Parliament of
South Australia

FINAL REPORT

OF THE

SELECT COMMITTEE

ON THE

MOUNT GAMBIER AND DISTRICTS

HEALTH SERVICE

Authorised to be published and distributed by the President of the Legislative Council,
The Hon R R Roberts MLC, on 14 February 2006,
pursuant to Resolution of the Legislative Council on 1 December 2005.

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1 EXECUTIVE SUMMARY AND RECOMMENDATIONS

The Select Committee believes that the conflict that has arisen from contract negotiations between the Mount Gambier and Districts Health Service (MGDHS), the South East Regional Health Service (SERHS) and the Department of Human Services (DHS)/Health has had a major impact on community confidence in the provision of health services within the South East. The Committee notes that the confusion over the responsibility for the negotiating of new contracts was a significant contributor to the escalation of the conflict.

The Committee believes that by failing to recognise fundamental problems in a timely manner at MGDHS, the Minister and the Department of Human Services exacerbated the problems and allowed many issues to fester, prejudicing the long term future of health services in the South East.

The Committee expresses its view that had there been greater clarity as to which body is responsible for negotiating contracts with general practitioners and non-resident specialists and had there been transparent lines of accountability established for such negotiations, some of the acrimony may have been avoided. Further, the Committee concludes that had general practitioners and medical specialists been able to collectively negotiate contracts with MGDHS, a more timely and mutually productive outcome would have eventuated. (*Recommendations 1 and 2*)

The Committee was concerned to hear repeated accounts of bullying and harassment by departmental staff, hospital administration and medical specialists. The Committee notes that such incidences have had an injurious effect on the morale of staff at MGDHS as well as served to destabilise the relationships between MGDHS and specialist providers within the region. The Committee believes the Department of Health should review its internal selection processes to ensure that due attention is given to appropriate workplace behaviour and any history of inappropriate behaviour is taken into consideration. (*Recommendation 3*)

The Committee identifies that the development of the regional structure of health services across South Australia has been accompanied by increases in levels of administration which may have inhibited the direct funding of health services to clients in the region. Further, the Committee views that the structure has served to obfuscate lines of accountability and responsibility for finance and staffing. The Committee concludes that the Government should review the regional structure to ensure that money for health services is delivered more directly to clients. (*Recommendation 4*)

The Select Committee notes that a number of witnesses repeated accounts of the difficulties experienced by MGDHS in delivering services to an area which is located so close to the Victorian Border. The Committee views that health units which are impacted upon by cross-border issues would benefit from the Government adopting a more collaborative approach to service delivery with its interstate counterparts. (*Recommendation 5*)

The Committee is cognisant of the significant impact that the provision of health services by MGDHS has on other health services in the region. This impact is felt in terms of the planning, co-ordination and delivery of services within the region and by individual health units more specifically. The Committee is also aware of the impact that the continued budget over-runs that MGDHS has accrued has had on the region. The Committee is of the view that

where a health unit incurs debt, the responsibility for the management of that debt should rest with the individual health unit and not be borne by the region as a whole.

While the Committee believes that debt management should be the responsibility of individual health units, it is also views that the Government should take into consideration the delivery of services by neighbouring health units when assessing the level of debt. The Committee is anxious to ensure that the region is not disadvantaged by the need for one of its health units to better manage its finances. (*Recommendation 6*)

The Committee recognises that a network of services usually exists within a region such as the South East. The Committee heard evidence that sometimes those networks are best established and developed according to the geographic, economic or familial connections that may exist amongst health units. The Committee views that while MGDHS has a crucial role to play in the region, it should more effectively develop relationships with geographically relevant health units, paying particular attention to the specialised services that those units provide. (*Recommendation 7*)

The Committee appreciated concerns raised about difficulties experienced by MGDHS in appointing and managing its workforce resources. The Committee asserts that a correlation exists between the confusion surrounding the responsibility and accountability for workforce planning and management of MGDHS and the matters that generated the establishment of this Committee. As such the Committee suggests that all health units should be able to appoint their staff and that local boards of management and hospital Chief Executives have input on any selection panels. However, the Committee stresses the importance of health units making such appointments within the range of their allocated budgets. (*Recommendation 8*)

The Select Committee notes that the introduction of new Salaried Medical Officers (SMO) to MGDHS has not been without controversy. Medical Specialists expressed to the Committee concerns about the process of accreditation of some foreign trained SMOs and the Committee recognises that it has taken time for some SMOs to gain the confidence of many in the Mount Gambier community. To alleviate some of the difficulties that may be experienced by both doctors new to MGDHS and its clients, the Committee believes it is imperative that new SMOs and junior medical personnel be provided with adequate supervision and appropriate orientation. (*Recommendation 9*)

The Committee notes the evidence presented that the MGDHS's Accident and Emergency Department has experienced a significant increase in the number of presentation in recent years. While such an increase is not exclusive to Mount Gambier, the Committee views that the cessation of the granting of admitting rights for local GPs to the MGDHS has exacerbated the stresses placed on the Accident and Emergency Department.

The Committee agrees with witness who advocated the employment of nurse practitioners in the health care system in Mount Gambier, particularly in Accident and Emergency. The Committee acknowledges nurse practitioners do additional training and are required to meet stringent standards to perform their work and believes that, together with the better utilisation of the resources of local GPs, a model should be developed for the improved provision of Accident and Emergency services at MGDHS. (*Recommendation 10*)

1.1 Recommendations

The Select Committee makes the following Recommendations:

Recommendation 1:

That the Department of Health conduct contract negotiations collectively with general practitioners and non-resident medical specialists and, if necessary, legislation be passed to enable this to occur.

Recommendation 2:

That the Government clearly define which body is responsible for negotiating contracts with general practitioners and non-resident medical specialists and that appropriate and transparent lines of accountability be established for any negotiations.

Recommendation 3:

That the Department of Health conduct a review of internal selection processes and that when allegations of workplace bullying are raised they be investigated and an independent process of mediation and conciliation be implemented at the earliest possible opportunity.

Recommendation 4:

That the Government review the structure of regional health services across South Australia to ensure that money for health services is delivered more directly to clients.

Recommendation 5:

That the Department of Health explore opportunities for a more collaborative approach to dealing with cross-border issues of health care without any resultant loss of funding for health units.

Recommendation 6:

That debt management be the responsibility of individual health units and not borne by the Region as a whole. However, in considering the extent to which the management of debt remains the sole responsibility of the particular health unit, the Government take into account the geographic relativities of the provision of health services between one health unit and another.

Recommendation 7:

That the MGDHS be encouraged to more effectively develop relationships with other geographically relevant health units with particular regard to the specialised services that may be provided by those health units.

Recommendation 8:

That all health units be able to appoint staff within the range of their allocated budget and that local boards and CEOs have input on selection panels.

Recommendation 9:

That those doctors new to the MGDHS and junior staff be provided with adequate supervision and appropriate orientation.

Recommendation 10:

That the Department of Health develop a model where nurse practitioners and local GPs provide the Accident and Emergency service and offer admitting rights to all local GPs

2 INTRODUCTION

2.1 Appointment of the Select Committee

On 15 October 2003 a Select Committee of the Legislative Council was established to investigate and report on the operation of the Mount Gambier and Districts Health Service.

The Select Committee was established as a result of a range of concerns raised by the Hon Angus Redford, MLC, in the Legislative Council on Wednesday, 17 September 2003. These concerns included reductions in the level of specialist medical services in Mount Gambier, the level of funding for Mount Gambier and Districts Health Service and decisions being made by the Mount Gambier and Districts Health Service and South East Region. The Hon Angus Redford moved a motion for the appointment of a Select Committee on the Mount Gambier and Districts Health Service setting out proposed Terms of Reference. Following debate, amended Terms of Reference were agreed and the Legislative Council passed the motion.

2.2 Terms of Reference

To investigate and report upon the Mount Gambier District Health Service, and in particular, the following specific issues:

(a) the negotiation of contracts with resident specialist doctors and other staffing issues;
(b) the impact of the budget of the Mount Gambier District Health Service on other Health Services within the South East Region;
(c) the involvement and actions of the Department of Human Services in the management of these issues;
(d) regional service planning as it relates to the health needs of the community;
(e) the impact on health services in the Mount Gambier area of these issues; and;
(f) any other related matter.

2.3 Membership

The membership of the Select Committee is:

The Hon T.G. Roberts MLC (Chairperson)
The Hon G.E. Gago MLC
The Hon S. Kanck MLC
The Hon A.J. Redford MLC
The Hon D.W. Ridgway MLC (Acting Chairperson from 21/12/05).

On 1 December 2005 the Legislative Council resolved that, on Prorogation of the Parliament, the Select Committee be given leave to sit during the recess and to report on the first day of next Session.

Subsequently, the Parliament was Prorogued on 8 December 2005 and the Committee noted a letter from the Hon P Holloway, MLC, Leader of the Government in the Legislative Council, advising that all Government members of continuing Select Committees would not be attending future meetings. The remaining Members elected an Acting Chairperson and continued conducting business.

2.4 Process

The Select Committee met on 19 occasions since it was established in October 2003. Following a call for written submissions, it heard evidence at Mount Gambier in December 2003 and May 2004 in addition to conducting several hearings in Adelaide.

The Select Committee received 80 written submissions and heard evidence from 46 witnesses since it was established. Several written submissions were received following evidence gathered in Mount Gambier and Adelaide.

Submissions and evidence varied in the extent to which all terms of reference were addressed. A wide range of people have expressed their views including Mount Gambier District Health Service staff and other health services, South East Regional Health Service staff and (then) Department of Human Services officers (noting that the Department of Health was created on 1 July 2004), community members, visiting and resident doctors, Members of Parliament, local councils and associations and unions.

Select Committee members note and appreciate the effort made by all parties in order to present their views.

Organisations and persons presenting public submissions to the Committee are contained in *Appendix A*, and a list of those making written submissions is contained in *Appendix B*. Note, however, this Appendix contains only those names authorized by the Committee for public disclosure as certain written submissions were provided on a confidential basis only.

2.5 Interim Report

On 20 July 2004 the Select Committee tabled an Interim Report in the Legislative Council together with the transcript of public evidence and written submissions that the Committee had received to that date. The Interim Report was presented to enable the release of the evidence. The Committee considered it particularly important that policy makers were aware of all available information provided to the Select Committee.

2.6 Background

The Committee heard that poor relationships at Mount Gambier Health Service had led to distressing circumstances. These had resulted in virtually the entire senior staff either retiring, or looking to leave for one reason or another.

In 1997 Mount Gambier hospital was moved and changed from a 200 bed hospital to a 96 bed hospital (76 public and 20 private beds.)

Since then, accruing budget overruns and resultant staffing issues together with questions of the relationship between medical staff, the Health Service administration, the SERHS and the Department, have resulted in an unsatisfactory situation which urgently needed to be addressed.

Changes in the overall structure of the South Eastern health service and changes in the provision of health services have occurred.

This has also included the introduction of changes to the conditions of employment offered to medical staff. These comprise the establishment of salaried medical officer positions, renegotiation of agreements from a form of collective negotiation to individual contracts, and different conditions within the contracts for services.

In an era of change and uncertainty, and with relatively poor communications between medical staff and administrative officers representing the Department, it is unfortunate that disagreement and conflict has arisen. Staff turnover at senior administrative and medical level has been high, with some medical staff feeling that they have been forced to leave the service.

3 TERM OF REFERENCE A: The negotiation of contracts with resident specialist doctors and other staffing issues

It became clear from the evidence that the negotiation of contracts with specialists occurred in the context of significant structural change and consequent changes in the Departmental management style, priorities and attitudes. It is therefore appropriate to document some of those changes first, before discussing the evidence given in local negotiation of contracts at Mount Gambier and Districts Health Service (the hospital).

3.1 Changes in Department, Changes in Culture

Evidence showed that the changes in Departmental structures resulted in a very different cultural climate and management style. One of the former hospital CEOs explained this in terms of a change from a 'negotiation' management style of the former Health Commission to one based on a traditional hierarchy of 'command' with the introduction of the Department of Human Services.

