already put in a submission and spoken to you and, in fact, we endorse the matters which it has raised. We have tried to focus on other issues which have not been previously addressed or which have a Queensland focus. Having said that, the issues particularly with regard to Indigenous health, mental health and aged care are extremely significant in Queensland, despite the fact that I am not referring specifically to them because I know they have been addressed.

There are four matters which I would like to bring to your attention. The first is training at the medical school and junior doctor level; the second is the public and private interface; the third is cost shifting; and the fourth is task substitution. With regard to the first issue of medical training and education, initially I would like to speak about university training. The attraction and retention of doctors to academic medicine is in crisis. I do not want to underestimate that. I have spoken to members of the academic staff and this is an issue which they have said is a disaster waiting to happen.

In Queensland prior to 2000 we had one medical school. We now have four. Queensland Health has now addressed some of the issues with regard to the salaries of our salaried specialists in their hospitals. There is a significant differential between the salaries which are paid to the academic staff and the salaries which doctors with comparable skills and qualifications can earn as staff specialists in Queensland Health. I reiterate what was said to me by one of the chief executives, an academic at one of our medical schools, ‘This crisis threatens the very existence of academic medicine.’ Basically, to appropriately train the next generation of doctors, we really need to have academics who are there as part of a hospital based discipline but who can also pursue quality research and evaluate research and care. If this matter is not addressed urgently, now, we will have the situation where our medical students will be taught by non-doctor educators and will have a fractional input from medical doctors into their training. This would be a disaster for future doctors, for their ability and expertise and, as a result of that, for patients in Australia.

The concern, from the universities’ perspective, if they address the salaries associated with these academics, is the flow-on effect, so of course they do not wish to address it from their

perspective. What we are proposing is a solution. Dr Cartmill has already alluded to the fact that we feel the Commonwealth government has a responsibility with regard to tertiary education. We have suggested two opportunities for this to be addressed in a particular way.

Firstly, the Commonwealth government should provide funding directly to the medical schools to bring the academic salaries on a par with the staff specialists in Queensland Health hospitals. Secondly, many of these academics are employed in Queensland Health, so it may be they could be employed by Queensland Health, paid a salary commensurate with that grade but then have an agreement between the state and federal governments as to the amount of time spent in teaching. The issue of teaching our medical students and our junior doctors is a matter of enormous concern. I reiterate that this needs urgent attention. If this requires the Commonwealth government directly putting funds into the medical schools, that really needs to happen now.

I would now like to look at the issue of medical students. As I said before, prior to 2000 Queensland had a single medical school and we now have four. Last year we had 285 graduates. By 2009 we will have approximately double that number. There has been a call, which has been agreed to by the federal and state governments, to increase the number of medical students with full fee paying students. We are extremely concerned about this. We see it very much as a knee-jerk reaction. We know that there is a shortage in the medical workforce and we know that it takes time for medical students to become practising doctors but, if there is a knee-jerk reaction of increasing the numbers going in at the bottom end without addressing other issues, then we are not going to see the outcomes that we would hope to have.

I have already addressed the issue that medical students need to have teachers—and there are doctors certainly in the community who are involved in the teaching of medical students, and I will address that later on—and they need exposure to patients. Sometimes people seem to forget that you cannot just take a medical student, put them in a medical school, feed everything in the top and not expose them to patients. You need a certain patient base for them to learn on. If we are putting in a hugely increased number of medical students and they do not have access to patients, then they are not going to be appropriately trained. That is a significant issue.

We have some concerns with regard to equity in terms of the full fee paying students. I know that at one of the medical schools in Queensland—I am not sure about the others—all the full fee paying places have been taken up. When someone is offered a full fee paying place at a medical school, firstly, it is important to realise that they have already passed the academic criteria to get in. So it is merely that there is a cut-off and they could only take so many. They have passed the academic criteria. If a student is sent a letter saying, ‘We can offer you a full fee paying place,’ their families and those who choose to support them feel a huge responsibility to allow them to take up that position—often with great difficulty and hardship. If Australia needs this 15 per cent increase in the number of doctors that has been proposed every year, then these places should be funded. I think this has been drawn to your attention in the past and it is an issue of significant concern.

The other issue, just as an aside, with regard to full fee paying students is that to get particular funding the federal government requires a percentage of HECS students to complete 50 per cent of their training in rural clinical schools, which is great. But even if the full fee paying students

choose to go to the rural clinical schools they are unable to take that option. I think this is another matter that may be of interest to you and which might need to be addressed.

The next issue is junior doctor training. Dr Cartmill has already spoken at length about this matter of great concern. I have talked about the increasing number of graduates. That means that we are going to need an increasing number of intern positions and then an increasing number of training positions after that. Last year there were 285 graduates. Currently there are less than 320 intern positions in Queensland. The maximum number that it is felt it is possible to have under the current system is 386. As I said, in a couple of years time, we expect that there will be 560. As there are specific requirements for supervision and training of interns legislatively to ensure competent, safe doctors, you cannot just pull these positions out of thin air.

