Michael FORWOOD

This is George Lewkowicz for the Don Dunstan Foundation’s Don Dunstan Oral History Project interviewing Mr Michael Forwood about his time in the Premier’s Department in the ’70s and later on in the health area, including in the early Health Commission. The date today is the 6th October 2009 and the location of the interview is the Malaysian Room at the University of Adelaide, 230 North Terrace.

Michael, thanks very much for doing this interview for the oral history project. Can you just talk a bit about yourself, some of the education and employment background you had, and then how you got into the Committee Secretariat, I think was your first public service job?

It was just about my first real job, George. Just a quick bio: I was born in 1948 in Adelaide, my family were fairly well-off and I had a privileged upbringing. I went to St Peter’s College in primary school and to boarding school in Victoria to Geelong Grammar School in 1959, and I went through to year 12/13 as was one’s wont in those days at Geelong Grammar and then went to Melbourne University, Trinity College, to do a combined law/arts degree. After four years I’d done half the Law degree and an honours year in Arts and needed to take a break; that was in 1971, early 1971. I went to Western Australia, where I had a mate working in a mine just out of Port Hedland, and was involved in a significant industrial accident – broke thirteen bones – and spent six days on the critical list in Port Hedland Hospital before being dispatched to Adelaide but was taken off the flight by a medical team in Perth where I spent another 10 days before flying on to Adelaide and The Queen Elizabeth Hospital. So it was sort of a life-and-death thing. I’m not sure that it (my near-death experience!) made a great difference to my outlook, but it slowed me down. That brought me back to Adelaide and, as I steadily recuperated, it was about halfway through the year and I needed to find something to do until Uni resumed in the following March. So I put in job applications all over the place including general applications to the State and Commonwealth public services. Fairly quickly I obtained a "special projects" job at John Martin’s, the local Rundle Street retailer, preparing them for ‘metrication’, as they called it – ie introduction of the metric system to replace imperial measurements – and I worked there for about six months.
until I received a phone call inviting me to an interview for a position in the Premier's Department. The call was from a Dr Neville Hicks, who was the Principal Research Officer for the Committee of Enquiry into Health Services in South Australia, alias the Bright Committee (after its chairman Mr Justice Bright a Supreme Court judge). What was I thinking? Well, at that stage of my life, because I hadn’t finished uni, I hadn’t thought terribly hard about what I wanted to do, but I was very much of a mind not to practise law. I was uncomfortable with a number of issues about our justice system and didn't fancy representing people who I didn’t want to represent: - these were moral issues for some and not for others, because the adversary system - that is the basis of the legal system in Australia - requires excellent representation for both parties if just outcomes are to be achieved. So I didn’t think I was going to practise law. When I was offered the position, there were two going. I accepted it because I was interested in social policy, politics and social justice and I had a great admiration for Premier Dunstan. The job I just really loved from day one. The original appointment (I vaguely recall) was until the completion of the enquiry report which was expected to be in around eight to nine months. However it turned out to be somewhat longer and my role with the committee changed as others left and I became more experienced.

What was the Committee Secretariat? It was located in the Premier’s Department?

The Committee Secretariat was established within the Premier’s Department to support the expert committee reviews that Dunstan had in mind to lay the foundations for public administration reform in key areas of State Government responsibility – namely Education, Health and the Environment and, somewhat later, his vision for a new ultra-progressive satellite city on the River Murray not far from Adelaide (the so-called Murray New Town - later Monarto). The Secretariat was located in the Adelaide Steamship Company building at 17 Currie Street, Adelaide and a comfortable distance from the main State Administration Building in Victoria
Square where the rest of the Policy Division was situated on the ninth to eleventh floors. But we were parked out there and I’m not entirely sure what specific major inquiries had been completed but, when I came in, my recollection is that the Committee of Enquiry into the Environment, (Professor Jordan’s Committee) was nearly finished and the Committee of Enquiry into Health Services was in full flight. I think it was intended to be somewhat shorter than it actually turned out to be, I think that they were meant to be finishing about the end of ’71 or early ’72 and the recruitment of the additional research and project people was because they had a better feel for how many outstanding issues and how much original research and thinking needed to be done to do the job properly -- and it was clearly going to need more staff and resources.