> *Mr. Overland: When the Health Commission was a separate entity on its own, before the Department of Human Services, it was always a very tough environment in which to work. Health is an… environment where conflict is common between clinicians, between clinicians and administrators, between head office and health units. There was robust debate over things such as money and resources generally. But, fundamentally, it was always a collegiate atmosphere. .*
>
> *When the DHS was formed we found ourselves dealing with a very different management culture. What we had was a more classically departmental culture which is bureaucratic, structured and hierarchical culture not at all sympathetic to the way that the Health Commission worked. You have to bear in mind that the Health Commission was conceived to work as a series of quasi-autonomous health units, not as a department. I think that the new management in DHS found that incredibly difficult, and they did not like it. They were used to and wanted to operate in a much more, if you like, command and control environment where they could say, 'Do this' and it was done.* [1]

The fact that the new Department of Human Services operated in a traditional control management style inevitably created friction with people who were used to operating in a different environment.

Written evidence stated that the Department had a history of bullying and/or harassment of both workers and other staff[2]. This was compounded by the fact that some management personnel in the new Department of Human Services had very limited knowledge of health and health issues. This lack of industry knowledge and knowledge of the 'culture' of the medical profession compounded the issues:

> *The health culture, on the other hand, was not command and control: it was a negotiated process, however willing, and people understood the positions of the other parties in those negotiations. I think that folks who came into DHS were also*

[1] Chris Overland, question 1942
[2] Submission No. 44

hampered, certainly initially, in that few, if any, of them knew anything about health.[3]

I was getting no response. There did not seem to me to be a real understanding of the environment I was operating in, the culture of the medical profession, why we were in the situation we were. There just did not seem to be that understanding of the situation at all.[4]

Equally, the medical practitioners failed to understand the potential impact of this change in style and methodology between the Health Commission and the new Department of Human Services.[5]

Former Minister for Health, the Hon Dean Brown, MP, confirmed that he too believed that a climate of intimidation of medical staff by the administration had developed. He stated that a series of incidents involving problems in management style occurred at MGDHS. These related to:

- Management of medical staff and the termination of admitting rights
- Unsubstantiated accusations relating to professional conduct causing stress leave of a medical staff member
- Reduction in surgery causing patients to travel elsewhere for treatment
- Bullying and intimidatory behaviour when negotiating contracts
- Inconsistencies between heads of agreements and service contracts

The Committee heard that the emphasis from the Department of Human Services was not primarily about health outcomes but about budget outcomes. George Beltchev, then Director, Office of Health Reform, Department of Human Services, gave evidence that a good deal of the issues were internal operational issues, but that in fact the key issue underlying negotiation was debt management strategy [6].

In many ways then, the main driver for the negotiations was that cuts in expenditure were seen as the best debt recovery strategy by the Department of Human Services. This was to be imposed on Mount Gambier, as MGDHS had been overspending its budget for many years.

Overall, the evidence suggests that this was not clearly understood by many of the players, apart that is, from those who had been placed in positions and instructed to cut costs through reduction in payments to medical practitioners.

3.2 Confusion over Responsibility for and Negotiation of New Contracts

One of the major problems in negotiation of the contracts was a good deal of confusion over the responsibility for the drawing up of new contracts and about who the individual contracts were to be signed with. This caused considerable perplexity, misunderstandings and led directly to rancor and hostility between the medical specialists and MGDHS and regional administrations.

Some were of the view that since MGDHS was the service provider they were undertaking the negotiations. This seemed to be the prevailing view of the medical specialists and

[3] Chris Overland, question 1942
[4] Chris Overland, question 1943
[5] Chris Overland, question 1943
[6] George Beltchev, question 1207

MGDHS Board at the time. As the previous Hospital Board Chair stated:

> MRS MULCAHY: *We had a new CEO at the time who was supposed to be negotiating contracts for us. We were not aware that the contract negotiations and mediation process were on a regional basis, signed for and on behalf of the negotiator and the region. We were under the impression that contracts were being negotiated for Mount Gambier and signed off in our name.*
>
> *Tom Neilson was our acting CEO at the time, and specifically when Helen Morton came in January the request from the Region and Tom was that they continue with the negotiations to maintain the consistency and reduce the confusion in the negotiation process.*[7]

This uncertainty is also illustrated in evidence heard from the Director of Anesthetics:

> Dr Kevin Johnston. *I think that in the 1997 juncture the contract negotiations flipped across to region (in an apparently transparent way) and, currently, the two services are disowning any responsibility; each says the other is responsible for contracts …The problem is that once we went to individual contracts, they are such a magnitude that they require approval either centrally or with the Minister.*

Confirmation of the confusion over who the contracts were with was given by Dr Goodman, who cited his Agreement with the Department (or SERHS or MGDHS) in his written submission. The Agreement reads:

> *'Facilitated agreement between Dr Paul Goodman and Mr. Tom Neilson, Regional General Manager for and on behalf of both the South East Regional Health Service and Mount Gambier and District Health Service Incorporated, and Dr Peter Chapman, Chief Medical Adviser for and on behalf of the Department of Human Services in relation to certain contractual issues.*[8]

However, the SERHS took over the responsibility of negotiating contracts. Evidence was heard that the Regional Board did not have the infrastructure to deliver their services,[9] which made matters more complex.

Perhaps the greatest contributing factor to the complexity was the fact that for some time the position of hospital and regional CEO responsibilities had been 'co-joined'. This meant that regardless of individual personnel in the position, the same person who was the CEO of MGDHS was at the same time also CEO/Manager of the SERHS.

> MRS. MULCAHY: (the negotiations) *were being conducted by Tom Neilson, who was joint negotiator for the Region and Mount Gambier. The Region, from the Mount Gambier Board's perspective, had facilitated the process and Tom and Bill DeGaris were actively participating to ensure a good outcome on our behalf*[10].
>
> *The Region employed the mediator for the Department. I am not aware of who paid,*

[7] Ann Mulcahy question 456
[8] Submission 35
[9] Ann Mulcahy question 1618
[10] Ann Mulcahy, question 457

engaged or focused on the mediator. The mediator was offered and, in order to get a constructive outcome, we said, 'Whatever it takes.'[11]

As a Board, we agreed that Ken would take over and sign off, but he worked on the negotiations in concert with Tom Neilson. He was not to take over completely; he was signing on behalf of the Mount Gambier Hospital Board.[12]

MR McNEIL: *I believe it was at the meeting in May for the Mount Gambier District Board that the decision to transfer the responsibility for negotiating the contracts from Tom (who was no longer the CEO) to me was made. The Regional Board was aware of that and I believe wrote to the (hospital) Board suggesting that that was the appropriate action to take as long as the (Regional) board and the Department were kept fully informed and involved. Mr. Neilson, Dr Chapman and I met with Lyn Poole the following week to discuss the parameters of the negotiation where they should go and what sort of limits would be expected*[13].

MR NEILSON: *In this instance that was deemed to be appropriate. However, earlier this year, with the appointment of Mr. Ken McNeil as CEO of the Mount Gambier Hospital, it was thought appropriate that Ken would take up the lead role in negotiating those contracts and that occurred. That has subsequently again been referred back to the Region.*[14]

Mr. Paul Dolan, Chairman, South Australian State Committee, Royal Australian College of Surgeons gave evidence that Mount Gambier and other surgeons consider the Department unsupportive of resident services. Mr. Dolan stated:

Mr. Dolan: *I would think that it has been building up for some time. The people to whom I have spoken who have made these comments are people who have been resident in the country for a long time, and over the course of their career have seen continual pruning of budgets, restriction of services, winding back of facilities and a sort of revolving door approach to hospital management, which has one administrator after another who appears to be mainly focused on the budget*[15].

3.3 The Contents of Contracts Offered

Evidence gathered indicates that the new contracts for services being offered to medical practitioners by the Department were radically different from previous arrangements. Medical practitioners raised major concern about particular omissions and additional clauses.

The major omission concerns the question of medical indemnity and who should pay for it.

New clauses were contained in the contracts that stipulated medical practitioners were not permitted to deal directly with the media and were bound by confidentiality arrangements. Medical practitioners objected to this, considering it in direct contradiction to their freedom of speech. Further, medical practitioners considered that the contracts gave no provision for time off or replacement staff. As Dr Paul Goodman stated:

[11] Ann Mulcahy, question 463
[12] Ann Mulcahy, question 463
[13] Ken McNeil, question 465
[14] Tom Neilson question 539
[15] Paul Dolan, question 2447

> DR PAUL GOODMAN: *In June 2002, the three GP anaesthetists heard nothing until November 2002 when a totally unacceptable contract, which had been drafted by Catherine Anderson, was delivered, certainly to myself and I assume it was also delivered to the other two. When one reads this contract carefully, it required our services for 24 hours a day, seven days a week, 365 days a year. If we wished to go away on holiday we would have to provide our own locum. Therefore, effectively this could mean in Mount Gambier that we probably would never go away on holiday. There were several other non-acceptable demands in this contract, such as that we were not permitted to talk to the media and we were bound by confidentiality agreements. There were many other problems with it as well.*[16]

All in all, the contents of these newly offered contracts clearly were seen as unacceptable by the medical practitioners concerned.

3.4 The Negotiation of the Contracts

In previous years, collective bargaining arrangements had been conducted for rural medical practitioners. This had taken the form of fee for service arrangements through negotiations between the (then) Health Commission and the Australian Medical Association.

However concerns were raised that the ACCC might view these arrangements as a form of price-fixing, and hence instigate prosecutions against medical practitioners for breaches of the Trade Practices Act. As a member of the Select Committee put it:

> THE HON. A.J. REDFORD: *You would be aware that negotiations for specialists have been conducted under the assumption that, if the doctors negotiate collectively with the hospital, that would be a breach of the Trade Practices Act and that the doctors involved might well be the subject of prosecutions by the ACCC. Indeed statements have been made to that effect by the ACCC and others.*[17]

The Hon RJ McEwen also gave evidence that he believed that the ACCC disallows collective negotiation to occur between service providers.

Disagreement over the legality of collective bargaining for medical practitioners emerged, as legal opinion from the Crown Solicitor obtained on behalf of the Committee advised that practitioners were quite entitled to negotiate collectively.

Medical practitioners were unaware of this advice and were under the impression, indeed were directly told by representatives of the Department, that they were obliged to negotiate individual contracts for services.

The medical specialists did not wish to change the basis upon which they were paid which was upon an activity related basis. Through all the processes the doctors consistently requested that the previous agreements they had operated under be rolled over. Mr. Overland elaborated on this point:

[16] Paul Goodman, question 1248
[17] The Hon. A. J. Redford, question 2567

The doctors who work there derive the great bulk of their income from work on public patients. They are not just flying in, doing a few sessions and flying out. So, they have a tremendous investment in the hospital at quite a personal level.[18]

So in that situation, management decisions in the hospital, insofar as they impact on the doctors' ability to do the work they want and feel they need to do for patients, or to earn an income, become a very serious matter.[19]

Contrary evidence indicated that the doctors failed to understand the potential impact of the change in negotiation practices by those who had been set the task of making budget savings.

It is important to understand that there were differences of opinion between Department, Region and hospital on the priority of and type of services required and how they should be delivered. MGDHS and its Board was directed to not specifically engage in contracts for a specific service, and that there would be ramifications if they signed or offered contracts as there would be no money forthcoming.

This led to MGDHS administration taking what, from the medical practitioners viewpoint, was seen as unilateral action in ending negotiations before some contracts had been signed. This had severe repercussions on at least one medical specialist as follows:

DR JOHNSTON: *In terms of renegotiating the anaesthetic contracts, I believe that I and my colleagues did everything possible to try to make this process happen. We all indicated that we were prepared to remain in Mount Gambier. Despite there being a contractual obligation on the health service to renegotiate contracts six months before they expired, that did not happen. The time lines came and went, and eventually my contract expired and I was left basically unemployed by the hospital for six months and just had to survive while trying to maintain the services from my end and trying to prevent the departure of the general surgeons.*[20]

Changes in the negotiating arrangements and the way in which they were handled led to a great deal of confusion and frustration on the part of medical practitioners. With the change in how contracts were negotiated, doctors sought the assistance of negotiators to assist them through the process. Perceived lack of consultation and appropriate information exchange, inconsistencies and secrecy over discussions created confusion and ill will. Dr Johnston also reported that at times there was a great deal of threatening and abusive behaviour.