**CHAIR**—Is that under Queensland health legislation? Is it different in all the states?

**Dr Hodge**—There is legislation in all the states with regard to intern training because the medical board controls that. But, even apart from the legislative issue, it is just commonsense. One of the biggest risks is to put a young graduate into a situation where they are not appropriately supervised. Not only is that disastrous for their patients but also it is disastrous for them. We have had that situation in Queensland very recently, with disastrous outcomes for a patient and for the doctor.

Funding for junior doctors requires funding of training positions, adequate specialists to provide the training, sufficient exposure to patients and sufficient exposure to procedural skills to acquire those skills. One of the major problems is that if you have inadequate bed numbers you are unable to provide the training. We have had the situation in the last few weeks that one of our major tertiary hospitals has had to cancel elective surgical lists because, while there are doctors, nurses, anaesthetists and all the other support staff, there are no beds for the patients. So that is a real issue with regard to training.

It has been said that the government will not increase the funding to produce more training positions in the procedural specialties until training positions in less popular specialties are filled. If that is the case, then it is a matter which should be discussed publicly and openly and appropriate decisions made, one way or the other. It certainly should be brought to the forefront of public discussion.

There is significant hypocrisy in both federal and state governments complaining about the medical profession restricting training. We have had issues with regard to the ACCC and the Productivity Commission when in fact a lot of the problem can be laid at the feet of the governments themselves where there are insufficient training positions and insufficient procedures to allow the colleges to approve training. We see that as an issue. Although some of these issues are state government issues, certainly the federal government has also been a party to this matter of referring some of our professional organisations to their specific bodies.

The tension between service provision and teaching, which Dr Cartmill alluded to, is an ongoing concern to us. In Queensland Health, an understanding that Queensland Health has a responsibility with regard to training has only very recently been acknowledged and sometimes it is pretty hard to change attitudes quickly. I draw to your attention a situation we had recently, where there was funding for a state-wide training facility and the doctor who was trying to

organise this was advised by a senior bureaucrat—who was of the new Queensland Health, not the old Queensland Health, which was even more of a worry—that this funding would be dependent on output with regard to category 1 patients in a specific hospital department. So it was a state-wide facility but it was going to be dependent on that. In itself that is absurd, but the absurdity of it was even greater because that was the same week in which lists had to be cancelled in that hospital because there were no beds for the patients, and that has continued in the weeks since then.

The issue with regard to training is significant and we ask you to address that specifically. I would like to emphasise, again, two of our very great concerns on which, we feel, the Commonwealth can have an impact. The first issue is academic medicine. You could address that issue with regard to academic salaries, whether as funding directly to the medical schools or in some other way, but that really needs to be addressed here and now. The second issue is increasing the number of medical student places without having due understanding of the issues with regard to training.

I will move on to task substitution. We have acknowledged that there is a concern with regard to the health workforce. As I said before, sometimes decisions are made to try to address issues with a knee-jerk reaction without actually looking at what is the ultimate outcome of that particular issue. There seems to be a tendency in government at times to see solutions which have been proposed by academics as having some purity of intent. I have been very supportive of my academic colleagues, but sometimes there needs to be an understanding that some academics have their own agendas to pursue as well.

If I can give you an example, as reported in the *Australian Financial Review*, Paul Gross, a health economist, has been advising one of the Commonwealth health departments with regard to quality and safety in hospitals. He put up a proposal that an extra payment to hospitals should take place if they follow certain protocols. What he specifically addressed was the issue of infections after surgical operations. He suggested that if all patients going into elective surgery were given antibiotics, that would address this issue. This is the problem when you have health economists advising on clinical matters and it is the issue when you have people who do not have a broad understanding of the knowledge that medical training provides trying to undertake clinical care of patients.

In Queensland there has been a specific move—not just in Queensland—whereby Queensland Health has specifically stated that they are looking at this whole issue of enhanced clinical roles, but we also know the Productivity Commission report has addressed the issue of looking at anyone other than the person who is trained to do it to undertake the job. As I said, we acknowledge that there are issues and we acknowledge that these need to be addressed. But it is really important that when decisions are made about this they are based on sound, properly evaluated practical outcomes in an Australian environment rather than just looking at what has happened overseas and trying to apply them here.

There is the task substitution model which, as I said, basically means that non-medical practitioners who do not have the breadth of understanding are substituted. May I say that this is not just medical practitioners, because at a conference held at the end of last year here in Queensland there was discussion about generic allied health workers and everyone else. That is

why I made the somewhat flippant remark that it is anyone other than the person who is trained to do the job.

AMA Queensland supports a medical led team approach to patient care. The supervised collaborative approach is the best approach for quality care. I am a GP. We work in a team approach. We have practice nurses; we work with our allied health colleagues. We are really committed to this sort of a process and we believe that our patients are best cared for in this situation. But we do have some concern as to the person who is to take the ultimate responsibility. Interestingly enough, usually it is the doctor who has to take ultimate responsibility, even when something goes wrong. But in fact they are not there leading the decision making. So we see that as a huge issue. I raise this particularly again alluding back to the medical students, because there is a move to look at having physician assistants.

