Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Australian Medical Association WA – Dr M Duncan-Smith
Date: 14 February 2022, Time: 1215 – 1240

KENNEDY, DR: Good afternoon.

Thank you for coming in this afternoon to speak for the Inquiry, and for your interest in appearing.

The purpose of the hearing is to assist me in gathering evidence for the Inquiry into Aeromedical Services in Western Australia. I'll start by introducing myself. My name is Marcus Kennedy, and I have been appointed by the Chief Health Officer, to undertake the Inquiry. And beside me, here, is Jonathan Clayson, who is the project - the Inquiry Project Director. I just need to remind you that the use of mobile phones and other recording devices is not permitted in this room, and if could you please make sure that your phone is on silent or switched off, which is for everybody.

This hearing is a formal procedure convened under part 15 of the Public Health Act 2016, so while you are not being asked to give evidence under oath or affirmation, it is important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that is false or misleading.

It's a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. I believe that you have previously been provided with the Inquiry's terms of reference, the Inquiry's current state considerations paper, a focused list of relevant considerations and information on giving evidence to the Inquiry.

So, before we begin, do you have any questions about today's hearing?

DUNCAN-SMITH, MR: No, thanks.

KENNEDY, DR: For the transcript, could I ask you to state your name and the capacity in which you are here today?

DUNCAN-SMITH, MR: Yes, Mark Duncan-Smith, AMA WA President.

KENNEDY, DR: Thank you.

You will now be invited to address the focused considerations list that's been provided to you, and you may speak to these matters for up to 15 or 20 minutes, if you require, and then, we can some - - -

DUNCAN-SMITH, MR: Sure.

KENNEDY, DR: - - - questions and discussion after that.

DUNCAN-SMITH, MR: Yes.

KENNEDY, DR: You are welcome to remove your mask, if you wish to, whilst speaking, for the purposes of - - -

DUNCAN-SMITH, MR: Thanks.

KENNEDY, DR: - - - fogging glasses and clarity of speech, and we'll try and take suitable precautions, generally.

Thank you, over to you.

DUNCAN-SMITH, MR: Thank you.

So, the Australian Medical Association is Western Australia's peak medical representative body and the only independent organisation acting on behalf of Western Australian doctors. We represent the views of WA's medical profession to the government, our community, and seek the resolution of major social and community health issues from a moral, ethical and medical perspective, with the interests of the patients and the people at the core of our engagement.

In the spirit of conciliation, AMA WA acknowledges the traditional custodians of the country throughout Australia and their connection to land, sea and community. We pay our respects to the elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Western Australia is entirely unique, in terms of its size, population distribution and geographical remoteness of many communities, as opposed to some of the other states and territories of Australia, with respect to aeromedical services. Many West Australians are reliant on aeromedical services to ensure their health and wellbeing, and services such as RFDS are integral to that.

AMA WA acknowledges the highly professional work being undertaken by doctors, nurses, pilots, engineers, in the delivery of aeromedical services in Western Australia. Just going through some of the considerations, certainly, from a clinical governance point of view, the - my understanding and readings of RFDS, with respect to their clinical governance, is that they've got overarching committees to ensure that appropriate and levels of experience are maintained and credentialed.

In some of the readings, there was a comment - which I can only assume was from someone that doesn't - possibly I shouldn't assume that, have a lot of understanding about aeromedical services. There was a comment that RFDS in WA was at risk of a failure with the PC 12 fleet, and that it would bring down aeromedical services in WA if that did occur, similar to the 737 Max.

Now, PC 12s were first introduced in South Australia, and used for five years there, without any significant problems, before they came to WA, and that was in about 2000. The 737 was not - it was a new airplane, it's got nothing to do with it, and I also draw - about comments about Ansett. I mean, Ansett would still be flying today if it didn't have so many types and different qualifications. It had no ability to integrate or change pilots from one type to another, and that basically brought down the company, because it had too many types of aircraft. So, there is a risk of going too far to the other extreme as well.

Sorry, one more note about their clinical governance - and again, note that RFDS is integrated in its approach to develop the Diploma of PHRM as well. One of the readings that I took from some of the notes was that there was a problem with different parties not being on the same page and the difference between the HSP and actually, the provider of the aeromedical services.

I mean, one extreme of this would be to say that a HSP - and certainly, in the readings, it would be suggested that it's WACHS, should be in charge of this, but I draw some of the recent

stuff about WACHS that it can't even supply Broome Hospital with adequate supplies of suture packs, dressing packs and about two weeks ago, Broome Hospital ran out urine bottles.