DR JOHNSTON: *I have provided you with a copy of the letter that Dr Gallichio received from my solicitor. It relates back to events in June where there were efforts to impose upon the anesthetists changes to their contracts, which contravene contract law, as I understand it, in response to Stokes and Wolff where we were obstructed from trying to implement changes to address the safety issues. At that time there was a great deal of threatening and shouting, and I felt at risk of some physical abuse.*[21]

Bitterness and acrimony followed. Mr McNeil stated in relation to negotiation of contracts that:

[18] Chris Overland, question1857
[19] Chris Overland, question 1858
[20] Kevin Johnston, question 2455
[21] Kevin Johnston, question 2555

> MR McNEIL: *Dr Goodman then continued to provide us with a variety of intermediate locum arrangements. On 11 July, Dr Goodman came into my office and stated that he would no longer provide locum services for Mount Gambier and Districts Health Service…. within a week or two after that Dr Goodman notified the board that, with regard to his reentering any contract negotiations, his precondition was that I be removed from my position.*[22]

Dr. Goodman's letter to Mr McNeil in reply to receiving his draft agreement stated that:

> *The facilitation process has in my opinion, become a farce with timings being varied from the original stated time and immediate expectations of 'sign off' as the requirement to 'flit' changes from hour to hour. The Draft agreement bears little no consideration of past, present or future expectations and contains an array of ridicule that I find insulting*[23].

The former Chair of MGDHS Board stated that the focus was becoming intensely personalised and the whole process was overwhelmed by personalities. The Board recognised this and addressed those issues with the Minister in the beginning of October. She agreed it was appropriate to have a negotiator do this work[24].

Specialists also reported they were pressured to sign the contracts and threatened with no contract if they refused to do so.

> DR JOHNSTON: *When I had no contract for six months, and the anaesthetic services were hanging by a thread, I went to McNeil and said, 'Here are my recommendations to include in a draft contract an interim arrangement to get the anaesthetists working again.' The regional board did nothing with that. I gave a copy to Mr. McNeil. On the day that the Premier visited Mount Gambier, McNeil called me to his office. He said, 'You sign this now or I am throwing it in the bin.' These were my draft recommendations. I said, 'That is not a contract: that is just a list of recommendations.' He said, 'I am going to get some good press. I am going to tell the Premier that I have signed up a consultant today. You sign this now or I am ripping it up.' He took it and scrubbed out all the clauses relating to medical indemnity. He said, 'We will put the medical indemnity back in later on, but you sign this now, otherwise you are out of here.' So, I signed it*[25].

In June 2002, three GP anaesthetists' contract expired, and they were replaced by Mr. Neilson, Acting CEO of MGDHS, replaced theml.

Dr Goodman believed that a deliberate search was undertaken on behalf of the Department of Human Services for a person with the ability to remove the present incumbents and install a cheaper system. His evidence states there was either a total failure on the part of the Department of Human Services to enact a proper search of Mr. McNeil's previous references and employees and assess his suitability for the job or, alternatively, it was a deliberate act.

The suspension of Dr Johnston as Director of Anaesthesia was done according to one witness

[22] Ken McNeil, question 465
[23] Written submission: Paul Goodman
[24] Ann Mulcahy question 476
[25] Kevin Johnston, question 2405

because there was a total breakdown in his ability to communicate with either the CEO or the Director of Medical Services. However, from Dr Johnston's viewpoint it is clear that he felt badly treated having been subject to intimidation and fearing physical abuse. He was clearly very bitter.[26]

The result of MGDHS administration's withdrawal from negotiations with medical staff, due to the direction from the Department not to offer or sign contracts for specific services under threat of funding withdrawals, was a further escalation of the tension and frustration of medical practitioners. Some more pragmatic issues in the negotiation of contracts included the length of contract, delays in signing and where the staff should reside.

3.5 College of Surgeons and Negotiations

Evidence was given that the College of Surgeons had been unaware of the problems involved in the negotiations of contracts at the Mt Gambier Hospital until it was too late. There had been misinformation and misunderstanding about the possibility of involving the college in such matters. The College has now established a rural task force that hopes to intervene effectively in similar situations as they arise. Whereas the College once did not enter into negotiations, it now increasingly does so in situations where they are trying to intervene effectively.

The College is also in the process of drawing up a template package, which can be used as a basis for attracting young surgeons and medical specialists to rural areas and subsequently negotiation of contracts with them.

3.6 Other Staffing Issues: Difficulty in Recruitment of Specialists

It is well known that rural areas have difficulty in recruiting medical specialists and practitioners.

Part of the difficulty of recruiting specialists for Mount Gambier was related to increasing requirements for service provision, complexity of services and because the specialists did not have any intermediate levels of staffing in terms of a registrar or intern to support them. The Committee heard that in Adelaide centres, and centres where people are trained, there are a variety of resident house surgeons and registrars who provide a buffer system for surgeons. In Mount Gambier the surgeon was always on first call and was required to provide all levels of care.

Due to a specific shortage of anaesthetists generally in Australia for a number of years, there was concern that if they left it would be even more difficult to find replacements for a regional town compared to a major capital city.

In the past, the medical practitioners in regional hospitals headhunted for skilled doctors and additional services, and made recommendations regarding doctors or the skills required to the CEO. A staff representative on the board kept medical specialists informed about issues of recruitment and selection and the board always had a representative on the selection panel of medical staff. The final decision or recommendation of that panel would then go to MGDHS Board for either approval or rejection.

[26] Kevin Johnston, question 2509

As a result of the changes a specialist was appointed who did not have to go through the same selection process as other specialists. This put board members in a fairly difficult position with the responsibility to sign off on staff selection without any knowledge about how the decisions were reached.

3.7 Other Staffing Issues: Staff Turnover among CEOs

The Mount Gambier Health Service has a history of high levels of turnover at senior administration level in recent years. The CEO of the now Department of Health attributes turnover and difficulty in attracting a suitably qualified CEO to MGDHS to:

- Rapidly changing health systems
- changing populations in the country,
- a movement of services from in-patient to community support, and
- reductions in beds but still the same number of patients

3.8 Other Staffing Issues: The Overall Climate and Relationships between Professional Health Groups

Witnesses from the Australian Nursing Federation and senior nursing staff from the Mount Gambier Hospital also gave evidence of bullying and harassing behaviour of nurses by medical practitioners. This impacted on the ability of nursing staff to work appropriately.

Evidence was provided by nurses that bullying had occurred during theatre procedures and examples were cited of staff being bullied during post operative care of patients.

The Committee was told of an example where a surgeon, abused a member of the nursing staff at MGDHS because he did not believe that she had followed his protocols post operatively for a patient. The Committee was further advised that in fact the patient was not the patient that he thought it was, it was not the operation that he thought he had done, and the nurse was right and he was wrong. The abuse occurred at the bedside in front of the patient.[27]

Anaethetists were also implicated in harassing of nursing staff, particularly in relation to after hours work. This behaviour impacted on whether or not a junior nurse would ring an anaesthetist, which in turn could affect the safety and wellbeing of the patient. The Committee heard that nursing staff were recognising medical issues but not addressing it because they were scared to phone someone.[28]

Australian Nursing Federation representative Mr. Rob Bonner explained that victims of bullying often provide excuses for the behaviour of their antagonist and this was found in the Mount Gambier Hospital situation.

> *For example, in theatre, a person was describing all the actions that would excuse the particular surgeon's behaviour the contract dispute was going on, they were under stress, they might have to move.*[29]

[27] Evidence given *in camera*
[28] Evidence given *in camera*
[29] Rob Bonner, question 1838

The reasons offered to explain the staff's reticence to report incidences of bullying, apart from fear of reprisal, included a lack of awareness that some commonplace behaviour was bullying and therefore unacceptable.

Some staff had attempted to deal with the problem by trying to excuse the behaviour on the grounds of extenuating circumstances in the life of the doctors concerned. An example given was the stress of the contracts dispute.

> MR BONNER: *Some of the victim stuff is when people identify causes as to why the person is behaving in that way towards them, so you get excuses made for the person who is acting as the aggressor or the bull……They were under all that pressure so it was understandable they would lash out. All that stuff is there and needs to be dealt with in a way that takes people to a point where they will report.*[30]

Some nursing staff found that the only way they could deal with the experience was to leave the workplace. Mr. Bonner suggested an educational program for all staff, including visiting staff, which informs on unacceptable behaviours and the appointment of workplace representatives to assist staff would aid the situation.

Several witnesses also provided evidence that there had been incidents of racist behavior within the Mt Gambier health care system. This had been directed to overseas trained medical staff largely by other medical professionals. It was reported that this racist behavior was in some cases taking place in quite public situations.

When questioned about how widespread these racist views are and whether they reflect the attitude of the Mt Gambier community in general, witnesses stated that they believed the problem was confined largely to a small number of medical officers.

One witness indicated that they were of the view that this racist behavior was a reflection of nervousness about change.

When questioned about the existence of a reporting process for dealing with instances of racist behavior it was affirmed that such a policy does exist, but similar to low levels of reporting harassment/bullying incidents, racist incidents are not reported. Several possible explanations were given for the perceived under-reporting of racist incidents. These included fear of reprisal, intimidation and the entrenched nature of racism.

A written submission from the MGDHS in August 2005[31], states that a number of actions have since been taken to address the issues. These include:

- Organisational culture issues, including addressing bullying and racism and conclusion of contracts in an amicable fashion. Negotiations with senior staff in surgery and anaesthetics are proving helpful.
- Senior staff Recruitment: Establishing links with Adelaide to get longer term contracts put in place and have some stability in the system. With those links with major centres, the appointment of registrars and in-house surgeons becomes a significantly easier action to accomplish.
- An increase in Specialist numbers considering other methodologies by which there

[30] Rob Bonner, question 1838
[31] Written submission dated August 2005, MGDHS

can be a guaranteed supply line of specialist staff. Most will be residents and some will be on a visiting basis.

- Indemnity Insurance
- Use of Locums
- A rural doctors' committee has been established to explore collective bargaining. At departmental level it is agreed that collective bargaining has worked well for rural communities. Contract negotiations are being progressed at Regional level.

However, other witnesses reported that contracts are still not resolved due to an inability to reach agreement with the provider about the position of the Region.

4 TERM OF REFERENCE B) The impact of the Mount Gambier and Districts Health Service budget on other health services within the southeast region.

4.1 The Nature of the Community/Region

The communities of the South East were described by a former CEO of MGDHS as tough, resilient, independent and fiercely parochial with a proud history in relation to their hospital.

> MR OVERLAND: *I had to learn to navigate the small P politics of the South East region and of Mount Gambier itself. It was an unusual hospital in a number of ways. First, it was a very old hospital. It had been there since 1869, and a long history is attached to it. The community built the original hospital, although for most of its life it has been a government hospital. As is the situation for most relatively isolated communities, the local community are very protective and concerned about their hospital because of the impact it has on their lives, and that is typically the case in the country.*[32]

A submission received by the Committee indicates that the South East has an ageing population, and in 2001, 30% of the population was aged over 50. Key risk factors identified in the region are:

- Overweight and obesity
- Smoking
- Lack of exercise
- Alcohol
- Diabetes
- Asthma[33]

Two factors were seen as important in the issue of defining the borders of the region known as the South East.

One of these was the proximity to the interstate border with Victoria and some towns just over the border. The second relevant feature related to the difficulty of defining the regional borders was the observed leakage of patients to Adelaide rather than to Mount Gambier, from the northern part of the South East region.

> MR BELTCHEV: *The South East region is interesting because we actually had a look at the pattern of leakage from individual hospitals in the region to Mount Gambier or to Adelaide and also within Mount Gambier itself, and we found that a lot of work was leaking out of the northern part of the region to Adelaide that could have been done in Mount Gambier they had the skill and the capacity to do it. When we looked at that, we found it was a combination of two factors. One factor was people's tendency to want to come to Adelaide rather than go to Mount Gambier.*[34]

However a former CEO stated that more regional connections were being made in the community.

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[32] Chris Overland, question 1856
[33] Written submission 55: South East Regional Health Services Inc, Clinical Services: Policy Framework, March 2004
[34] George Beltchev, question 1210

MR OVERLAND: *In the long-term, I believe that what will emerge anyway will be 'natural' regions: that is, regions that have logical connections geographically, economically, and familiarly even. We are seeing some of that occurring in country areas now where you have two, three or four hospitals in the same general geographic location forming into one organisation: Clare, Burra, Snowtown is an example. There are logical community interests between those facilities.*[35]

To develop a regional health focus for the area, Mr. Jim Birch, CEO, Department of Health and formerly CEO of the Department of Human Services, emphasised the need for a regional approach versus a single hospital approach with consideration of cultures and operational differences.