As I said earlier my understanding is that Premier Dunstan had selected a number of areas where he felt there could be exciting and demonstrable changes in the basic institutional fabric of the State. Education, (the Karmel Report) was the first of his major reviews, and he brought in people of great intelligence and commitment to social reform and at a much higher level than I think a lot of government inquiries used to operate in those days. The Dunstan approach involved high-calibre academics and others in public life who were strategic and visionary thinkers backed up by teams of people who had some brains. I think it was the forerunner of what was to come in policy development and planning; a demonstration that Dunstan was considerably ahead of his time. We were talking about the ‘youngies’ earlier on; I think there was a place for us in that, George!

**Interesting. And how many of you were there in the Committee Secretariat?**

All up about seven or eight, as I recall. There was the Committee Secretary, Henry James, who was the administrative head of the Secretariat, and then a research team dedicated to the Health Enquiry Committee including Dr Neville Hicks, Helen
Parsons and myself, and a couple of people who were in what would have then been called a secretarial pool who were doing typing, filing and admin and so on for all of the committees. We were later joined by a young lawyer, a social worker and a numbers person -- all on a part-time basis.

From different disciplines, if you like? Helen Parsons, was she a lawyer?

No, Helen was a BA Hons – first class, I think – and I think she had majored in History and English. Neville Hicks, Neville was very bright and extremely articulate with a background in history, sociology and demography. I think that Mrs Wheaton had a teaching or social work background, she was part-time, later on. Christine Elstob, a recently graduated lawyer, came in near the end I think to work mainly on the dental chapter.

In the prompt questions for this interview there’s a question about how we worked together: we actually were fairly independent. Initially Neville set us particular areas to work on. At the beginning I was involved in a survey of non-government agencies; medical workforce data collection and analysis; and researching and writing discussion papers for consideration by the committee in areas such as services for the elderly and domiciliary care and drugs and alcohol. As time progressed and different members of the committee were assigned to writing particular chapters of the report, the research staff became increasingly involved in finding answers for committee members on specific questions and in assisting in the drafting. At this stage the report was starting to take shape and the enquiry committee’s policy stance in some areas was quite well-advanced, though in others much less so, and so we were just sort of tasked to particular things and got on with it. Apart from talking to each other and giving each other support and advice we were not really required to work as a team, it was rather more a group of individuals that gave support to each other.
And this was structured by the terms of reference, presumably, although sometimes people veer off those.

Well, the terms of reference were very broad, which reflects the very strategic approach that the Premier and his advisers took to it. The review was quite comprehensive with no prescribed outcomes and the committee report ended up a substantial document of over 450 pages 17 chapters and 14 appendices. The report was structured to cover a broad canvas of health and disability services including public and environmental health, community health, hospitals, mental and dental health, drugs and alcohol, and disability. It also, necessarily, addressed organisation structures, inter-sector relations and medical and nursing workforce issues. Although I wasn't present when it happened, my guess is that the committee as a whole, under the leadership of Justice Bright, agreed on the underpinning values and then jointly designed a broad framework for the report before assigning chapters to particular members to draft as per their areas of expertise and interest. All of this was within a very clearly and strongly articulated statement of values namely Humanity, Imagination, Universality, and Economy.

Members of the research staff didn’t attend many of the enquiry committee meetings except to present our research and discussion papers and to answer questions on these. However Neville Hicks stayed there the whole time as did the Committee Secretary, Henry James, although his role was clearly limited to ensuring that the administrative side of things ran smoothly. I don’t think he ever made any contribution to the deliberations of the committee. So the main drivers were the Chairman Justice Bright and Principal Research Officer Neville Hicks.

And when you did attend the committee, if you could talk about it – presumably later on; you mentioned earlier on you only went when you had something to say about your particular piece of research; but later on you went for full meetings?