Now, to suggest that WACHS is somehow going to manage complex assets, pilots, engineering, maintenance, relationships with CASA, is bordered on ludicrous. A central control system for the aero retrieval, certainly, is logical, and it is my understanding that RFDS is already moving in that direction what is termed a, "Federated control centre", and certainly, that would seem a logical conclusion that would actually help with coordination, but also, maintain respect of each individual party's expertise.

There was also questions raised about closing the gap, and I mean, that gap could be closed tomorrow, with adequate funding. I mean, you know, if there was RFDS bases in any town with greater than a thousand head of population, then, we wouldn't have the problems of a gap at all. But there's an economic reality and a practical reality as well, but certainly, if it is considered that there is inadequate service that has holes in it, then one way to fill that gap is to increase the funding.

The other potential danger - and I don't really see it from the comments, but it's a similar comment about St John's Ambulance, in that Inquiry, is it because RFDS is an independent, not-for-profit organisation, it is a far, far, far more attractive proposal that it could gain donations from public and industry sectors. And the idea that a - and again, I don't know whether this has been proposed or not, but the idea that a government run RFDS type entity would attract the same sort of benevolent donations and attract the same sort of support from the community outside their taxes, I find, would be doubtful.

With WA compromising a third of the continent of Western Australia, there is no doubt that there is an absolute need for significant fixed wing assets and also, rotary wing assets, with complete difference in activity for the South West of Western Australia, for example, as opposed to the far North West, Kununurra, Halls Creek, Fitzroy Crossing - areas like that.

Agree - AMA agrees entirely that there should be an overarching WA State strategy for aeromedical services, and I find it hard to believe that there isn't one, and certainly, would suggest that, as a matter of priority for government, that that should be addressed. I think that the Inquiry or recommendations need to be set in light of what hopefully will be occurring this year for WA Heath, including mental health, which is - I called for a corporate governance review of WA Health early last year. The then Minister of Health agreed to that, and the new Minister of Health has also engaged and wants it as well. So that's been initiated, it should be happening in the first six months of this year.

So, there could be whole-scale changes to WA corporate governance and the way that healthcare delivery is delivered in this State, and I think that the - it would be advisable to give consideration to that with respect to future recommendations. It should be noted that WA Health, in the current structure, does not deliver any healthcare, but it has HSP boards and some CEO-led HSBs, but do deliver the healthcare. Other than the doctors, who are employed at WA Health, WA Health does not employ any other doctors, they're employed by the HSPs, and we have this absolutely absurd and ludicrous situation where the boards that currently exist don't even employ their CEO.

So there hopefully will be whole-scale change in the way WA Health is run. Hopefully, it will be flatter, better transparency, better lines of communication, better responsibility and better ability to address State-wide overarching policy and strategy, including aeromedical services.

And that was really all I had to offer, and happy to take questions or questions on notice, if there's more detail that you require.

KENNEDY, DR: Okay. Perhaps, if you could provide a little bit more insight into the proposals around WA corporate governance that you've spoken to there - if you have them - - -

DUNCAN-SMITH, MR: Sure.

KENNEDY, DR: - - - in terms of, you know, well, where that may end up and what it could look like it, what the goal is, really, of that reorganisation proposal?

DUNCAN-SMITH, MR: Sure. Look, it's actually - at the moment, the HSPs are either board-run or executive-run, at the discretion of the Minister. The Director-General of Health employs all the Chief Executive Officers, the boards do not employ their CEO, and as such, you have, obviously, potential for asymmetric information, asymmetric power, CEOs who answer to their employer, but not necessarily the board, and conflicts of interest that are clear and its corporate governance 101 that that is a system that is not the way it should be.

KENNEDY, DR: So can I just clarify that, because it's a little bit of a strange concept to me, I mean, there - what I would be more familiar with would be the board employing the CEO, the CEO answering to or being responsible to the board.

But having a relationship with the Department, from the point of view of policy and strategy frameworks and overarching requirements, so you're saying there's no relationship between the CEO of the HSPs and their board?

DUNCAN-SMITH, MR: From an employment point of view, no.

KENNEDY, DR: From a responsibility and performance point of - - -

DUNCAN-SMITH, MR: They - - -

KENNEDY, DR: - - - view, or - - -

DUNCAN-SMITH, MR: Well, they do - - -

KENNEDY, DR: Do they separate that in some funny way?

DUNCAN-SMITH, MR: Well, it's the - I don't know, I'm not on one of the boards, but there is no direct employment relationship between the board and the CEO.

KENNEDY, DR: But the board sets a strategy for the organisation within the Health Department's framework?