There was a much more regional focus (certainly from my understanding) in the South East notwithstanding the specialties that exist in Mount Gambier. I think that specialties were still going into other towns and there was not a regional focus. That critical mass, or economy of scale, is actually quite important. I think there are some historical operational differences that exist in the South East. I think they cannot be underestimated in terms of the differences between how towns grow up and their cultures.[36]

4.2 Role of MGDHS in the Region

Mount Gambier Hospital has a broad role and a relatively wide spread of population in that it supports other hospitals in the region with the provision of weekend operating theatre services.

MS GILBOY: *We also provide weekend theatre for those hospitals which refuse to have on call staff on weekends. So anyone who needs an operation is sent to us on the weekend. We have acute patients sent to us from regional hospitals, and we may keep them and try to send them back, or we may have to send them on. It depends on how long we keep them whether the original hospital funds that transfer or if we fund the transfer.*

MS FALLAS: *The same with obstetrics. We take them from outlying regions because the after-hours service is not there.*[37]

An issue raised a number of times was that due to the number of patients crossing the border from Victoria, the amount of funding the region received did not reflect the population base it was servicing.

MR OVERLAND: *About 7 per cent or 8 per cent of the patient load at Mount Gambier hospital was from Victoria. Interestingly, about half the joint replacement operations were done on Victorians. We were surprised when we did some analysis. We also knew a lot of people moved across the border into Victoria for certain types of procedures, as well. There is traffic across the border all the time. Similarly, Naracoorte takes in a lot of people from across the border; and I imagine Bordertown*

[35] Chris Overland, question 1932
[36] Jim Birch, question 157
[37] Nancy Gilboy and Elizabeth Fallas, question 1739

did, as well. It was just a normal part of our business.

In terms of funding under case mix, it did not matter where the patients came from because you were funding activity. It was not influential except in so far as that we got some unusual patterns of services, where a disproportionate number of Victorian patients might be getting particular services because they could not get them anywhere else[38].

MGDHS was criticised for absorbing resources not withstanding it was expected to provide expanded services for the region that had an impact on the budget. Mount Gambier offered a unique number of specialist services not commonly offered by other areas.

Witnesses raised the issue of hidden costs related to performing health activities on behalf of the region. These activities were funded by hospital budgets.

MR BONNER: *part of that is about recognising from a service planning structure and funding point of view that those things occur and that, as a consequence, smaller places will use the expertise that is situated in those subregional hospitals as advisory systems for their own local practices. However, it is not structurally recognised that there is a reservoir of expertise here, nor is there any funding attached to that from a nursing point of view that then recognises that some of the work is done not in looking after patients in Mount Gambier but in advising people who care for people in Millicent or Penola or other places.* [39]

MS GILBOY: *Some of the staff in high dependency have been involved in establishing an advanced life-support training group. We have offered this service to the regional hospitals. Some people have taken advantage of that, but other people get resources from outside of the region. As far as I am aware, all of the costs associated with that come out of my budget because those staff are rostered to high dependency. They are not rostered to regional training or anything like that. My costs to high dependency wages include the coverage of providing the advanced life support to the other staff and regional staff, as well. The other thing is that one of my staff members is the coordinator of the cardiac rehabilitation service, which we have offered to regional services as well. His payment is half-funded from community health and half-funded from high dependency*[40].

Evidence was given of a lack of recognition of the roles of staff in providing advice and training for staff in neighbouring centres including Millicent, Penola and others.

4.3 Debt Management, Hospital and Regional Funding

Mr. George Beltchev, Director, former Office of Health Reform, Department of Human Services, gave evidence that a number of issues at Mount Gambier Hospital were common to other rural and regional health systems.

Those issues related to the funding formula and in particular the difficulty that the case-mix funding system, introduced in 1994, presented in applying to regional hospitals. Issues of

[38] Chris Overland, question 1938
[39] Rob Bonner, , question 1736
[40] Nancy Gilboy, question 1737

work force relations were common to all the regional hospitals, although there was a specific issue in Mount Gambier that related to the medical work force. An internal review of regional health systems was commissioned in 1999. The inquiry began in Mount Gambier, took 18 months to complete, and was conducted in 4 regional areas; Mount Gambier, Whyalla, Port Augusta and Port Pirie.

The review addressed common and local issues and found that, in Mount Gambier, the relationship with doctors was clearly an issue. It recommended that the debt at Mount Gambier be managed through amortisation over a ten-year period and that MGDHS could either cut activity or gain increased funding.

Two reasons were offered for the blow out in costs that had been experienced in the region. One was the change in the nature of services offered, particularly those involving high–tech equipment, and the other was the need to keep beds open in areas where bed occupancy was low. Explaining bed day occupancy rates, Ms Roxanne Ramsey, Executive Director Country Division, Department of Human Services, outlined the measurements of available beds in the South East Region and the percentage of the time that they are occupied.

> MS RAMSEY *It varies from 48 per cent at Kingston up to 73 per cent at Mount Gambier, which is actually one of the issues for the country health area, in that there are a lot of beds within Country that are not occupied. However, in terms of needing to provide the services, we need to keep the staff and the doors open, so it is one of the tensions that sit there for us*[41].

Mr. Birch gave detailed evidence of the funding structure operations under regionalisation. This was summarised as: the Department enters into a service agreement with Regional Boards who are responsible for development and planning across the region. They in turn allocate budgets to local units and monitor performance.

> MR BIRCH: *In relation to regional boards, DHS enters into a regional services agreement (SLA) with the regional boards, usually for a three-year term. In terms of the regional board's interim memorandum of understanding has an annual budget agreement with each health unit. In addition, service agreements may be entered into for specific program areas. The regional board manages the regional budget and is responsible for service development and planning across the region and for each unit in the region. The regional board allocates budgets to local units and monitors the performance of those units against budget. The regional board is accountable to the department for budget and service outcomes throughout the region*[42].

The responsibility and functioning of the SERHS in the provision of community health care was described as follows:

> MR NEILSON: *The South East Regional Health Service does have direct responsibility for the provision of community health services. So, the regional board is actually a service provider in its domain of community health. With regard to the relationship with the hospitals, the region's role is quite clear in that it is responsible following negotiations for delivering to those hospitals budgets in association with agreed outcomes for service delivery. The process utilised is for me, the regional*

[41] Roxanne Ramsey, question 100
[42] Jim Birch, question 14

finance manager, and the regional planning officers to meet with the executives and representatives of the boards of the hospitals.[43]

MS RAMSEY: *That* (the local board) *is funded by the regional board. There is no management accountability but there is certainly a funding and output relationship between the regional board and the local board; and the department then funds the regional board.*[44]

The regional boards are able to make some decisions about the allocation of funds from the Department.

MR BIRCH: *They will be given funding for a volume of work, and they can then determine whether they want more ophthalmology or psychiatry or whatever, based on the local need. If they want to spend their allocation on ophthalmology, theoretically, the board can decide to do so.*[45]

MR NEILSON: *In regard to money coming in and money going out, the situation is that the region, as is clearly articulated, has redirected $1.7 million over two years the moneys that historically would have gone to other hospitals into Mount Gambier. Again, as I state, I anticipate that the activity levels that are being talked about need to be distinguished that is, the activity that the medical practitioners produced, as opposed to the activity that was funded by the DHS.*[46]

Some problems were being experienced at MGDHS Board level resulting from a lack of clarity in what was to be provided and how much funding was available for it. This had been found to have particular impact on the formation and implementation of hospital budgets.

It was explained that in addition to the regular funding process as described above some specially targeted funding has been provided by The Department. The provision of special grants also included the funding of the Keith Private Hospital.[47]

An issue of funding, unique to the South East, relating to interstate service provision, was described. This was seen to be problematic in that the funding went to Adelaide rather than to the South East, Mount Gambier in particular, where the services were being provided. As Mr. Johnston pointed out:

All that effectively means is that we are being funded for a population in the 58 000, I think, from Neilson's report, when, in fact, we are treating an actual population of close to 78 000[48].

Recommendations for future planning in relation to the provision of funding were invited. At the policy level it was implied that the new funding formula that is population based would prove to be superior to the old case mix model. There was also indication of a change in consciousness in the local community around local community funding of MGDHS and the provision of volunteers.

[43] Tom Neilson, question 537
[44] Roxanne Ramsey, question 161
[45] Jim Birch, question 96
[46] Tom Neilson, question 598
[47] Tom Neilson, question 616
[48] Kevin Johnson, question 2323

MR BELTCHEV: *We found that the communities much smaller than Mount Gambier were contributing financially and in other ways as the Mount Gambier community was. It was to start building the relationship between Mount Gambier Hospital and its community. We did not have detailed estimates, but we were estimating that the Mount Gambier community would be donating more funds to the Women's and Children's Hospital in town than it would to the Mount Gambier Hospital. This was starting to develop a profile in the community to attract volunteers and funding rather than looking for business*[49].

4.4 Funding Model

The Beltchev report argued that the case mix funding model did not give sufficient recognition to the opening-the-door costs of a hospital like Mount Gambier. The effect of case mix funding is that it exposes regions like Mount Gambier and Whyalla and leaves them positioned between the city and smaller country places. As a previous CEO stated:

MR OVERLAND: Yes; I am sure every medico would agree with that. I should say, though, that it has been a driver for still more efficiency as well. So, it is not all a bad thing. However, the effect of case mix funding is that it exposed places like Mount Gambier and also Whyalla as being stranded in a halfway house. If you are a very big hospital like the Royal Adelaide, and you provide a broad range of services, the unders and overs the wins and losses of the different DRG's tend to even out. If you are very small, you select only the products you make money on. It is pretty much like any business in that you select where you can make money.[50]

Mr. Overland emphasized that when case mix funding started in 1994 that was when the problems started.[51] Attempts were made to reinforce Mount Gambier as a regional hospital and to be supportive to the other hospitals. For example arrangements being made with Naracoorte Hospital for the two obstetricians to provide services there.[52]

Mount Gambier had a large specialist service base, which based on the evidence, wished to carry out relatively complex procedures that did not earn money for MGDHS under the case mix funding method. As a result the department demanded more budget cuts. Evidence suggests that managers at Mount Gambier perceived that for some years their budget was used to support regional initiatives that were not funded by the Department[53].

A potential outcome of the 'fee capping' funding policy put into place by the Department was that medical attention could be refused to those requiring it. Evidence was given that this was raised.

MR OVERLAND: *In the case of Mount Gambier, what they did was, I think, bizarre, because they said, 'Okay, we accept we have to pay you this higher rate but what we will do is we'll cap payments in an accident/emergency department.' I said, 'That does not make any sense whatever.' As if we are going to say, 'Sorry, you are patient*

[49] George Beltchev, question 1217
[50] Chris Overland, question 1881
[51] Chris Overland, question 1889
[52] George Beltchev, question 1207
[53] written submission 51: Australian Nursing Federation

6 001, you cannot come in.' That was not going to happen. The answer was that we just had to live with it[54].

In fact as a result of fee capping, the Committee heard that operations were indeed delayed until specialists' funding allocations were available. The Hon RJ McEwen gave evidence that a patient from Tantanoola was advised that her knee replacement surgery would have to be put off until after June as the Mount Gambier Hospital had told the surgeon he could no longer do that sort of operation until 1 July 2000 as he had used up his funding allocation.[55]

This indicates that no matter what budget issues in Mount Gambier have had on the other health services in the region, certainly patients in the region have suffered directly as a consequence of the budgets and funding models.

However, exactly where and what services have been directly impacted in the Region is not easy to assess. It appears that no direct assessment has been made, as Mr. McNeil referred to in his evidence:

> MR MCNEIL: *Going back to what we alluded to before about regionalised services, there has been a considerable number of variant services that have grown in different facilities around the region over the years.*
>
> *There has not been a considerable amount of work done to see whether or not any of that is too much, too little, or at the right level.*
>
> *Nobody is looking at health outcomes to see whether any of the money that has actually been put into this region is achieving what would be healthy outcomes for the residents of South Australia and for the residents of this region in particular*[56]

4.5 Funding and Public or Private Health

Previous CEO, Mr. Chris Overland's evidence gave a background to the introduction of the new hospital at Mount Gambier. There were administrative expectations that budget savings could be made through efficiencies and savings on nursing and other staff because the new facility was of a single storey building.

He explained that in the early nineties, post State Bank, the new government was keen on privatising and it wanted to privatise a hospital. Mount Gambier was chosen as 'hospital most likely', because it needed to be rebuilt. A group, which was part of Mayne Nickless, was asked to come in and determine firstly whether they would build a new hospital in Mount Gambier and, secondly, whether they would operate it and upon what basis they would do that.