Physician assistants have been around in the United States for quite a while. I do not know whether the committee is familiar with that. Basically, in the States, as happens with their medical degree, they do a primary science based or some other based degree. Physician assistants started when the medics came back from Vietnam. They then do a college degree, which is probably about a year or a little less shorter than a medical degree. So they are quite well trained. They are trained on a medical model and they work in a situation where they are probably about the level of a second-year resident. They always work in a delegated position role. There may well be consideration given as to whether this is an appropriate way to address workforce problems. It has been raised that, particularly in rural Australia, this may be a matter for consideration.

However, can I say two things of concern with that proposal. In discussions that I have had with rural doctors, their feeling is that if this needs to be addressed we should not be looking at giving what would appear to be a second tier of care to rural Australia. There are innovative ways to bring in medical practitioners to treat those who live in rural Australia, so doctors would have grave concerns about bringing this model in as a way to solve the problem in rural Australia. Also, similarly, they were introduced in the States to address rural issues and to look at cost saving, and the information found that these people did not want to go to rural areas any more than anyone else did, and their salary increase was greater than the CPI every year.

Another issue is of course to do training. There is a proposal with a number of the medical schools to bring these programs in in the very near future. They would then be coming online at the same time as our new medical graduates and would be competing with them for training. Even if this issue with regard to physician assistants is seen as being a solution—and there are concerns about it—we do not think that this is the time to do it. We need to look at how we train our medical students.

Another issue is with regard to national accreditation and assessment of competency. Again, there has been a suggestion that the Productivity Commission look at an overarching national registration system. Our concern is that this is going to be across all health professionals. That is what the proposal is. In fact, it could never work to oversee all health professionals, so the colleges, the AMC in medicine and the appropriate groups for the other health professionals would still have to assess the training and competency of their own groups. So although we totally support national registration—and again Dr Cartmill alluded to this, and this is a very

good thing—the idea of this overarching body overseeing all the registration boards is basically another layer of red tape and wasteful bureaucracy.

The other issue which is very current is the assessment of competency with regard to IMGs. This has been talked about, but there is a move to look at this across the board, across all professionals. If this is going to be done, it requires good quality data, and overseas experience has indicated that it requires a remediation process to be in place before you actually set it up, otherwise you can have disastrous outcomes.

Regarding the public-private mix, Queensland, unlike some of the other states, has a really well-developed private hospital system. I guess this is long term, because we had a public hospital system for a long time, so most of our private hospitals are of an equal standard to our tertiary hospitals. Our complex cardiac work and other areas are dealt with within the private hospital system. So that is a little different.

There has been a move to train students in the private sector. Some of this has been alluded to with regard to indemnity and those matters, so I will not go over that again. However, it is important to understand that in the private hospitals there is no structure of residents and registrars, particularly with regard to teaching medical students, so teaching would need to be done by the doctors and specialists. Doctors of course have a commitment to training those who come after them but, if you are in a situation where there is a financial imperative to maintain as well as a need to do training, it is not easy to say, ‘We will just do training.’

As a GP, when I have medical students in my practice, that certainly slows down our appointments—they take more time. So I think the issue is: if there is going to be training in the private sector, who is going to fund it? There has of course been some success with this in Queensland, with pathology registrars who are funded by the Commonwealth government and who work in some of the private laboratories. They are part of the rotation within the public hospital pathology system as well. That is a positive.

The other issue is outsourcing patients to the private sector. We basically see that this would lead to the eventual destruction of an appropriately funded public system—patients would be unable to receive quality care in the public system and our teaching environment would be destroyed. So we see the whole issue of outsourcing as a significant concern.

If you just look at this, it is interesting. Human nature being what it is, people who may well be able to afford to look after their costs privately would learn to work the system if this came in and obtain, as public patients, care in a private sector. Those who really need the public care will not be able to access it because the public hospital system will be destroyed. In fact, this process of a voucher system has been shown by the Blair government in the UK to not solve any of the problems.

The only issue I think we do need to raise, and I am sure that Dr Cartmill has raised this as well, is that in some of our regional hospitals there is a very good rationale for paying VMOs by fee-for-service, because those VMOs do not have the support of registrars within the teaching hospital. As has been alluded to already, there are often doctors working in the private system who do not work in the public system, and they may have skills which would be useful there.

The next and final issue—you will be relieved to know—is specifically with regard to cost shifting. We have a concern about this because ultimately the medical practitioner is seen to be responsible for cost shifting. Often, it seems that the states move in to Medicare funded medical care and the federal government turns a blind eye. But doctors need to have some clarity on what is and is not acceptable, because doctors basically want to do the best for their patients but they do not want to end up having legal ramifications on them because they are trying to circumvent the huge disparity and disorganisation between the state and federal governments.

An example of cost shifting is public patients being sent either to have their pathology and radiology undertaken in private practice clinics at the public hospitals or to GPs to have their request ordered privately. I can give you a quite bizarre example of this. I had a patient who wanted to have total obstetric care at our public hospital. She did not want to have shared care; we do a lot of shared care. So she went into the public hospital. She then came back to see me with a form which had been filled out by a midwife asking me to sign it so she could take it back to the private practice pathology clinic at the hospital to have her pathology done there. That was absolutely ridiculous because she was choosing to be a public patient. Apart from the cost, there was the inconvenience for the patient to have to traipse backwards and forwards to me. That really needs to be addressed.