Well, later on, throughout most of 1972 –after Neville moved off to his full-time university job - I was the only full-time member of the research team who remained,
so from then on I was working directly to the Chairman, to Charles Bright, to get the report written and to tidy up the appendices. This role involved writing up most of the research that hadn’t been completed, proof-reading, editing, reconciling differences in style and content between earlier and later chapters of the report and giving him advice. By this time the full committee only met on rare occasions though I imagine that draft materials were widely and frequently distributed. So I didn't meet often with the full committee, I attended to the matters to which the chairman directed me. My recollection is that in those last six months or so before publication the committee didn’t actually meet as a committee very often. A lot of the material had been written – I think it was written, or most of it was written, particular bits, by members of the committee. Like Dr David Game I imagine had quite a lot to do with the medical issues and medical manpower, and Professor Ray Brown and others would have been actively involved in the community health, public health, social health issues; and I think the way the report was put together was they agreed on an overall structure and then people did the primary drafts of things and then Charlie Bright worked on a lot of it himself. And the last bit to come in – I remember this was why it seemed to be running over time – were the organisational and administrative issues, and Peter Owens, who was the managing director I think of *The Advertiser*, had the principal carriage of that and that was the last piece of the jigsaw to come together.

The chapter headings tended, as I said before, to cover everything in the terms of reference but they weren’t structured around the set of the terms of reference; they took more the shape of what a health system looks like from cradle to grave, from primary health through to acute health and then picked up intellectual disability, mental health and aged care and other population and functional areas.

*Just when I was doing some research on the enquiry, the terms of reference seemed pretty extensive. I was just wondering whether you had a feel for why it*
Interviewee would like to be notified in the event that anyone wishes to quote the transcript in a written publication or interview.

was set up in that way. It seemed to be a total revamp, or look at a total revamp, of the whole health area. Was it to you simply an area that the Government through the Karmel Report had had the education area looked at comprehensively and now it was the other big expenditure area, the health area, and a highly-important area for the community? Did you get a sense of there were particular things that the Government wanted looked at or was it a sense of we needed just to look at the health area, anyway.

No, most of my sense of what the Committee of Enquiry was doing came from the Chairman and from Neville Hicks as the principal research officer. The first discussions, I think, about setting up the committee were in 1969 and then it took a while to establish, to recruit the people that they wanted. But, as I said earlier, I think the Premier had a passion for public administration reform and a clear sense that there was much to be done to humanise, modernise and strengthen health and human services in this state. I doubt that he had any personal convictions about how to undertake the task or about what the outcome should be. But he would have been conscious that it was a complex area jurisdictionally - the Commonwealth had some roles or responsibilities, the State had some, local government had a role; non-government agencies were also major stakeholders, and there was a significant contribution of country communities that had set up their own hospitals that had for many years been independent of government funding. It was complex and messy to the point of being dysfunctional. Within the hospital sector there were four major metropolitan government hospitals (the Royal Adelaide, The Queen Elizabeth, Modbury and Lyell McEwin) and Flinders Medical Centre was just in the pipeline. There were two teaching hospitals founded by public subscription that were incorporated under the Associations Incorporation Act (the Adelaide Children’s Hospital and the Queen Victoria Hospital) that had been set up as not-for-profit organisations in the late nineteenth century and their governance was different and their ability – or their willingness, I think – to collaborate and work with the Government within a policy and planning framework was different to the Royal Adelaide and other government hospitals. Four regional country hospitals were
government hospitals (Whyalla, Port Augusta, Port Pirie, and Mount Gambier) but the vast majority of country hospitals were community hospitals. So whichever way you looked at health it was messy - legally and administratively: it was complicated, it was uncoordinated.

The Premier and his advisors would have known about many exciting developments and new directions in health services in Europe and North America in areas such as public and environmental health, community health, women’s health and even policy planning and hospital administration. I doubt whether there would have been more than a handful of senior and experienced people in the public health sector and academia with a knowledge of such things and a commitment to reform. The SA health system at the time would have been dominated by fairly limited and conservative hospital and medical administrators with a small number of reformers headed by the highly intelligent and astute Director General of Medical Services, Dr Brian Shea.