> MR. OVERLAND: *They came along and did a study into Mount Gambier and they presented the government, or the Health Commission, with a report that said that they could build and operate a hospital and they would do so at a recurrent cost which, coincidentally, exactly matched the then recurrent cost of Mount Gambier Hospital.*

[54] Chris Overland, question 1892
[55] Hon Rory McEwen, question 2152
[56] Ken McNeil question 409

> *...I went to my staff and said, 'How on earth have they been able to do this?' We knew that about $2 million a year of the recurrent price they had nominated had to be devoted to capital servicing, because we knew how much it cost to build a hospital. So, I said, 'Somehow they are achieving savings in the order of $2.5 million to $3 million a year,' because we had worked out roughly what the capital servicing cost would be and we knew that they had to make a margin…[of] 12 per cent. .*[57]

To manage the extra expense of the new hospital, the then Health Commission estimated a saving through staff reductions of approximately 90 full time equivalent staff in order to match the private hospital quotation. Subsequent discussions with the three major unions (Australian Nursing Federation, Public Service Association and Miscellaneous Workers Union) were held in which the then CEO stated:

> MR OVERLAND: *and we said, 'This is the deal. We can either (a) become a private hospital, or (b) offer the government an arrangement it cannot knock back, which is that we will equal what Mayne Nickless can do*[58]

The hospital was progressively downsized with closure of wards including the rehabilitation and assessment ward and the children's ward, closure of the School of Nursing and reduction of the maintenance team. This was described by the then CEO as *a catastrophic event*[59] and undoubtedly had effects on health provision in the region as a whole.

Ms Lyn Poole, Director, Social Justice and Country Division, Department of Human Services and Mr. Birch informed the Committee about the revenue targets that are applied to regions. As Ms Poole stated:

> MS POOLE: *The patient revenue is revenue that is earned by the hospitals for treating privately insured and compensable clients. The revenue budgets reflect the revenue lines that are set at a regional level. So, we would set a regional revenue target for each region and they, in turn, then apply those revenue targets down to their local health units.*[60]

Allocation of Commonwealth block grants for public patients was described by Mr Birch. He explained that allocation is tied up with private health premiums in that, if the State wished to maximize every opportunity for taking on private patients, it would increase the money that would flow out of the private health insurance funds and in turn increase the cost of insurance cover premiums. Hence the Commonwealth government applies block grants to the states for public patients, and it believes that that is sufficient to cover all public patients.[61].

Mr Birch explained that the Department takes into account shifts in private health insurance participation rates, which then impacts advantageously on the overall Departmental budget. However calculations are complicated by the fact that the impact tends to be more on metropolitan health than in country areas.[62]

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[57] Chris Overland, question 1864
[58] Chris Overland, question 1870
[59] Chris Overland, question 1871
[60] Lyn Poole, question 36
[61] Jim Birch, question 39
[62] Jim Birch, question 45

4.6 Other Health Units in the Region

A submission from the Limestone Coast Regional Development Board expressed concern that issues associated with the provision of services at the Mount Gambier hospital should not and must not adversely impact on services provided in other centres within the region. Rather they should complement other regional health services.[63]

The Naracoorte Lucindale Council considered that the Mount Gambier Health Service and how it is run had clearly impacted on the South East region. The inability to attract specialists to service the region and the loss of surgeons had also placed significant pressures on the region. The end result for the community has been for greater delays in receiving medical attention, and families being forced to seek medical attention outside of the region by having to travel to Adelaide.

Naracoorte Health Service had to factor significant reductions of over $500,000 a year into its operating budget, and the focus on Mount Gambier meant that any future expansion plans for centres such as Naracoorte are delayed or put on hold[64].

A submission from one of the health services in the region stated that the budgeting process had impacted negatively on the services they were able to offer. This was because the statewide benchmark price for activity funding is modified at regional level and from there distributed to the individual health units. This had directly resulted in a much smaller allocation in the benchmark price (per equisep) than for Mount Gambier, and hence the health service concerned considered that the price difference equated to about $350,000, which they indirectly contributed to the regional reserve.[65]

Another regional health unit considered that the standard percentage cut applied by the region across individual health services, penalizes those who have created and maintained efficiencies. It rewards those units who have not yet undertaken the reforms necessary for sound financial management.

It argued that the case mix target (instead of a purely case mix basis measurable against agreed activity targets) had an historical base, but hoped that the situation would be rectified once the funding model is replaced by the population-based model.[66]

[63] written submission 46: Limestone Coast Regional Development Board
[64] written submission 41: Naracoorte Lucindale Council
[65] written submission 39: Bordertown Memorial Hospital Inc
[66] written submission 12: Millicent and District Hospital and Health Service Inc

5 TERM OF REFERENCE C) The involvement and actions of the Department of Human Services in the management of these issues.

5.1 Difficulties in working with the Department and the Regional Office

Evidence was given that the Department and the Regional Office were wielding the power.

There was also evidence given that the Department has failed to provide leadership and support to local managers in the implementation of the recommended strategies. In fact Departmental practice was to give direction to the regions and then to leave that region to implement their instruction. Evidence suggests that there was no responsibility on the part of the Department about the facilitation of change. As a representative from the Australian Nursing Federation put it:

> MS THOMAS: *That degree of being left in the wilderness with a set of marching instructions, those issues filtered down to nursing staff, who equally felt like they were left holding the baby to a certain extent. It was not just at the upper level. That feeling of almost helplessness and of, 'I really want to fix the problem down here but I don't have the tool box to be able to do it and nobody is giving it to me.'*[67]

There were also claims that bureaucratic rules prevented Mount Gambier from acting independently. It was evidenced for example that in seeking legal advice, MGDHS was obliged to use the services of the Crown Solicitor's office. It was pointed out to the Committee that the Crown Solicitor's Office may not hold the expertise required, particularly in relation to the type of health-related contracts in Mount Gambier. However, Mr Neilson clarified that a request to access independent advice was possible:

> MR NEILSON: *If the Mount Gambier Hospital felt that it needed legal advice which was beyond the scope and capacity of the Crown, they can ask, through the region and the department, for the engagement of an external individual or other solicitor.*[68]

It may be helpful to observe that MGDHS's right to seek alternate legal advice would evidently need to be requested and negotiated with the Department.

Evidence shows that some personnel in the Mount Gambier Health Service found the bureaucratic procedures in the Department were very slow and ponderous to deal with. Others suggested that this was not unduly the case; it just depends on the actual situation, and the way in which you communicate that through the department.[69] Clearly those more closely in contact with the Department and who had knowledge of the systems and people experienced less difficulty in communicating with them.

Dr Gallichio stated that in his view the communication and speed of processing matters with the Department was not how it should be. He considered that this related to a lack of the definition of the roles between executive staff at regional level and at local agency level.

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[67] Lee Thomas, question 1781
[68] Tom Neilson, question 628
[69] Tom Neilson, question 629

5.2 Management of Health Units: Division of responsibilities

Overall the evidence suggested that there is a need for very clear accountability and delegation lines between different bureaucratic levels.

Evidence was given about the division of responsibilities between the Department, the SERHS and MGDHS Health Service. Mr Jim Birch explained that the South Australian Health Commission Act provides a role for the Minister for Health, for the South Australian Health Commission, for advisory committees and for incorporated hospitals and health centres. He also explained that structural changes in the Department had led to the creation of a Social Justice and Country Division within the Department. He elaborated on the extent of the influence of the Minister and Department on the activities of individual health units.

> MR BIRCH: *The ability of the Minister to direct is actually quite limited. For example, the Minister cannot direct on a matter of staffing, or on an individual within staffing. In other words, if there is a disciplinary matter in relation to an incorporated body, the Minister cannot direct in relation to that, and the Minister cannot direct in relation to matters specifically associated with financing. By financing, we are talking about specific financing. Certainly, the Minister can determine and direct matters of total appropriation. In day-to-day operational and finance matters you cannot direct. So they are quite limited powers.*[70]

He provided an example in relation to safety and quality where, as CEO of the Department, he has no powers. He explained that the Minister could issue a letter to the board seeking a response to a quality and safety issue. If the response is not satisfactory, the Minister can then issue a direction about that matter. If the board does not abide by that direction, the Minister has powers to dismiss a board and put an administrator in place. However, if there is a disciplinary matter regarding a staff member within an incorporated health unit, the Minister has no powers of direction whatsoever over that.[71]

In respect of the appointment and dismissal of CEOs, Mr. Birch explained that the appointments or dismissals of individual Health unit CEOs are subject to approval or endorsement of the Department. Where a health unit Board has a majority of ministerially-appointed members, the Department has the authority to either veto or approve an appointment. On the other hand, where a board has a minority of ministerially-appointed members; all the board is required to do is to consult with the Department. The Department has no power of veto or authority to approve.[72]

The Social Justice and Country Division of the Department was responsible for the South East Regional Health Services agreements and the appropriation. The Division was responsible for service planning, coordination, purchasing, monitoring, evaluation of efficiency and effectiveness of services, business improvement, management development and support to rural and remote areas in South Australia.

Regional Boards were delegated functions and powers under the South Australian Health Commission Act to manage such things as regional work force resources, financial resources,

[70] Jim Birch, question 5
[71] Jim Birch, question 7
[72] Jim Birch, question 13

assets and procurement. However this did not include power to direct a health unit.[73]

Pay rates for locum clinicians were set centrally by the Department, based on the South Australian Medical Schedule of Fees. However evidence was given that quite frequently regional or health units negotiated their own arrangements and payments.[74] This was not encouraged by the Department of Human Services.

To assist in establishing a mix of doctors needed, the Regional Boards make the determination. It was explained that Regional Boards will not necessarily be given funding for a particular number: they will be given funding for a volume of work, and they can then determine whether they want more ophthalmology or psychiatry or whatever, based on the local need. If they want to spend their allocation on ophthalmology, theoretically, the Board can decide to do so.[75] The Regional Board can then determine where those procedures take place within their region.

As the Director of Country Health and Operations, Social Justice and Country Division of the Department explained:

> MS POOLE: *it is important to note that we fund the Rural Doctors Workforce Agency. It is a co-funded organisation by the state and the commonwealth. In 2003-04 we invested $1.9 million into that organisation, whose role and function is to support doctors in country South Australia. They do that through a range of programs, some of which you mentioned. It also includes providing a locum service for solo and two-practice GPs so that they can have relief from their clinics. They do continuing medical education, recruitment and retention and they have done a lot of work with the department in recruiting overseas trained doctors, and this has been a significant initiative in South Australia over the last several years.*[76]

5.3 Departmental Action Regarding Appointments of Overseas Trained Doctors

The Department's action in recruiting overseas trained junior doctors led to severe disquiet amongst the resident medical specialists in Mount Gambier. Anaesthetist Dr Paul Goodman explained the reasons for this:

> DR. GOODMAN: *GPs were removed from running casualty—a job that we had all excelled in, I consider, since before my arrival in 1976—by a bureaucracy who knew better, that is, they could do it cheaper or so they imagined, until after two years budgetary blow-outs continued to expand. The importation of foreign-trained, junior doctors with inadequate supervisors, usually the Director of Medical Services at the hospital whose other commitments preclude the full-time supervision of the junior staff, led and continue to lead to severe disquiet amongst the resident medical specialists in Mount Gambier. The imported doctors' central accreditation by the DHS did little to ascertain their medical standing locally.*[77]

Evidence was given that problems in emergency due to the inadequate supervision and

[73] Jim Birch and Lyn Poole, question 14
[74] Roxanne Ramsey, question 178
[75] Jim Birch, question 96
[76] Lyn Poole, question 97
[77] Paul Goodman, question 1375

accreditation levels of salaried medical officers have been occurring since salaried medical officers were first introduced at Mount Gambier Hospital. An opinion was that the inadequate supervision of young medical staff inadequately trained for cases they were managing led to the death of a patient[78].

The Committee notes that that there is to now be a Coronial Inquest into the death of a young woman and has resolved to not examine these matters in as much as detail as it might otherwise have done.

5.4 Departmental Actions Regarding Negotiations

During the period of contract negotiations the Department attempted mediation to resolve the major issues. The department chose and paid for the mediators.