The other issue, as a GP, is that often, if we send a patient in as a public hospital outpatient, a letter comes back telling us it will take a really long time to get in and would we please send a named referral to this particular doctor and they can be seen as a bulk-billed patient in the private practice clinic.

We are also aware that there was a patient who went through this sort of process of being referred in for a procedure. They got in to be seen and were told they needed the procedure to be done. They were then rung by one of the administrators at the hospital and asked: ‘Do you have private cover? Because if you do we can have you done with no out-of-costs as a private patient bulk-billed at a scheduled fee by one of the staff specialists.’ The patient said they did not have private cover and asked what the hospital cost would be to have it done privately that way, and was told that. They then went to see their GP to get a named referral to see the specialist. It is an interesting thing about queue jumping for a fee, isn’t it?

In one of our public hospitals, we have been told that the majority of the public patients referred for endoscopy and colonoscopy et cetera actually have the procedure as bulk-billed private patients. There is no facility fee charged. The issue is not only cost shifting and all those other factors; it also means there is a loss of opportunity for training of registrars.

**CHAIR**—That is comprehensive. I do not think there is any room for questions—and as a former economist in the health department I wouldn’t be game to ask them!

**Mr VASTA**—Dr Hodge, thank you for that very good submission. You have obviously spoken to the health minister, Tony Abbott. What are his thoughts on some of the recommendations that you have made?

**Dr Hodge**—Do you mean has AMA Queensland spoken to him?

**Mr VASTA**—AMA Queensland, yes. Have you spoken to the health minister?

**Dr Hodge**—Do you mean specifically about the academics?

**Mr VASTA**—With regard to, say, the Commonwealth taking over some of the state jurisdiction.

**Dr Hodge**—We have not specifically spoken to the health minister about that. If you are talking specifically about the academics and that area, it is issue that has only very recently come to a crisis stage. Queensland Health has addressed the staff specialist positions. The issue with regard to an increasing number of academics has been a bit ongoing, but I guess it has just reached a crisis. We certainly have spoken to Queensland Health about how that might be addressed. I know that the medical schools have also tried to broach that.

**CHAIR**—You, together with Dr Cartmill—who gave his evidence before you—have comprehensively covered everything that I could possibly think of. Can we think about what you have told us and possibly seek further advice from you in writing or from you personally when we are considering all the statements?

**Dr Hodge**—Certainly. And can I plead with you to address the issue of academic medicine, because it is critical and I do not think that it has been addressed anywhere else. It is something that has only very recently been brought to our notice.

**CHAIR**—It has been mentioned to us two or three times today.

**Mr ENTSCH**—It has been mentioned by James Cook University. They suggested that $150,000 to $200,000 was the order of the day to address the differential between academic staff and public hospital staff.

You mentioned allied health. We had the rural and remote doctors here earlier and they seemed to suggest that they were not overly concerned about having the support of allied health professionals in remote areas. Psychiatrists and psychologists were mentioned. Psychiatrists are very thin on the ground—the more remote you go the more difficult they are to get—but there is quite a significant number of psychologists. They discussed being able to use those in primary assessments and things like that and having Medicare numbers for them as health providers in working with rural and rural remote doctors.

**Dr Hodge**—The issue is working with them, but I think it was the College of Rural and Remote Medicine who spoke to you this morning. You should also speak to the Rural Doctors Association, because the College of Rural and Remote Medicine is a specialty college. The Rural Doctors Association—

**CHAIR**—We have met with them.

**Dr Hodge**—We do know that there is a big issue in rural areas, and we agree that we need to look at innovative ways of addressing that. When we talk about psychologists and psychiatrists, we need to understand that they actually look at different areas. Looking at psychologists to support the GPs, and the ability to delegate to that, is a different issue from looking at someone who needs psychiatric care and having a psychologist to look after them.

**Mr ENTSCH**—But a psychologist could identify a need at an early stage to recommend that a person be dealt with by a psychiatrist.

**Dr Hodge**—As long as they are in a delegated model with a doctor. An issue which was raised very informally with me with regard to the physician assistants and the experience in the states was that sometimes they did not know when to refer. So I think that is a bit of an issue.

**CHAIR**—Thank you very much.

[3.05 pm]

**SMALLHORN, Dr Ralph, Chair, Redcliffe-Bribie-Caboolture Division of General Practice**

**STAFFORD, Mr John Watkins, Project Officer, Redcliffe-Bribie-Caboolture Division of General Practice**

**CHAIR**—Welcome. Do you have any comments to make on the capacity in which you appear?

**Dr Smallhorn**—I am a general practitioner who works in an accredited practice and is vocationally registered.

**Mr Stafford**—I am a health bureaucrat with no clinical training.

**CHAIR**—Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament and the giving of false or misleading evidence is a serious matter which may be regarded as contempt of parliament. I am required to say that. Do you wish to make a brief opening statement?