So there was a lot that needed to be done. Also, as you say, health care was very expensive for the State, and I just think the Premier had a feeling that it could be done much, much better but the way to get there was not by incremental reform but designing a whole new system.

Yes, it’s interesting. And can you remember any of the demographics, were they starting to feature at all, like the age structure, like the issues now?

I had a glance at the Report this morning and flipped through the chapters and just had a quick scan, and it is remarkable the extent to which it’s both ahead of its time and was quickly and aggressively picking up on the new trends and themes. There is a whole chapter on ageing. Dr Peter Last, who was head of health research in the first Health Commission, but who was around at the time and would have been talking to the Director-General of Hospitals and Mental Health Services, would have been among the first in the world to start talking about the ratio of the number of
people who would be in employment as opposed to those who would be retirees – issues which didn’t get picked up effectively by government for another twenty years. And there’s a chapter on that in the report. Justice Bright himself had a very strong personal interest, I'm not sure why, in intellectual and physical disability and was an incredibly humane man and committed to social reform, and the language around the principles underpinning a health and human services system. I mean it is terrific stuff.

Interesting. What was your sense of the four hospitals you mentioned, the public ones are all in the city; then you mention others and presumably they were – the two other big ones were not-for-profit, then you have a lot of others, including in the country, which were some local government, some self-incorporated through whatever community group – – –.

Yes, the country regional hospitals at Port Augusta, Whyalla, Mount Gambier and Port Pirie were all government hospitals, so there were eight government hospitals. But everything else in the country was really a community hospital. These received State Government recurrent funding but were incorporated under the Associations Incorporation Act and in many respects were independent from the government in terms of who they employed and how they operated. Many of the country hospitals were very small and not really viable. But their local communities were represented on their boards, their communities raised considerable funds for capital equipment, buildings and renovations and many were fiercely independent of government direction. With the introduction of the new national health system arrangements by Dr Neal Blewett under the Whitlam Government, things changed. Most of the country hospitals were absorbed into the state health system with a long-term agenda to abolish their individual hospital boards, and went private to avoid this fate. You’ve got to smile. But in the 1960s and 70s (and prior to that) hospitals, particularly country hospitals, were really doctors’ workshops. The majority of doctors were altruistic and highly ethical people, but the administrative side of things was often managed by a local part-time officer – you know, a person who might be a bank clerk, shop owner or retired police officer. They
were really just doing the books and counting the patients and doing the stats and stuff, and all of that was on the beginning of a whole revolution, because of the cost of health care, in hospital management.

There was very little systematic policy and planning. A major thrust of the Bright Report was that you needed to understand what was happening with the population, with trends in medical care, you need to plan linkages between community-based and acute services in terms of admission and discharge in order to get the best outcome for patients and to save money, because the most expensive thing was continuing to occupy a hospital bed with all the nurses and doctors and the infrastructure around that, and there was precious little of anything like that in the early ’70s, anywhere.

So your observations of the way the committee worked, you had these differing people from different backgrounds, probably different agendas given their interests, and I’ll come to the Health Commission later on and how that was structured in its three full-time and I think five part-time commissioners, which was an interesting –

Hybrid.

– hybrid, yes.

And not what was recommended by the Bright Committee.

I see, right. So how did you observe the committee working? Charlie Bright was the chair – – –.

I think the dynamics of the committee were pretty good, actually. As far as I was able to observe the committee contained an excellent spread of interests and expertise and I was not aware of any conflict between them, except possibly in relation to be organisational and administrative arrangements proposed by Peter Owens. This chapter was the last to be completed and distributed to the committee and by this time the committee was pretty well dispersed. I'm not sure what the problem was -- whether it was to do with its lateness or whether it was more to do with its content -- but there was quite a lot of "discussion" behind closed doors for
some weeks. Judging from the key parties’ demeanours, that I noticed from time to time, there was some real disagreement. Apart from that I think there was genuine agreement on the report and its recommendations. And I think the committee members worked well together and were of one mind. As I said before they were chosen for the different skills and experience and in the main had complementary rather than overlapping interests. They were also, I think, polite gentlefolk with good manners, who were proud of being asked to undertake this task, and who are bound together by this common enterprise. When you talked about tension and conflict, one might have thought that the people with the business and administration backgrounds might be at odds with people with medical and social health backgrounds, and I don’t think that was the case, no.