Evidence from medical practitioners indicates that the department appointed them unilaterally without consulting them. The impression of some doctors was that the particular person was not acting as a mediator but more as an agent of either the region or MGDHS. Hence, those chosen to act as mediators were not considered competent by the doctors. At the same time the doctors' confidentiality agreements meant that they felt isolated during the process. The negotiation process was further hindered by changes to personnel co-coordinating contract negotiations, resulting in further lack of confidence and faith in the process by the doctors.

The mediation process with the appointment of mediators selected through the Department failed to produce the desired outcomes. Mr Richard Strickland gave evidence that this was due to a lack of will and competence on the part of the local or regional administrations[79].

The Committee is disappointed that the mediators did not ensure that the parties signed-off on any agreement made during the process. As a consequence, misunderstanding as to the nature of early agreement occurred without exception. In future, the parties' legal advisors should be requested to attend the mediation so that all parties are in a position to finalise agreements at mediation.

Recently specialists have discussed the issue of having a representative on behalf of the hospital and the health service involved in these negotiations so that there can be some continuity and to help keep the discussions objective.

The region is attempting to bring in services, and is focusing on the need for the community to have services clearly articulated with long-term sustainable solutions. The preference is agreement on the retention and development of specific services, with long-term individuals placed there.

5.5 Departmental Actions Regarding Appointment of CEO

The appointment of the chief executive of the Mount Gambier is a hospital Board appointment through a selection process. Generally, but not necessarily, the Chair of the hospital Board chairs the selection process. A nomination is usually supported by the Chief Executive of the Department of Health. Mr Birch clarified the process:

[78] Evidence given *in camera*
[79] Richard Strickland, question 747

MR BIRCH: *Well, in this instance…… in the case where a board has a majority of Ministerial nominees I approve or veto. In the case of the Mount Gambier Hospital it is to only endorse; it is not to approve or veto, because the Minister does not have a majority of nominees on the Mount Gambier Hospital board. So the board makes the decision*[80].

Further information about the Department's expectations of the appointment was provided by Ms Ramsey.

MS RAMSEY: *Not always, but generally the department is invited to be part of the selection panel and, if we are invited, we will normally provide someone to be part of that. Then we expect but cannot require that boards have performance agreements with their executive, and there are occasions when we are invited in to make comment if there are appraisals of executives; again not consistently but quite frequently. If asked, we provide feedback about how we see an executive performing. When there are issues of budget or other things, we would put that information before the board.*[81]

Evidence indicates that the whole appointment process of the CEO was subject to some degree of veto by the Department of Human Services.

MR CUNNINGHAM: *I could not speak with any confidence on the issue of the appointment. It is fair to say that the people who pay have the say, and I understand that DHS would require to have some input into the person and the selection process. It is a two-way street. I do not think it should be the sole responsibility of the hospital board to do the whole thing themselves.*[82]

Feedback about appointments may be provided face to face or in writing depending on the stage of the appointment process. Intervention by the Department is not considered appropriate unless there is a serious issue. However evidence from a former Board member, considered it was the Department and not the Board that was controlling events.

5.6 Departmental Actions in Workforce Planning

Ms Poole and Mr. Birch provided evidence that work force planning is now a significant topic for country health and an area that the Department of Human Services is addressing.

MR BIRCH: *Until my arrival in the department, the amount of departmental work force planning that occurred was minimal. We had good data in some areas, such as nursing and midwifery, but there was no work force response to that. There has been a significant increase in departmental effort on work force planning in the last 20 months.*[83]

MS POOLE: *In relation to the country medical work force, we are currently developing what we call the strategic rural and remote medical services framework. This is to determine the determination of services and work force models and plans*

[80] Jim Birch, question 170
[81] Roxanne Ramsey, question 183
[82] Leslie Cunningham, question 1482
[83] Jim Birch, question 71

based on the current and projected community demographic and health trends and forecasts. It will give an overview of clinical planning for specialist services across country South Australia. It is also a determination of the recruitment and retention strategies for us to sustain service delivery, particularly in those difficult to staff remote locations.[84]

The Department has also taken specific measures in relation to anaesthesia services in Mount Gambier. As Dr Kevin Johnston, the former Director of Anaesthesia put it:

DR JOHNSTON: They appointed a new anaesthetist to take the strain off us. They created a new Regional Director of Anaesthesia program above my head to take away any control and power I had, but he is based in Adelaide and does not do a single case.[85] *... And we now have an arrangement where we have one specialist at a time rotating from the Royal Adelaide. But that only puts us back to an establishment of four people, which is where we were in 2002, before they took Dr Goodman's admitting rights away from him. So, we still have only four people.* [86]

Operationally the Regional Director of Anaesthesia is based in Adelaide to supervise rural anaesthetists. But these are all based in Mount Gambier.

[84] Lyn Poole, question 66
[85] Kevin Johnson, question 2360
[86] Kevin Johnson, question 2361

6 TERM OF REFERENCE D) Regional service planning as it relates to the health needs of the community.

6.1 Health Care Needs of the Community: Outlying Areas

In the South East, as in all rural areas, a large proportion of the population is obliged to travel some distance to their health service. When planning regional services, the time taken to get help and achieve the best possible health outcomes must be considered. Mrs Mulcahy spoke of 'the golden hour; meaning that:

> MRS MULCAHY: *the sooner a person obtains medical help, the better. If it takes a whole hour you are in deep trouble. After an hour you are in even deeper trouble. Hence for those in outlying areas, service delivery is compromised.*
>
> *We still have to look at the golden hour concept in outreach from the outlying communities, meaning that, if people do not receive urgent medical help within the first hour of when they have their issue, their future chances of survival are extremely compromised. When you consider that from Mount Gambier to Bordertown you are looking at two hours, that golden hour issue is something that must be addressed.*[87]

6.2 Health Service Planning Responsibilities

The responsibility of the Regional Board for the planning of health care for the entire region was emphasised. As a former Chair of MGDHS Board stated:

> MRS MULCAHY: *For the planning of absolutely everything. Every service that is delivered in the name of health across the region has to be paid for and funded by the regional health service.*[88]
>
> *The local board can only provide services that it is contracted to provide to the Regional Board. The Regional Board has to formulate the services that are needed and then agree with the hospital or the other regional hospital units on how they will be provided and funded accordingly.*[89]

Further, as the President of the Australian Medical Association told the Committee:

> DR HEDDLE: …..*the regional health board has responsibility for looking at the health care plans for the region. If we are moving towards the population health funding model, which we probably are, you would be aware that the actual dollar health funding for the regions in South Australia is much less than the area past the metropolitan area. You need to redress those inequalities. The regional health board has to determine, in consultation with all the stakeholders locally, the way they are going to be given a certain amount of funding and resources and work out the best way of delivering the services they want to the community, and the community is going to participate in that decision-making. It is one of the reasons that regional health boards have community representatives they can work out what they think is the best*

[87] Ann Mulcahy, question 1565
[88] Ann Mulcahy, question 1525
[89] Ann Mulcahy, question 1526

way of providing the health services to that region[90].

Although the SERHS Board is responsible for the planning of health care, evidence was given that there was in fact no overall plan for the health care system in the region. This had made the task of MGDHS Board very difficult, as they had no direction or firm goals to work towards.

Recent changes have been made at Departmental level that may well impact on Regional planning of services. Evidence was given that structural arrangements within the Department had involved removing the integrated housing, community services from the Social Justice and Country health Division, to focus only on health provision and issues. The new Division is now Country Health, which may result in an improved situation for country health provision. The role played by the Regional Board is seen as central to the operation of this model. As Mr. Neilson explained:

> MR NEILSON: *Our role certainly is to facilitate planning through quite a comprehensive process, community planning and, indeed, bottom up or top down planning a whole raft and range of structures associated with planning is used by the region and we would look at entering into understandings which are contained within the budget letters and memorandum of understanding between the hospital with the relationship between the region and the individual facility.*[91]

It was explained that Regional boards have been delegated functions and powers under the South Australian Health Commission Act to manage such things as regional work force resources, financial resources, assets and procurement. However it was pointed out that this does not include power to direct a health unit[92].

A public meeting was held in Mount Gambier which the Minister attended where the development of a Health Service plan was mooted.

> MRS MULCAHY: *The Minister said there would be no cut to services and the services that were delivered at the time would have been analysed to identify what was being provided and funded appropriately so that there would be clear accountability in that plan for time lines and what would be done, by whom and when.*[93]

However the planning document subsequently produced did not assist the MGDHS Board in relation to what it needed to do.

> MRS MULCAHY: *I hesitate to use the word 'fluffy', but that just about sums it up as far as I am concerned. As I said in my submission, what I heard is right: it is a plan to have a plan. There is no accountability; there are no time lines. It is just a framework for the future, but it is not a plan. It is not even a shopping list.*[94] *.... I would be incredibly angry if I was on the current board and I had been waiting to receive this document. I think I would be quite scathing in my rejection of it.*[95]

[90] Dr William Heddle, question 2590
[91] Tom Neilson, question 538
[92] Jim Birch, question 14
[93] Ann Mulcahy, question 1560
[94] Ann Mulcahy, question 1561
[95] Ann Mulcahy, question 1563

Then Hospital CEO Mr Ken McNeil agreed that a long term plan for health services in terms of recruitment really had not been formalised nor implemented:

> *Our funding for the hospital is on annual cash basis. We have to work within an agreed plan with the department. Until we can get confirmation that they will support the long-term regional plan, and Mount Gambier provides services within it, our ability to contract for the long term and commit funding is limited*[96].

A submission received by the Committee from MGDHS dated August 2005 complained that the South East Region Clinical Services plan had still not been published. Until this occurs, MGDHS considered it could not finalise its own strategic plan, as without a regional plan to reference to, the strategy stands without validation by the Department.

At the time of writing, the Committee learnt that there was no clear indication of what the medium to long term aims of the SERHS are in relation to service provision. The submission stated that a considerable amount of good will and positive energy is lost due the lack of a clear direction in which to channel these energies.[97]

A later submission to the Committee in December 2005 by Hon John Hill, the then newly-appointed Minister for Health, stated that his Department is conducting a consultation process (from November 2005 to January 2006) with all rural resident specialists. The review will assess the requirements for specialist services in country areas and allows for planning the number and mix of specialties needed.

This work will incorporate the quantity and mix of resident specialists, the role of visiting specialists, and the quantification, qualification and contribution of metropolitan based services in contributing to the delivery of specialist services in rural locations.

6.3 Service Planning and Workforce Planning

Evidence was received on a number of general issues relating to staffing. These included: the attraction and retention of staff, staffing to provide certain services, and a number of issues relating to staff contracts.

Although service planning encompasses the need for planning for the personnel to deliver those services, recruitment and retention of staff was seen as the foremost issue by a former MGDHS CEO. Some evidence was given that additional incentives, such as extra loadings for which only resident rural doctors and specialists are eligible, have been offered to assist in this process. The attractive lifestyle on offer in Mount Gambier was considered a positive in attracting staff to the area. However, the difficulty in recruiting staff and the intimate connection between service planning and workforce planning was made clear.

> MR OVERLAND: *The driver will not be planning; the driver will be the ability to attract and retain the staff required to run those hospitals.*
>
> *That is the central problem. It has always been far too hard from a planning*

[96] Ken McNeil, question 409
[97] MGDHS written submission August 2005

perspective to come up with the right answer, for exactly the reason as the chairman just said: for whom? Who is the beneficiary out of all this? [98]

I think it was always going to make it more difficult. Even though Mount Gambier Hospital should be the jewel in the crown in terms of country hospitals, because of the culture and the known difficulties with the medical staff, it was always going to be difficult to get people to volunteer to come forward.[99]

MS POOLE: *Work force planning is a big topic for country health. ...It is not wise to do work force planning in isolation of service planning. You must have a picture of the service planning, the service delineation and the volume of activity that you want to perform, of whatever nature. That is the most informing thing you can know to then say, 'So, what are the service models? How will we deliver this service? Therefore, what is the work force requirement we need to reflect that outcome?'*[100]

There have been a range of strategies put into place in an attempt to maintain the workforce at an appropriate level, including the introduction of overseas trained doctors. The regional approach to service provision has meant that staff will most often be located where the bulk of the population resides. This has implication for the provision of services, especially emergency services in more outlying areas.