**Dr Smallhorn**—We have come to lighten your afternoon, we hope, and offer you the fresh, not-so-young face of general practice! Our health system is obviously failing. We are treating more and more patients in our hospitals at increasing expense and there are signs that we are failing the population. For example, the Australian Institute of Health and Welfare estimates that 80 per cent of illness in the elderly is preventable, 60 per cent of the Australian population are overweight or obese, 21 per cent of Australians are current smokers, over one-third of Australians do not take any exercise and 70 per cent of smoking pregnant women are not getting advice about the risks of smoking. We need to address these lifestyle issues—to put a fence, as we say, at the top of the cliff rather than an ambulance at the bottom—if we are going to have a healthy society.

The gap between the rich and poor has been widening for the last 50 years, and it is timely to acknowledge that poverty is the greatest cause of illness and that a social gradient of disease identifies that the poorest are the sickest. An historically important role of the health system has been to reduce health inequalities and provide services to those who need them. By developing a funding model directing resources to the areas of highest health need, investment would be directed to achieving health for all Australians. This could be achieved by targeted funding on top of the base grants, using funding formulas providing weighting with a morbidity-mortality index. Investment in the areas of greatest need would be built upon a wellness model. The evidence of the benefits to health of shifting funding from hospitals to primary care would seem to support weighting the funding towards addressing the geographic maldistribution of both morbidity and mortality. Simply moving the funding to primary care may not in fact address some of the issues.

Queensland has the compound problems of increasing chronic disease, a rapidly ageing workforce—of which I am an example—and too much work for too few doctors, as no doubt

you have heard numerous times during your inquiry. We hope to address this by having a new model of primary health care based on wellness centres: we have decided that it would be a good idea if people did not get ill! We intend that nurses and health practitioners work in collaboration with general practitioners to help patients do all of the healthy things, like stop smoking and do exercise and dieting, which none of us wish to do but probably need to do. Care could be coordinated through an electronic health record, of which the country is woefully in need.

Sadly, the existing funding system does not cope with the types of care we want to provide. Nurses and allied health practitioners can claim only for diagnosed conditions. The exception is the nurses' immunisation items. It would be useful to have items for group treatments in areas such as mental health. There are no items for things like Tai Chi or exercise programs to keep people well. There is no funding available to put nutritionists into shopping centres to advise people on what they should or should not be buying.

Since writing the paper, the division has tried to engage both the federal and the state governments and departments of health, with the objective of having a trial of this model. We have failed miserably. The twin barriers of funding sources and models of funding have meant there is little chance of a model being implemented. The dual funding system is incomprehensible, with armies of bureaucrats—my colleague excepted—to shift costs, as you have heard from the last speaker, and to make sure that everything is kept to a minimal cost. At least in Queensland there are community health services that duplicate general practice services and provide some other services that are not provided by GPs.

It would be easier to make trade-offs between providers if there was a single source of funding. For example, in New Zealand the district health boards are funding GPs to take over care of patients with such things as cellulitis. The hospitals are providing supply packs to meet the cost of those things. One of the things about being in general practice is that if you put an expensive dressing on somebody's leg ulcer you in fact spend more than the consultation fee that you receive. Therefore, there is a disinclination to treat anything that is very complicated. We have, as a result of our funding system, a six-minute medical system because seeing 10 people per hour pays you more than seeing two people per hour. If I go to a nursing home and see three people I am paid correspondingly less than I would be for seeing one, although they all would hopefully have the same comprehensive care.

The funding system must have incentives aligned to what we want out of the system—that is, people who are actually well. We reward illness. General practitioners make their money out of people being ill; they do not make money out of people being well, which is a perverse incentive. There are no real incentives to reduce, obviously, the cost of pharmaceuticals, as the health minister knows. One solution would be to pay GPs set amounts to buy pharmaceuticals for their patients. It would encourage them to use generic drugs where there were some savings to be made.

General practice is being squeezed out of parts of care that it is ideally suited for because of the funding system. As I mentioned, doctors have to refer patients requiring dressings to hospitals because it is not economical to treat them, so there is a rise in costs to the system of treating people who would normally have been treated by GPs. I heard that South Australia is funding nurses for general practice, instead of rivalling general practice by putting nurses out into the community. It makes more logical sense to enhance general practice by making it more

efficient and funding it to have nurses in a better way than it is funded currently, where there are EPC, extended primary care, items that people do not use if they are in small practices because there is too much paperwork. If you can employ a nurse to do them for you, you can maximise income without necessarily producing any benefit for the patient. That is obviously quite a crazy way of financing things.

There is ample evidence that money spent on primary care achieves more on total health outcomes than money spent on secondary and tertiary care in very expensive hospitals. I would advocate that the hospitals be closed and that we treat everybody in a primary care situation. To summarise our submission, we need to move more funding from a secondary care situation to the primary care situation. The funding needs to be on the basis of wellness so that people are in fact paid to keep people well. This might involve having some form of capitation payment. My AMA colleague sitting at the back might graunch at the thought of a capitation payment, but certainly partial capitation payments to practices which would enhance the current practice incentive scheme would be sensible. It would allow practices flexibility to utilise the wellness model to promote a healthier population.