They all wanted a better planned, better organised and coordinated and more humane system. So yes, so they worked well together. How it panned out afterwards, of course, is slightly different.

**So in the framing of the recommendations, were you heavily-involved in those at all?**

No. I’ve got a feeling that, apart from the organisational structure, most of the values, new policy directions, and the framework of the report - as well as the impending recommendations - were well down the track before I graduated in from being a lackey research officer into the key Principal Research Officer/committee adviser role that I occupied during the second half of 1972.

**And did you get any sense of who was more influential or what particular submissions might have been more influential, from whatever groups there might be?**

No . . . . and I’ve considered this from several different perspectives. One of my first projects was a survey of voluntary organisations. What I know from that is that there was a number who didn’t want to talk to us or see the point in it and my instructions
were just to keep being civil to them and to keep going back and saying that the number of people who hadn’t made a submission or who hadn’t talked to us was an ever-shortening list and they were one of the few that were remaining on it. I think we only ended up with two or three organisations that neither completed the survey nor met with me for an interview. Justice Bright was a very courteous man and I suppose his approach flowed through to the research staff about how to do that. He was very consultative and keen for us to contact and gain input from everyone with a legitimate interest.

Also I didn’t have any sense that the industrial/political arms of organisations like the Royal Nursing Federation or the AMA were trying to pull strings and influence outcomes. I was pretty new to this kind of a project and very focused on the specific tasks I was assigned to, but I was reflecting on it all this morning. I never had any sense that there was party political opposition or organised resistance from any quarter. Also I am not aware of any strong reaction against the report or its recommendations after it was released. As you may recall I stayed on in the Committee Secretariat in the Premier's Department, Policy Division from 1973 to 1977 when I went into the newly formed South Australian Health Commission. And during that time I continued to represent the Premier's Department on the various committees established to consider the Bright Report recommendations and prepare for implementation. So I think I would have known of any concerted moves against the report as a whole, or particular recommendations. Furthermore I went virtually straight into the Health Commission in 1977 after it was formed and worked alongside many people, both in government and outside it, who had an interest at the time of the Enquiry. Broadly speaking I don't recall any adverse reaction or resistance until we got into detailed drafting of the new legislation and design of the organisation structure. The first serious reactions occurred when it became apparent who would be the winners and losers in terms of the redistribution of power within the system.
In summary from 1973 onwards I met a lot of people who had made submissions to the enquiry and, indeed, I worked with many of them. Generally they supported the vision of trying to draw together all the disparate services and interests within a new coordinated, integrated and policy-driven health framework, and that largely happened. So I got to meet lots of people and my feeling was that for most people this was a little bit of a side issue at the time of the enquiry and immediately after, that it was not a politically-charged exercise at any level, and that there were not strong competing interests who were thrashing it out and trying to influence the judge and his committee. I think there’d been so little of this kind of major intellectual and social reforming activity in South Australia or elsewhere in Australia that people were simply getting on with their jobs and largely cooperating when asked to express an opinion or provide information, apart from those who kind of had a built-in resistance to anything to do with the public sector or the public service or this particular reforming government, although I didn’t come across any of the Dunstan haters and there were not a few of these in South Australia at the time.

Interesting, yes. And you didn’t get any sense of – or did you? – of any political directions coming through, apart from ‘Have a good look at this’?

No, I didn’t. Perhaps I wasn't close enough to the real action (if there was any) during the term of the enquiry in 1971 and 72; but during the time that I was more involved and engaged I didn't pick up any of this. With regard to the organisational arrangements that involved the amalgamation of the Department of Public Health with the Hospitals Department and its Mental Health Division under the new South Australian Health Commission, and there was definitely a scrap. My understanding is that Dr Woodruff who was the Director General of Public Health did his utmost to resist the amalgamation. But that was considerably later in the piece.