DUNCAN-SMITH, MR: It has to comply with overarching Health Department strategy - - -

KENNEDY, DR: Yes.

DUNCAN-SMITH, MR: - - - and policy, yes.

KENNEDY, DR: But the way it achieves the strategic goals of the Health Department is up to it, which it then instructs the CEO to facilitate, presumably?

DUNCAN-SMITH, MR: It does, but it doesn't employ the CEO. It has no direct power over the CEO. If it were - is not happy with CEO, it has to talk to DG.

KENNEDY, DR: Okay. Thanks. So where do you see this moving to - that and other aspects of that reorganisation that you'd be providing?

DUNCAN-SMITH, MR: Well, the other thing to keep in mind, as far as the HSP boards go, is they're skill-based appointments, they're appointments by the Minister, so there - it's just - well, it's ultimately not a skill-based appointment. So, all board chairs are appointed by the Minister or directors are appointed by the Minister or are dismissed by the Minister. So, it does result in also an incredibly tall bureaucracy, of which there's clear communication problems that occur as the information passes up the chain, and down the chain, for that matter.

So what I would like to see is a much more flatter system, a system whereby there is transparency, accountability, any decision coming out of WA Health should have a sponsor of the committee chairperson or the person making that decision, which currently does not happen. It's a black box situation, whereby decisions are made, and it is - people outside do not understand who made the decision or where it came from.

What we would like to see - which will be part of our submission, there should be a board in the system. It is - the system is too big for a DG to run, and the board - there's different models. Certainly, the model that I came to in my conclusions, was similar to Wesfarmers, which manage a budget three times the size of WA Health with one board, one group CEO and all the other boards are management boards, they're not boards as such.

KENNEDY, DR: Okay. And so, the implications for that, in terms of the aeromedical system - - -

DUNCAN-SMITH, MR: Well, for example, the - at the moment, let's say a patient's in Kalgoorlie, was going to be coming to Perth - and yes, that will involve WACHS, well, they could be going to East Metro - that's one HSP, South Metro, another HSP, and they're going to PCH, which is Child and Adolescent Health - it's another HSP, they could be North Metro, that's another HSP.

It gets even more complicated with psychiatry, because the Mental Health Commission gets all the money. They then purchase activity from the Director-General and so the psychiatry patients go through the Mental Health Commission, then, through into the HSPs.

And so, any overarching aeromedical strategy or policy is - it is intrinsically complicated by dealing with multiple HSPs.

KENNEDY, DR: That's - it's working across a competitive environment, which has the need to protect its own resource and flow requirements - - -

DUNCAN-SMITH, MR: Correct.

KENNEDY, DR: - - - and workloads et cetera?

DUNCAN-SMITH, MR: And typically, the HSPs act in silos, there - - -

KENNEDY, DR: Yes.

DUNCAN-SMITH, MR: - - - are duplications, inefficiencies - - -

KENNEDY, DR: So whether it's by wholesale reorganisation of the Health corporate governance system or another mechanism, from an aeromedical system point of view, are you suggesting that there needs to be some process, which we've talked about, in this, in place, which is a central coordination capability that makes sure that those things don't get in the way of good patient care and patient movement from where they are to where they need to be?

DUNCAN-SMITH, MR: Yes.

KENNEDY, DR: Okay. In terms of the workforce, do you see any particular issues or challenges in any of the materials that have been raised in the considerations paper?

DUNCAN-SMITH, MR: Yes, I think that the - from the point of view - given - again, given the distances involved, and the potential for clinical deterioration during a flight, then again, that the longer haul fixed wing type transportation, I think, the model that is used currently, with a doctor and a flight nurse is, I think, the preferred model.

KENNEDY, DR: Yes.

DUNCAN-SMITH, MR: It allows greater safety, flexibility, the ability to make changes and act in flight, that a paramedic would not be able to provide.

KENNEDY, DR: Okay. You talked in terms of the central coordination concept of RFDS moving or suggesting movement to a federated comms centre arrangement, what do you understand by that or mean by that?

DUNCAN-SMITH, MR: Well, my understanding is that it's already happening, to a degree, and that, for example, WACHS, St John's and RFDS are - - -

KENNEDY, DR: And the APTC?

DUNCAN-SMITH, MR: - - - in a co-located - - -

KENNEDY, DR: Yes.

DUNCAN-SMITH, MR: - - - area. I think that, again, the guidelines around exactly how that works and who has control of the assets, really, is where the subspecialty expertise of the aeromedical with RFDS, for example, really needs to be recognised. And it's - you know, it's a little bit like when we had the Bali bombings, we, very quickly, found out that you can't control a military asset. You can request, with great respect, and if they think it's appropriate, they will assist.