The funding model also needs to enhance multidisciplinary care. The wellness centres that we have proposed, and which have failed so far to materialise, would be a good model for this, with general practitioners in charge of multidisciplinary teams who could then move into the community and, we would say, improve their health, longevity and wellbeing. I think the question of equity in our system is an issue that I would ask you as a committee to address, because I think there are a lot of inequalities. I understand you are going to Caboolture tomorrow, which is part of our division of general practice. It is a socioeconomically disadvantaged area which is very close to some quite new developments that are very advanced in their populations. But when people are poor they have no money to go on buses, trains, taxis or even cars to go to health centres that are even a few kilometres away. If a network of wellness centres were put up across a community, that would enable people to access information that would prevent them becoming ill in the first place, and then they would not need to use our very comprehensive and quite excellent health system.

**Mr Stafford**—Part of our submission has been written in response to our issue about the North Lakes area, where we are getting an additional 70,000 people coming in. The area is already underdoctored, and with no prospect of getting anymore, and with 28 per cent of our GP workforce aged 55 or over and patients sicker with more chronic diseases we cannot deliver the kind of service that we have traditionally provided to meet that demand.

**CHAIR**—Do you have different demands for services in outer metropolitan areas such as Redcliffe and Caboolture, which is almost regional but not quite, compared with, say, in the western suburbs of Brisbane?

**Dr Smallhorn**—The health needs of the population are pretty similar but their access to health facilities differs greatly. You no doubt will be bombarded tomorrow by the stories of the Caboolture Hospital. We are very lucky that we actually do have a first-class hospital system. What we are saying is that by preventing people needing the hospitals we will save a lot of money.

**CHAIR**—I do not think you would get an argument from this committee on the value of primary care or the value of primary care regarding preventive measures. We support the AMA initiative with the Commonwealth on obesity and other from the cradle lifestyle issues that need to be changed because of the increasing incidence of diabetes et cetera.

**Dr Smallhorn**—North Lakes is an interesting example where a major developer decided to build a new town—

**CHAIR**—And a golf course.

**Dr Smallhorn**—and a very good golf course! The initial planning involved the Queensland education department buying enough ground for a 12-grade school on the day that the whole thing was announced. Some years later we realised that with the burgeoning population there were going to be no doctors to look after them and we had a greenfield site situation. That was why we looked at other models of care, because finding the 60 doctors needed to look after 90,000 new people was obviously going to be an impossibility.

**CHAIR**—Why?

**Dr Smallhorn**—Because they were not being trained. In our division we have areas that are designated areas of need but as soon as the number of doctors rises they are no longer areas of need, and we wait. If you take Redcliffe itself, we have six or seven people over 65 who are working just because they enjoy it. They are full-time male doctors, two of them have had bypass surgery, one has had a major cancer, and all seven could resign tomorrow morning, go off and go fishing very happily. They work because they are slightly crazy and enjoy it. The replacement Gen X doctors are not going to work as hard as those seven. But we are not an area of need and we cannot address getting new doctors to our area until they have actually died or gone. So we have to wait for the horse to bolt and then we start to do something about it. That is obviously not good planning in anybody’s language.

**Mr Stafford**—The shortage of doctors is right around the peripheral areas of all our major cities.

**CHAIR**—That is why I asked.

**Mr Stafford**—The last time I looked in one of our newsletters, Brisbane North had 40 vacancies for GPs. Those GPs who want to work in cities generally prefer to work closer into the cities. So we are a bit further out in the pecking order.

**Dr Smallhorn**—My own practice has gone from five doctors to me. That is kind of scary.

**CHAIR**—Do you have a locum in today?

**Dr Smallhorn**—No, I am afraid that they are going to the hospital if they are seriously ill. This is the crazy situation that you cannot get a locum.

**Mr ENTSCH**—In relation to primary care, what the Chair said earlier on is right, there is quite a focus in that area. If you are looking for examples—what you are suggesting in relation

to these wellbeing centres is a very good initiative—one back in about 1998 or 1999 was that funding was made available for doctors, particularly in the Torres Strait, for example, with the diabetes issues. There has been ongoing funding there since about 1998 or 1999. The doctor is not there treating diabetes, he is part of an education program. That is a good example of where there has been a measured reduction in the incidence of full-blown diabetes. There was a calculation recently of the numbers of arms and legs that had been saved—it was something like a 50 per cent reduction in loss over that period since, I think, 1998. Dr Wooldridge was the one who provided the funding for it. If you are looking for examples of where there have been some serious positive outcomes I do not think you need to look any further than that, where you can see the value to the community of people still walking around with arms and legs that they would have lost under normal circumstances without that doctor, Dr Singer.

**Mr Stafford**—I have done quite a bit of research into diabetes education and the implications of it. But it seems to me that what we do is wait until the person has diabetes and then give them education to look after it. It would be much better if we had got them 10 years before when we noticed they were overweight and got them onto exercise programs while they were still capable. We see new diabetics coming in who are physically not capable of doing enough exercise to help reduce their weight.