The recent (2005) submission from the Mount Gambier & Districts Health Unit seems clear that despite the lack of a services plan at the Regional level, workforce issues at MGDHS are now on track. One permanently appointed specialist surgeon has taken up residence, a second was due to begin in September 2005 and the third was due to arrive in January 2006. In the interim, specialist coverage would continue to be provided through the Queen Elizabeth hospital. Protocols and policies relating to anaesthetic service have been reviewed, and the result is that is now a stable service, meeting expectations. Two resident physicians are in position with relief support from Flinders University hospital.[101]

6.4 Workforce Succession Planning

The medical profession in Australia is essentially a culture of independent consultants doing their business on a fee-for-service basis through the schedule of fees. One of the reasons medical staff like that arrangement is that they are their own master, as they see it. This allows them, at points in their lives, to have less or more activity, more or less commitments.

MR OVERLAND: *If someone wanted to scale back their activity they basically just did. I had people in the early nineties who were slowly withdrawing from full-time practice, and that was just something that the doctors organised amongst themselves. The other thing is that if you want to be a specialist practising in places like Mount Gambier it is not safe, in the long haul, to do it alone—you at least need a partner—and so—*[102]

The point I am making is that you do need two people, and that means you have to

[98] Chris Overland, question 1932
[99] Chris Overland, question 1953
[100] Lyn Poole, question 73
[101] Written submission MGDHS, August 2005
[102] Chris Overland, question 1860

structure your business arrangements outside of the hospital to ensure that if you are backing out the door as a retiring surgeon, you are creating space for someone to move in so that you can maintain those two specialists there who can support one another. That can become a bit tricky sometimes and it has become tricky down at Mount Gambier because what happens is that they start to put pressure on the person running the place, or on government, to provide more money so that they can get a new person in while the other person is backing out in a transition process. That has actually become a problem, from what I gather, over the past few years.[103]

Due to natural attrition through lifestyle and other changes it is necessary to allow for partial or gradual change in medical workforce without loss of specialty area.

6.5 Regional Plans and Review of Planning

Contradictory evidence was given on the advantages and disadvantages of services and governance being conducted at the Regional level.

Among the advantages were said to be the opportunity for regional planning and working towards shared goals within a region; the ability to bring a higher level of expertise to country health care; the enhanced likelihood of reducing the duplication of services.

Mr. McNeil enlarged on the issue of regionalisation in reducing duplication of services thus:

MR McNEIL: *Basically what you are doing is identifying that a service needs to be provided for an identifiable catchment and that the volumes that the government decides to purchase can then be defined across that catchment, rather than having the historical way; that is, this service has always been provided in Naracoorte. This service has always been provided in Naracoorte, Penola and Bordertown, and the issues of whether or not any of those are complementary or duplicating does not get addressed in the original contracts. By having regionalised contracts it is a step by the South East Regional Health Service to begin to address the duplication issues.*[104]

The Committee heard that expectations about the level of health service provided have changed a great deal, and present plans, structures and levels of service may not necessarily be appropriate. As a former hospital Board Chair observed, if the Department is implementing the policy of the government, it is only appropriate that they plan to implement and plan to fund that process. She also made the point that MGDHS had finite resources and infinite demand, as the community's expectations of their health services are developing along with their level of education. As she put it

MRS MULCAHY:....I am sure there is not one person around this table who does not expect to be able to have a hip replacement, should it be necessary. The fact that that was not an expectation or an option 20 years ago has to be taken into account. If the technology exists to make somebody's life better, it is reasonable that it be an expectation[105].

Evidence was given that the Regional Board commissioned an external consultant to draw up

[103] Chris Overland, question 1861
[104] Ken McNeil, question 399
[105] Ann Mulcahy, question 1637

a strategic plan, but that the draft was not acceptable to the Regional Board, hospital Board or the clinical centre for the South East. The Regional Board has since asked the consultants do further work on it to improve and refine it, and to get agreement on it.[106] Working together on the plan has meant that relationships between MGDHS and regional Boards have been relatively cordial and efforts have been made to improve things.

Questions on whether the Regional Board shares the same vision for Mount Gambier that MGDHS Board has for its community, produced differing views. Similarly suggestions on changing or maintaining the current 3-tiered hierarchical Department – Regional – Health Unit structure varied considerably.

[106] Brendon Kearney, question 2645

7 TERM OF REFERENCE E) The impact on health services in the Mount Gambier area of these issues.

7.1 Health Services: Reductions in Specialist Staff

Evidence highlighted issues relating to visiting specialists. Smaller rural centres had been negotiating to arrange for visiting specialists from Adelaide. It was suggested by several witnesses that there appeared to be a deliberate policy to wind down the appointment of specialist resident in the South East in favour of a policy to fly specialists in from Adelaide. Some evidence was provided that this policy had led to less than adequate patient care. A report commissioned by the Department delivered in November 2002 quoted in evidence stated:

> *'Should a decision be made that effectively reduces access to the anaesthetists, then this will reduce the capacity to provide elective procedures. Should this be considered desirable and/or coupled to agreed reductions in elective procedures, then it is an acceptable risk'.*[107]

Several issues were seen to be impacting on referral patterns in the region. These included the proximity of some Victorian towns over the state border, the preference of some patients in the northern part of the region to be referred to Adelaide, Adelaide specialists visiting Mount Gambier and the choice of some local GPs, especially in the time when tensions were high, to refer their patients to Adelaide.

Evidence was given that other regional areas such as Whyalla had a long history of partnerships with large city hospitals that had worked well, and it was suggested that partnership arrangements were likely to increase in the South East. However if this were to be effective, much better communication would be needed.

Issues relating to the distribution of specialist services in terms of where they reside were also mentioned. Historical issues and policy matters were considered important in this regard. Factors seen to be important in determining the staffing levels of specialist providers included regional demand issues, population drainage, and the age of particular individuals.

The ability of specialists to work in particular locations was determined by the application of the clinical admitting and privileging rules. Different communities would apply them according to their needs and the facilities they had available.[108]

The Committee heard that there were no specialist services offered at MGDHS for dental or mental health care.

7.2 Health Services: Reduction in available surgery

The Hon Dean Brown gave evidence that when MGDHS terminated negotiations with the doctors there was also an expectation that the degree of surgery conducted would be reduced by up to 25%. As a result of reduced surgery levels, the number of anaesthetic procedures also reduced.

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[107] Paul Goodman, question 1247
[108] Roxanne Ramsey, question 137

Mount Gambier had hosted one of the best medical specialist services in rural South Australia, however, since 2002 there had been a significant change in the number of resident specialists and the areas of work they cover.

Dr Johnston summed up the current state of surgery in Mount Gambier as.

- Theatres are left empty;
- All day lists get used for three hours in the morning;
- A few emergencies get done;
- General practitioners are not referring general surgical cases into the one specialist who they do not know for quite proper reasons;
- Patients are coming to Adelaide;
- Patients are going interstate;
- patients are not being operated on; and
- The hospital is just a skeleton of what it once was.

As a result of all the changes there is no urology, neck, vascular, aortic aneurysms, or carotid surgery being done. Another service still lacking from the region is an epidural service, particularly for women in labour.

7.3 Health Services: Locum Services

The loss of former resident specialist doctors resulted in gaps in services for the residents of Mount Gambier and districts and as a result, MGDHS needed to rely on expensive locum services which incur the cost of bringing in specialists for a short period of time.

Locum specialists do not undertake regular clinical work. Some costs such as that of seeing people prior to surgery are transferred from an MBS (federal government expense) across to a hospital outpatient expense. This is potentially a significant additional cost for the hospital, which usually in country areas would be a MBS expense. In addition, extra costs for medical indemnity, accommodation, providing a car, the expense of flying in and flying out and meals must be included.

Defending the use of locums in Mount Gambier then CEO, Ken McNeil, stated:

> MR McNEIL: *The role of Mount Gambier as a regional referral centre is where the consideration is; it is the second largest city in South Australia and the largest facility outside the metropolitan area.*
>
> *Basically, in relation to industry standards, the role delineation model being used as the basis for clinical plans for the development of Mount Gambier specifically identify that, if you are going to have a regional referral centre where complex cases are sent in from peripheral places for stabilisation and treatment, we must have a salaried medical officer on site 24-hours a day. Using the GP system we did not, and could not, achieve that standard*[109].

[109] Ken McNeil, question 521

Providing after-care for the patients that were treated by visiting locum specialists became a very contentious issue as, unless the visiting surgeon made some payment out of his own pocket, there was no incentive for the resident specialist to provide the after-care.

Evidence confirmed that specialist locums who are flown in are far more expensive in the short term and in the long term than resident medical specialists. But witnesses were unable to clarify whether the practice of bringing in specialists is a trend, or an unstated policy given that they are difficult to acquire and that regional communities appreciate specialists and any qualified professionals within their communities.

7.4 Health Services: Accident and Emergency Department

The Committee heard that the use of the Accident and Emergency service at Mount Gambier had increased significantly. Reasons for the increase vary, but as none of the GPs offer bulk billing, there have been instances where patients who have outstanding GP bills cannot access GP or medical clinic. They then present at the hospital for free treatment. Evidence given stated that A&E presentations had increased to a figure of well over 15,000.[110]

The Committee received evidence that many attending the A&E department were assessed as category 4 or 5 and should more properly have attended GP services.

This increase of use of MGDHS's A&E department for non-emergency cases has in turn increased pressure on the provision of services.

It has also increased financial pressures on the hospital. Evidence was heard from Departmental representatives that increased funding from an initial estimate of 3 to 7 salaried medical officers, specifically to provide the A & E service, has been given.

The Committee heard that currently GPs do not provide any care for their patients in the hospital. Since the appointment of salaried medical officers, the rights of GPs to have their patients admitted to the hospital had stopped. This is the same process as applies in the metropolitan hospitals.

One witness believed this process represented a retrograde step in relation to care and continuity of care in accident and emergency, where patients are seen up to several hours later by a fulltime state salaried SMO and both patient and doctor meet for the first time. Patients are admitted through A&E through the salaried medical officers who change from day to day.

The relative benefits of having a GP service attached to the accident and emergency department of the hospital were discussed. Some were of the view that this would be beneficial in dealing with the less severe cases which did not need emergency service and so free up hospital staff to deal with 'real' emergency issues. The possibility of employing nurse practitioners in the health care system in Mount Gambier was also discussed. The Committee heard that nurse practitioners do additional training and are required to meet stringent standards.

[110] George Beltchev, question 1231

7.5 Health Services: Outpatient Services

One witness enlarged on some of the problems relating to the difficulties experienced by visiting specialists in providing adequate out-patient services at the Mt Gambier Hospital. Some had felt obliged to provide their own facilities and staff, an exercise that had proved very costly.

As these were privately owned facilities, MGDHS was left without any outpatient service when these specialists left. The subsequent provision of out-patient facilities had been funded by the state at considerable expense.

7.6 Health Services: Theatre Management

Issues raised in both the Beltchev and the Coombe reports pointed to the inefficiency of operating theatres. In relation to budget overruns, Dr Johnston gave evidence that there had been some deficiencies in funding. Costs of medical treatment are going up, and the increases in funding have not kept pace. Overtime payments for nurses working in operating theatres also contributed to budget overspending. Some overtime was due to admission and discharge practices, where patients were being admitted on the same day before people were being discharged. That means that there were two workloads going on.

The Committee heard that, in an ideal situation, a surgeon would book a patient into an identified slot. This appointment would then be sent through to Mount Gambier within a 24-hour period for entering on the theatre list for the nominated day. The nurse manager would then roster staff members to deal with the number of cases and organise patient admissions and their post-operative care.

However there were times when a nurse manager received a phone call that a patient was on the way to the hospital for theatre that day. The nurse manager would organise extra staff and pay casual rates, as there were only enough staff to cover the planned list. There may have been three, four or five patients suddenly added to the list for that day. Such conduct makes it difficult for the theatre to manage its budget and it precludes patients from accessing services such as the pre-admission clinic, which is widely accepted as being important for a patient's preparation.

Another issue was the suggestion that creating waiting lists would assist to control the numbers of elective admissions. There was contradicting evidence as to whether this had been part of a strategy to create lists to manage theatre units more efficiently, or a consequence of shortages.

Witnesses informed the Committee that current restructure processes in MGDHS for how it is managed internally will enable senior nurses to have more input into decisions. They anticipated that they would be participating in the consultation process and helping to establish waiting lists.

Preliminary work was done on how theatre management systems had worked in other environments. This was submitted to MGDHS board as an information document and caused great trauma, because it was interpreted as a policy document that had to be enacted rather than a draft document showing the stages of consultation that had taken place so far. The

level of defensiveness encountered made it difficult to get acceptance.