So, it's the same sort of concept that, really, there's RFDS that understand the aerial asset and its relationships, fatigue management, scheduling efficiencies of potential changes in flight plans so that you're not overflying someone and then flying back, for example. So it's all of those - that sort of expertise, I think, needs to be respected in that environment, but also, it's got to be coordinated and collaborative, so that ultimately, it is the patient's best interest that is served.

KENNEDY, DR: Yes, I would agree. So I think where you've described that it needs to be coordinated, that has two elements - correct me if you don't agree, that there's an element of collaborative work, so that's shared knowledge, shared visibility of situations, situational awareness in terms of the State and particular missions - so that kind of makes sense out of comms centre, but it also has a control point, at which decision-making must sit, in terms of occasions where decisions to this instead of do that, as opposed to - would otherwise need to be made, if there's a need for arbitration.

DUNCAN-SMITH, MR: And can I make one more comment about beds, because that was on the papers as well, currently, WA's medical system is - we started at the pandemic with the lowest number of beds per head of population of any state or territory in Australia. We started the pandemic with the lowest number of ICU beds of any state or territory per head of population.

We have had some increase in beds, so we might be second from the bottom now, but our hospitals - the tertiary hospitals are often a hundred - 105 per cent occupied, which is basically gridlock - bed lock. And again, some of the problems related to patient movement and transport is also very much related to that lack of capacity, and again, that isn't necessarily something that the aeromedical service has control over and nor would you expect it to, but it is something that can affect their efficiency, their ability to do things, possibly, as efficiently as they would want to, but they can't, because there's actually no beds, which can lead to this problem.

I know there was communication problems and this concept of having a, you know, a one-stop telephone number, but again, if it - if that's the wrong person you're calling, then, that could actually cause even more problems.

KENNEDY, DR: Yes, I understand what you're saying. And I mean, I think we have general input from across the State, in terms of the one-stop shop concept, when it comes to aeromedicine, that generally, people who are referring from austere environments don't need to have the same conversation 10 times and be trying to push their way into a destination, they need the system to pull the patient out of their setting. So I think that's understood.

The issue around bed numbers is obviously not solvable at an aeromedical perspective, but is exactly relevant, as you say, in terms of where do you go - you know, where's the destination? So yes, having systems to arbitrate that are important. You did raise, in talking about that coordination space, the concept of a federated environment, which is something that RFDS have talked about from - at different times. A federated environment is fundamentally one where the organisations that come together are autonomous, and - which are frequently in competition, although, broadly aligned, in terms of the goals for what they do.

Coordination centres in emergency systems tend to more command and control, in the aeromedical setting, you've got a situation where you need a bit of both, you need cooperation and collaboration, but you also need command and control to allow arbitration. The federated arrangement, where people come together as equal parties that have, basically, the same power in that setting, can you see any difficulties arising in that scenario, given that they may have, from time to time, quite different priorities?

DUNCAN-SMITH, MR: Yes, I think that there could be, and that's where I - there would have to be, I would've said, a clinician, who would be overarching.

KENNEDY, DR: Patient-focused?

DUNCAN-SMITH, MR: Correct, and also clinical prioritisation.

KENNEDY, DR: Yes.

DUNCAN-SMITH, MR: And again, not necessarily who's making the loudest noise about whose patient should be picked up first.

KENNEDY, DR: Yes, making sensible, informed, patient-focused decisions. Okay. I think, unless there's any - is there anything else that you wanted to raise from your perspective?

DUNCAN-SMITH, MR: No, I think that's pretty well it, and - thank you.

KENNEDY, DR: It's been a - thank you for a very considered presentation and a - the - and a very much systems perspective, in terms of the overarching State system, which, obviously, the aeromedical world needs to work and live within. So again, thank you for your attendance today at this hearing, and a transcript of the hearing will be sent to you, so that you can correct any minor factual errors before it's placed on the public record.

You'll need to return that transcript to us within 10 days of the date of the covering letter or email, otherwise, it will be deemed to be correct. And while you cannot amend your evidence, if you would like to explain particular points in the transcript in more detail or present further information to qualify that, you can provide this as an addition to your submission to the Inquiry when you return the transcript.

So once again, thank you very much for your time today and for your input into the Inquiry.

DUNCAN-SMITH, MR: Thank you.

KENNEDY, DR: Thank you.

DUNCAN-SMITH, MR: Thanks for doing it.

KENNEDY, DR: Thank you.