**Mr ENTSCH**—That is exactly what Dr Singer has been doing since 1998. He has not been targeting diabetes patients. He has been targeting a community that is at high risk—that is, all of the Torres Strait—of getting diabetes and has over the last seven or eight years actually reduced the incidence of full-blown diabetes by about 50 per cent.

**CHAIR**—Has this model been taken up by the divisions generally? We regularly meet with Kate Carnell in Canberra on behalf of the divisions. We are all pretty close to our own divisions. I am on the Sunshine Coast.

**Dr Smallhorn**—John is a master of the art of shameless self promotion and our paper has gone all over the world really. Everybody expresses an interest in it, but the interesting thing is that nobody actually commits to it. Queensland Health has committed a lot of money to building a community health centre at North Lakes. It is really a continuation of the model that exists. They are obviously looking at chronic disease management, as is the federal initiative to do that. It is just that the skill base of general practice is already outside their working. The reason you do not have younger people here today other than John and I is that they are all busy working and hopefully seeing the patients that I am not seeing. Everybody is flat out. Unless that workforce is utilised better, the system will in fact fall apart. We need to go into some forms of alternative primary care using the multidisciplinary team. It makes sense to use that.

**CHAIR**—Isn't everybody doing that now with the emphasis on school tuckshops, healthier food and compulsory exercise for school kids? This has to start very early in life.

**Mr Stafford**—It is a multifactorial problem. I think you have to approach all of those angles. I think the one thing that general practice has is that people come to general practice. The average member of the community comes to a GP six times a year. Presumably those people who have unhealthy lifestyles come even more. That is an opportunity to get at those people and give them education to get their lifestyle issues sorted out. There is no incentive for the GPs to do that. It is outside their business. They do not get paid to do that so they do not do it. I exaggerate. But, in

terms of setting a new diet, you have to spend hours and hours on it. You tend to think you can get by by just handing over a piece of paper and an exercise program, telling them to just go and do some more exercise. I am trying to sort my lifestyle out and get my weight down, and it is really hard to do. It needs a constant reinforcement.

**CHAIR**—It is not hard to go the other way!

**Dr Smallhorn**—Exactly. One of the things we could do is have nurses and dieticians ringing people. In fact, we would need some research among young women. They actually use SMS a lot. That is their preferred method of communication. There is no way that the current systems are set up to deliver information in the way that people want it. We are trying to get into a preventive model. It is a lot about reinforcing. It is a behavioural model.

**CHAIR**—What do you want us as a committee to do? Should we endorse your proposal?

**Mr Stafford**—Obviously!

**CHAIR**—I have no difficulty with doing that. But, from the point of view of the federal government introducing this model into future primary care, what initiatives can the federal government take to achieve that?

**Dr Smallhorn**—If you took over the hospital system and funded the hospital system federally and poured some of the money that is currently pouring into the gap between the federal and state boundaries into primary care, you could enhance primary care to a major degree.

**CHAIR**—You will not get an argument out of me or Tony Abbott. Unfortunately, the Prime Minister would not agree with you.

**Dr Smallhorn**—We have to have dreamers, don't we?

**CHAIR**—One of the objectives of this committee is to recommend to the government—

**Mr JOHNSON**—Recommend the dreams.

**CHAIR**—a relationship between the Commonwealth and the states.

**Dr Smallhorn**—I have been in divisions of general practice now for 10 years and at the very first national divisions conference I attended, in 1993, everybody said that is the problem: 'The funding system is crazy, there is no centralised planning and this needs fixing.' We are now about 15 years down the track and we still have not achieved anything. The federal government has spent an enormous amount of money on IT for medicine and has very little to show for it. Queensland Health has spent enormous amounts of money on IT and has nothing of any consequence to show for it. It clearly needs to be fixed. You have the opportunity to lean in that direction. That would be my plea.

**CHAIR**—So you would have no objection to private health funds providing gym boots and exercise equipment to their members.

**Dr Smallhorn**—Absolutely not. Obviously large companies do that. There is no reason at all that that should not happen. It would also be logical to subsidise people to do the exercise. The cost-shifting thing that Dr Zelle Hodge referred to happened to us: we spent $100,000 of federal and state money setting up a project so that GPs could take over the pre-admission of patients to hospital. John was initially employed by the division for that. Everything was agreed and we had launched the program, and I mistakenly wrote to the Health Insurance Commission, whom we had asked for special item numbers to run the project and had been refused, and said, 'We will be billing this under these item numbers,' whereupon we were rung up the day after we had launched it and told, 'You can't do that: the Professional Services Review Board will be looking at your division.' That is cost shifting. Even though this had been a federal-state initiative, we were not allowed to do it: $100,000 worth of taxpayers' money was literally stopped in its tracks and that was it—the end of what was in fact quite an intelligent suggestion and a lot of hard work on John's behalf. That sort of thing happens so often that it makes people despair.

**Mr JOHNSON**—I have many questions but I know time is running out now. One point which made my ears prick up was when you mentioned something about electronic records or profiling. Did you say something to do with that?