And the terms of reference, of course.
No, I think if you look at the terms of reference they are genuine and broad and non-directive. As we both know it's often the case that terms of reference are crafted to include, or exclude, particular political agenda. They can mandate or restrict or exclude. That's certainly not the case here, these are so broad that the only reasonable conclusion can be that Premier Dunstan simply wanted the necessary reforms to achieve the best health system in Australia (and quite possibly in the world)! He was a man of great vision and I think he had faith in this committee to do the job: this really is an invitation to a high level expert committee to design a better system, I think.

What about the Commonwealth? They would have been interested, but did they -- --?

No, not much interested.

Not much interested, right.

No. I remember ringing them on a number of matters and there was very little interest in our enquiry. I think in the early 1970s that Health was very much in the States’ domain (a state responsibility under section 51 of the Australian Constitution’s division of responsibilities between the Commonwealth and states) and that they considered this almost entirely a State matter at the time of the enquiry ie 1969 to the end of 1972. But it certainly did change soon after that with the Whitlam reforms and the introduction of Medibank.

So I guess later on, when the funding programs were discussed in a bit more detail, and they might have been at the time, they got a bit more interested – like the Commonwealth/State agreements.

Well, the report really is a report on the issues to be faced in the coming twenty years, where we were at the time and the kind of organisation structures and skills that were needed in the head office and regions and so on to make it operate. Looking back at the report indicates that there was precious little on funding and
future funding requirements - which is a bit of a surprise. The report doesn’t go into
‘This is how much is being spent, this is how much more is required’. It didn’t get
into funding programs. Part of the background that was acknowledged, was that
there were jurisdictional exclusions and overlaps, but it didn’t make clear statements
like ‘Commonwealth should hand over responsibility for domiciliary care or aged
care to the State’ or that funding in such-and-such an area should be increased. It
wasn’t that kind of report.

There were a lot of kind of suggestions and recommendations that were implicit
and explicit in the report but they were not listed out as recommendation 1, 2, 3, and
I looked this morning at the conclusion, which is interesting. It says, ‘There’s a lot
of material in here . . . certain things have to happen if the rest is to be enabled and to
take place over a period of time, but that whatever you design needs to reflect the
four principles of humanity, imagination, universality, economy’, and that was a
really Charlie Bright-type statement.

Yes. Interesting. So the report was written and I guess went through the political
process, the Cabinet process, of submissions – and, maybe even before that, was it
written with the recommendations intended to go straight through, or was it
written for public comment again?

It was definitely a public document. There were hard-cover copies, red cloth
covering – very impressive -- and a pretty large run of soft copies that were sent to
all and sundry. I’ve got a feeling that we printed a couple of thousand copies, I don’t
know where that’s come from. I couldn’t confirm that. And the last I saw of it was
when it came back from the publisher and I had to take a copy down to Parliament
House and I had to do various other things to assist with its release and public
distribution, but I don’t recall a covering submission. I wonder – there’s a copy of a
ten-line letter from the Chair of the Committee to the Premier that’s bound into the
report; I imagine that he would have met when he handed it over, but I don’t
remember a whole lot of Cabinet submissions or anything like that. It was front page
news in The Advertiser and The News but I don't recall for how long there was public interest. I don't remember their being an invitation to interested parties to make further submissions. It seemed to disappear into a hole for a while and then, all of a sudden, in late 1974 or early 75 I think, a high level steering committee and representative interdepartmental planning committee were established to start organisational design, and implementation planning consistent with the broad thrust of the report and to prepare a brief for Parliamentary Counsel to draft Health Commission Bill.