Questioned about what had been done to address issues in relation to theatre management, Dr Gallichio, Acting Director of Medical Services, assured the Committee that there is now a collaborative approach to addressing these concerns with responsibility taken for the use of high cost items such as orthopaedic prosthetics.

MGDHS CEO, Mr McNeil, raised the need for an information system that provides information both to the clinicians and management with regard to the operations of theatre to assist in this. However the lack of a management system inhibits the clinical review and clinical audit programs that would give more opportunity to involve management and/or staff with clinical governance activities.

Planning the theatre lists well in advance would allow for better use of the pre-admission clinic. This would reduce any risks to patients through assessment of any particular needs during their hospital stay. In doing so it affects occupational health and safety issues for the patient, but also for the staff.

7.7 Health Services: Patient Transfers

Evidence was provided that from high dependency there had been an increased number of patient transfers to Adelaide. MGDHS initiates treatment and then sends the patient a lot more quickly than previously, so they can get quicker and more effective treatment of their condition. It was stated that the number of transfers has jumped from about 15 per cent to 20 per cent, and that is mainly because MGDHS has closer ties with Flinders Medical Centre, and many patients go up for tertiary treatment, which MGDHS cannot offer them.[111]

In defence of an inference that the increased transfers were due to a lack of confidence in care and staff, nursing staff stated that they have no control over transfers to and from Adelaide. Patients to be sent to Adelaide must be authorised by a medical person, and responsibility for surgical transfers lies with the surgeons and no one else.[112]

7.8 Health Services: Use of Private hospital

One submission suggested that MGDHS can help to either recover or generate further income by activities within the private hospital. However evidence was given that patients residing in Mount Gambier understand that, as public patients, they will get the same doctor they would if they were private. They are fully aware that they will receive the same standard of accommodation and nursing care. MGDHS does not and cannot offer an effective private patient service because there is, in reality, no private product to be offered. What is offered is a public ward with a sign on it stating 'Private Wing'.

As both facilities were built at the same time, they are both in good condition. The main difference is room sharing in the public hospital.

However one advantage of having a private facility is that it has allowed joint replacement procedures to occur that might otherwise been prevented or postponed through the fee-

[111] Nancy Gilboy, question 1787
[112] Nancy Gilboy, question 1787

capping funding policy. The evidence suggests that the private-public mix improves the service to the community by allowing more procedures to be performed.

7.9 Health Services: Quality of Health Care in Mount Gambier

Reference was made to circumstances in which preventable mortalities had resulted when the system had 'gone awry'.

One of the specialists was asked to discuss the circumstances of one case, the death of a young woman suffering from asthma. He had been called from home by the casualty sister, requesting help for the patient in the high dependency unit.

In his view the administration of an inappropriate drug by an unsupervised, inexperienced medical officer was probably critical for the patient. He believed that if there had been senior staff on site, the patient may have survived.[113] He considered it essential that medical officers on duty in a casualty department be able to intubate.

On a different occasion, another specialist stated that failure to resuscitate an infant had occurred resulting from lack of skilled available staff. The circumstances were such that the anaesthetist on duty was unable to attend the baby for 10 to 15 minutes because he was working on an anaethetised patient in the operating theatre at the time, and unable to safely leave that patient. Other staff were unable to intubate the child and it died[114].

[113] Paul Hubert Goodman and Susan Goodman, question 1377
[114] Written submission 31: Dr Steve Simmonds

8 TERM OF REFERENCE F) Any other related matter.

8.1 Funding Cuts, Funding Models and Budgets

Mount Gambier had a large specialist service base, which undertook relatively complex procedures that did not earn money for MGDHS under the case mix funding method. As a result the department demanded more budget cuts. The Committee heard evidence that MGDHS management had argued vehemently and repeatedly for years with head office over budget cuts and the inappropriateness of the case mix funding model for MGDHS.

The downsizing of staff, accumulated deficits from the new hospital, and instructions from MGDHS Board not to reduce procedures further strained relationships.

As discussed in Term of Reference A, the changes in Departmental structure from the Health Commission to the then Department of Human Services entailed changes in personnel with a very different management style. Reductions in the cost of service provision from medical practitioners were imposed on MGDHS from the Department, and both the contents of the contracts and the way in which they were negotiated resulted in a clash of cultural expectations.

Medical specialists became highly indignant during the negotiations, which escalated into bitterness and acrimony. They were also scathing about the use of salaried medical officers, particularly those from different ethnic groups, and that their hostility towards MGDHS management transferred to their dealings with and behaviour towards other staff.

8.2 Confused Areas of Responsibilities

It is clear from the evidence that a lack of differentiation between Regional Boards and health unit boards, particularly MGDHS Board, with consequent doubtful good governance, contributed to the many difficulties at MGDHS. Although local hospitals are managed and accountable to a local hospital Board, it is apparent that the Mount Gambier Board felt that the region and the Department were taking away their control, rather than giving them the support they needed to manage their own affairs.

The Committee heard deep criticism of MGDHS Board, which included lack of skills and competence, and instances of Board members being too closely involved with those day-to-day decisions that should be the sole province of management.

It appeared that the great deal of confusion over roles and responsibilities between Regional and Hospital Board was compounded by three major factors.

Firstly, this was the fact that for at least part of the time, the CEOs of MGDHS also served as CEOs to the SERHS. We have seen that during the negotiation of contracts, both medical staff and MGDHS Board were quite bewildered as to which level of governance was responsible for signing them and exactly which organisation was properly one of the contracting parties.

The second factor was the very high turnover of hospital CEOs. No less than eight people were appointed or acting in the position from May 2000 until 22 April 2003[115] This can only

[115] Written submission 43: MGDHS

have exacerbated the confusion that existed at the time, and evidence was given that suggestions for improvements put forward by the MGDHS Board had not been implemented. It was evidently difficult to attract the right person into a situation that was riddled with problems.

The third factor was that the MGDHS Board was short of members with the appropriate skills needed at the time. Faith in the competence of the Board to formulate an effective health plan or conclude negotiations was not held by all witnesses.

Opinion on the quality of work of MGDHS administration and its Board produced was low by one witness, judging by a poorly written annual report. In attendance at an annual general meeting this witness wondered whether or not the administration and Board really knew what was happening.

> Mr OSBORNE: *No-one is on the board who has had any training in business at a reasonable level. I think that is unfortunate. There is no-one on the board who has any training in strategic planning. No-one on the board has any training or expertise in financial management. I think that is a bit sad.*[116]

Indeed lack of appropriate skills of both Regional and hospital Board members to handle the large budgets necessary for this type of operation, the conflicting interests of having the same person in both CEO positions and competing regional and hospital interests further compounded the situation.

Clinical input into the management of budget allocations would have helped to address areas of misunderstandings and conflict. No shared decision making on levels of urgency and emergency relating to surgical cases had occurred, which the Committee considered would be appropriate for good governance and for management of MGDHS services as a whole. Such a shared management strategy was known to occur at other hospitals from a peer-review committee.

The failure of the MGDHS Board to respond to media reporting was detrimental in dealing with issues. The public held the view that problems being experienced at the MGDHS were due to inadequacy on the part of the Board. Lack of response by the Board to the media reporting possibly reinforced this public misconception. Further, the Board was not allowed to publicly comment on deficiencies in other parts of the system. The Committee heard that to a large extent, the hands of the Board were tied regarding those issues for which they were publicly blamed.

8.3 The Results of Changes in Cultural Expectations, Ambiguous Responsibilities and Imprecise Governance

As a direct result of changes in cultural expectations, ambiguous responsibilities and imprecise governance, and compounded by a number of factors referred to earlier, over time the situation in Mount Gambier deteriorated.

Many of the negotiations with medical practitioners at MGDHS broke down and those negotiations failed, leading to much resentment and animosity between the parties.

[116] Jim Osborne, question 807

Conflict and inappropriate behaviour was widespread, and may have transferred from management-clinical personnel to include other staff at MGDHS. This gave rise to allegations of bullying and racism, and relations deteriorated to the extent that one of the former specialists at MGDHS took formal action against a senior manager. The senior manager was in fact cleared of the bullying charge, but the fact that the issue went to arbitration does illustrate the very high levels of hostility at the time. Arbitration failed because it did not address the specific complaint and the systemic hostility within MGDHS itself and this cause a lack of confidence in the general management of the Health Service.

Budget cuts imposed and the conflict generated meant that medical service provision was adversely effected, and patients experienced long delays and poor service in gaining medical attention including surgical procedures. The quality of care may also have been adversely effected, with evidence of mortalities indirectly attributable to reductions and changes in the delivery of services.

The Hon D W Ridgway MLC
Acting Chairperson

Parliament House
ADELAIDE SA 5000
13 February 2006

APPENDIX A: SCHEDULE OF WITNESSES

Public evidence was received from the following persons and organisations:

Human Services, Department of
- Jim Birch, Chief Executive Officer
- Lyn Poole, Director, Country Division

The Hon D C Brown MP
Mr Barney McCusker
Mount Gambier and Districts Health Service
- Ken McNeil, Chief Executive Officer
- Ann Mulcahy, former Chairman of the Board
- John Gallichio, Acting Director of Medical Services
- Sue Thomson, Director of Nursing and Patient Services

South-East Regional Health Service
- Tom Neilson, Regional General Manager
- Bill DeGaris, Chairperson

District Council of Grant
- Don Pegler, Mayor
- Russell Peate, Chief Executive Officer

Dr Douglas Brown
Susan Scarlett Goodman
Richard Strickland
Jim Osborne
Dr David Sare, Medical Practitioner
Paul Jenner
Dr Steven Simmonds and Marian Simmonds
Ian Matters
Thomas Rymill
George Beltchev, Director, Office of Health Reform, Department of Human Services
Dr Paul Goodman and Susan Goodman
Robert Klintberg
Leslie Cunningham, former Board Member
Ann Mulcahy
Australian Nursing Federation
- Lee Thomas, Secretary
- Rob Bonner, Senior Industrial Officer
- Elizabeth Fallas, Clinical Nurse Consultant, Medical Unit
- Nancy Gilboy, Clinical Nurse Consultant, High Dependency Unit and Emergency Department
- Elizabeth Case, Clinical Nurse Consultant, Private Hospital
- Teresa Bueti, Clinical Nurse Consultant, Pre-Admission Clinic and Surgical Outpatients Project Officer

Chris Overland, Director, Ageing and Community Care, Department for Families and Communities
Hon R J McEwen MP
Dr Kevin Johnston
Royal Australasian College of Surgeons
- Paul Dolan, Chairman, South Australian Committee

David Thompson, Rural Services Manager
Anne Wilson, Regional Manager, SA Branch

Australian Medical Association
Dr William Heddle, President
Duncan Wood, Chief Executive Officer

Professor Brendan Kearney

Professor Guy Madden, Director, Division of Surgery, The Queen Elizabeth Hospital

Professor Guy Ludbrook, Head of Anaesthesia, Department of Anaesthesia and Intensive Care, University of Adelaide and Royal Adelaide Hospital

Peter Whitehead, Chairman, Board of the Mount Gambier and Districts Health Service Inc

APPENDIX B: SCHEDULE OF WRITTEN SUBMISSIONS

The following persons and organisations made written submissions to the Committee:

Australian Doctors' Fund
Australian Medical Association
Australian Nursing Federation
Barry, Dr Christopher
Bordertown Memorial Hospital Inc
Brown, Douglas S C
City of Mount Gambier
Cunningham, Les, JP
DeGaris, W S
Filby, Dr D
Goodman, Dr H P
Goodman, Mrs S S
Grant, District Council of
Hains, Daniel
Hill, Hon J, Minister for Health
Human Services, Department of
Jenner, Paul Robert
Johnston, Dr K R
Kearney, Professor B
Landy, Mark J
Limestone Coast Regional Development Board Inc
McCusker, Mr Barney
McEwen, Hon R J
Maher, Jim
Matters, Ian
Millicent and District Hospital and Health Services Inc
Mount Gambier and Districts Health Service Inc
Mulcahy, Ann
Naracoorte Lucindale Council
Naracoorte Health Service Inc
Peres, Dr Matthew
Poole, Lyn
Public Service Association of SA Inc
Royal College of Surgeons, Division Group of Rural Surgery
Rymill, Thomas
Sare, Dr David
SA Ambulance Service
Simmonds, Dr Steven
South East Regional Health Service Inc
Stevens, Hon L, Minister for Health
Strickland, Richard
Tatiara District Council
Wattle Range Council
Whitehead, Peter