**Dr Smallhorn**—Part of the federal government's initiative in general practice prescribing was an IBM report in about 1987, and $2.5 million was spent on the IBM report. We computerised our division of general practice on the basis of what the IBM report recommended. The mistake, as I see it, was that they did not then tell IBM to fix it and give them $100 million or whatever was needed at the time. They had a perfectly comprehensive assessment of what had been, what was needed and what should be done, and it was promptly ignored by everybody.

**Mr JOHNSON**—Sorry, is this an IT issue or—

**Dr Smallhorn**—This is an IT issue.

**Mr JOHNSON**—I see. It is not about electronic profiling of people's health or—

**Dr Smallhorn**—That would be part of it. A comprehensive electronic medical record will come. It is just taking time. I will be retired and probably buried before it appears, and that is very worrying when I have already been looking at it for 15 years.

**Mr Stafford**—I would see each practitioner at the wellness centre having a computer on their desk which helps guide them through good health care decisions and enables a GP to take care of a greater number of patients although they do not necessarily see them. Every time a patient came to see the dietician, for instance, the notes that the dietician wrote up about the patient would be seen by the GP, who would flick through them, like you do with your emails, so they could keep track of the big issues.

**Mr JOHNSON**—So who would enter those notes? Would it be the dietician when they see the patient?

**Mr Stafford**—Yes, the dietician.

**Mr JOHNSON**—Would they then type in the stuff from having seen the patient and so expand the record?

**Mr Stafford**—Yes.

**Mr JOHNSON**—So it is cumulative.

**Mr Stafford**—And the information from all the various members of the team—because I am really talking multidisciplinary teams—would be available to all of them. Then, ideally, when they reach certain clinical criteria, the patient could be automatically booked into hospital systems where they need to go for that, because all the investigations that are required and everything that is done is done—these people really need care. There is no reason why the GP cannot book them into the hospital's book and, equally, when the hospital is ready to discharge them, there is no reason why the hospital could not book them in to see the GP.

**Mr JOHNSON**—Could we return to this IBM study in 1987. It was before my time.

**Dr Smallhorn**—It was very comprehensive. I think about $2.5 million was spent. It basically said, 'This is what you need to do to do it.'

**Mr JOHNSON**—So it was part of that prevention model that we are trying to introduce?

**Dr Smallhorn**—Exactly.

**CHAIR**—Could you send us an email with a reference to the report, so we can look at it?

**Mr Stafford**—That was that, within a wellness centre, all of the information from the various allied health practitioners and nurses would amalgamate into one common record that was accessible to all, and of course the GP—a prime GP, taking the primary care of that patient—would be able to look at that and keep a constant eye on it, just to pick up the odd time that someone else was not picking something up.

**Dr Smallhorn**—The North Lakes development for Queensland Health is going to be a paper based paperchase, which in 2006 is completely crazy. But they do not have the capability to set this in process—I guess they just do not go to big enough computer companies!

**CHAIR**—Will you be at Caboolture tomorrow?

**Dr Smallhorn**—Unfortunately not. I will be seeing the patients I did not see this afternoon!

**CHAIR**—Is there anything we should know before we go there?

**Dr Smallhorn**—In terms of the emergency debacle, about 100 people a day were attending Caboolture Hospital emergency room.

**CHAIR**—Where are they going now?

**Dr Smallhorn**—Queensland Health has been spending approximately $45,000 a week on ambulance transport from Caboolture to Redcliffe. Some of them are now being seen and it is in process of being reopened. It is open all day and they are planning to open it until late evening and then open it 24 hours a day.

In terms of the actual numbers, one critically ill patient every two days was being seen and approximately nine seriously ill people. So, of the one hundred, 90 per cent were category 3, 4 and 5 triage patients, who were actually general practice patients. Our argument is that they should never get there. Then you have to argue whether you should have a vast expensive emergency department open for 10 people a day—and as an economist you could argue on that yourself, I am sure.

**CHAIR**—I can argue as the local member too!

**Dr Smallhorn**—Once you have opened something it becomes impossible to close it. Once you have set something in process the expectation is there. The fact that Redcliffe and Caboolture hospitals were developed as separate entities some 20 kilometres apart was a quirk of electoral boundaries more than hospital needs, so Redcliffe-Caboolture is really one hospital stuck in two places. Obviously, there is some duplication of services with that. They are trying to get centres of expertise in each one so that people will travel to the other one. The problem is that the infrastructure for travel is quite difficult. I think there was an awful lot of politicking and probably not enough straight-talking in the Caboolture issue, from a candid point of view from a general practitioner who has observed it.

**CHAIR**—I am sure we will find out tomorrow. We are really out of time now. Thank you very much for coming along to give evidence to us.

**Dr Smallhorn**—Thank you.

**CHAIR**—We will look at your submission carefully and at the evidence you gave us and include it in our final recommendations. Thank you very much.

Resolved (on motion by **Mrs Elson**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

*Evidence was then taken in camera—*

**Committee adjourned at 5.18 pm**