**Okay. So when did you reconnect with the aftermath of the enquiry?**

Well, I was asked to stay on because I was thinking of going overseas for further studies and I’d become really engrossed in and excited by health and health reform. Hardly anyone ever starts, in their first position, at a time like that in a department like that with a government led by a man like Premier Dunstan. I hadn't really ever imagined being in the public service during my university days but I really did love my involvement with the health enquiry and working in the Premier's Department during the Dunstan era. They were very exciting times; and the more informed and the more passionate you were about whatever your particular field was, the more seriously you were taken and listened to. I got really engrossed in health reform. And then they sort of said, ‘Well, look, if you’d like to stay on in the department there’ll be some other things in the meantime and then, when we get back to it, we would like to involve you further’, and then I don’t think anything much happened for twelve months. I haven’t checked diaries and notes, but it was a long time. I got involved in some other things. And then, after a good period, the next thing that I knew was that a steering committee was being formed to start designing the structure and pulling it together, getting ready for the enabling legislation, and that would be supported by a project or planning team and I was the Premier's Department nominee on that.
I see, right. So what was your role with that, then?

(laughs) Well, we were funny little bunnies in those days. As I said I was the Premier’s Department representative on the Planning Committee, which was chaired by the Commonwealth Public Service Commissioner in South Australia, a man called Cruickshanks, and they’d clearly chosen the most forward-looking and the smartest people around the departments to be on the committee.

So it had representatives from the Mental Health Division, the Hospitals Department and the Public Health Department, ie the three entities that were to be amalgamated into a new entity called the South Australian Health Commission. This was to be a statutory authority, not a traditional government department, and therefore slightly outside the normal accountabilities of the State public service. Mr Justice Bright felt strongly on this matter -- that it would not be possible to coordinate State Government services with non-government and community hospitals and health services through a traditional government department.

The steering committee comprised the heads of a number of State government departments including Premier and Cabinet, Hospitals, Public Health and I think the Public Service Board (but I don't remember Treasury representation). The Director-General of Medical Services was Dr Brian Shea, (head of the Mental Health Division and Hospitals Department) and Dr Phil Woodroffe was the head of Public Health Department. Bob Bakewell was the head of Premier and Cabinet.

The planning committee included a wonderful bloke called Dr Bill Symes, who had a public health background - a very able and open-minded person; Dr David Roder a qualified dentist with a strong interest and expertise in health statistics and epidemiology (ie the origins of disease, the natural history of diseases and so on); and Dr Peter Last, who had a very fine mind (and a perfectly retentive memory) who was interested in all things medical and to do with health. They were the main three
that I dealt with. There must have been finance and admin people as well, but their names don't come to mind. Which says something about me, I suspect.

So the Planning Committee was mainly "domain experts" from the various health departments and me from Premier and Cabinet. It was chaired by the Commonwealth Public Service Commissioner in South Australia. He attended the steering committee meetings, but I'm not sure if he was a member of that committee. I was invited to attend one or two steering committee meetings generally because I was frequently at odds with Mr Cruickshanks’ ideas and agenda. That was when I first met Dr Brian Shea who was to become the first chairman of the South Australian Health Commission.

**When did Bob Bakewell get involved?**

I imagine that he was heavily involved in setting up the steering committee -- and perhaps also the planning committee -- but the first involvement that I know of for certain was his role on the steering committee. I’m pretty sure that committee comprised Bakewell, Brian Shea and Cruickshanks and then, when you mentioned Dr Keith Wilson, I reckon that – though I’m not sure - that it started off with Dr Woodroffe from Public Health on the steering committee and that he later resigned and was replaced by his deputy Keith Wilson., Dr Woodroffe went some time before the Commission was created, but I’m not sure if he was the person who sat on the steering committee representing that part or not.

But it was the Steering Committee that I think, George, was the – well, I was going to say the ‘stumbling block’ – in accepting the recommendation in the Bright Committee for a five-part-time-person authority with a full-time Director-General. I don’t know where it came from, but our guess was that Brian Shea, who was a very, very able administrator and a very progressive one as well, (so it wasn’t like he was a liability to the drift of the report in terms of services and programs), was not prepared
to accept the role of Director General of the Commission reporting to a part-time authority; he wanted to be on the authority as a full-time member and the D-G, and that was where it ended up: with three full-time and five part-time commissioners. The five part-timers came out of, I think, a compromise and concession to the Bright Report, (and I think to Justice Bright himself who I believe was in there arguing vigorously for the structures that he had recommended). I believe his view was that it was important to have people with a degree of detachment from management and administration of the system and from different backgrounds – you know, it was about connecting all the different parts of health and human services and the ability to think freely with regard to policy and strategic planning.

So what did you do as part of that planning group?

We did more number-crunching. ‘This is what the dental service looks like now; if this is where we want to take it – – – then, - - -.’ We were frequently looking into the implications of the general principles and the drift of the recommendations in the Bright Report but we weren’t told to slavishly follow them. But, as I said earlier, it hadn’t been written with a whole lot of specific recommendations that you had to accept, reject, or vary. It was much more a matter of ‘What do you have to do to create this different kind of new coordinated and integrated system to replace the current fragmented one?’ We were coming from a highly-fragmented system with no policy and planning and research capability and we were moving into an evidence-based, policy focused system within which people with a reasonable amount of devolved authority and responsibility would be working towards common ends and have some mechanisms for linking, that was what we were trying to design.

And the Public Service Commissioner, who chaired it, he and I had some disagreements. At times I really felt like I was carrying the torch for the Bright vision on the project committee, and to the extent that it looked like it was going to be significantly compromised, although I wasn’t the most senior person there, it was
Michael FORWOOD

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up to me to fight for the Bright view of things. I had a bit of fun speaking up. But it wasn’t always fun. (laughs)

Did you have instructions from anybody?

No, no, I didn’t.

Did you report back to anybody?

I used to report back to the head of the Committee Secretariat—by then Henry James had gone . . . and – who was it? –

Brian Hill?

– Brian Hill had come in, and I let him know if I thought there were any issues that might come up as a result of discussions or disagreements. Not that there were that many, and they were mainly again about organisation structures. There wasn’t much debate about linking hospital to community health, having more community health services, special population health programs, those sorts of things.

Interesting. And was that group also working on the – not so much the Parliamentary Counsel’s work on the legislation, but the instructions for the Parliamentary Counsel?

Yes, we did– I don’t know how we came to do it in the form that we did it. I think we must have been advised by somebody from the Parliamentary Counsel area what they needed in terms of a brief, and then we worked on I think two or three versions of what they were proposing to put forward. I remember working through first and second drafts of the Bill both as a committee and in the presence of Parliamentary Counsel and I remember assisting with the second reading speech. I think I did that on my own -- as a member of the Premier's Department -- and not as the planning committee. I recall that we undertook some pretty heavy editing of the draft legislation before it was submitted to Parliament
Michael FORWOOD

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Wasn’t some medical bod out somewhere in the system doing it that you’re aware of?

No, I don’t think so.

That’s interesting. Just this debate about the new body, the Health Commission, and its role, and you mentioned earlier on the fragmentation and so its role was one of coordination at this very high level, at the same time, from my reading of the report, there was discussion about devolution and I was just wondering whether there was any debate in your group about how best that might work.

Well, that was one of the issues that we discussed quite a bit – and I was in strong disagreement with our Chair, Mr Cruickshanks. I thought he had very rigid views about administrative control whereas one of the major thrusts in the Bright Report was devolution of responsibility (to allow flexibility at decision points and at the point of service delivery) within clearly defined policy and planning guidelines. The Chairman of the planning committee was not sympathetic to this view. I think I had the support of most of the people from within Health, but not many of them had been – and I hadn’t either, to that point – much involved in this kind of organisational review and change, and I’d fairly quickly developed a view that when you looked at structures it was important for them to be enabling of what you wanted to achieve and that when you’re looking at what you had, when you were revising that, you could quite often see what the barriers were to doing sensible things. And so organisational design was partly a matter of designing new enablers and partly a matter of removing the barriers.

But there were some people who were looking to have a much more directive and controlling kind of structure and management approach than Bright had in mind and, while there’s quite a lot about detailed positions and how they related to each other and so on, I think his vision was that if you get everyone locked into the sorts of things that needed to be done you needed to have quite extensive devolution at each level and down to the local level, and actually doing things in order to get the best outcomes. But the eight government hospitals had actually had all their effective
administration done out of the department. So whether they were Whyalla, Port Augusta or the Royal Adelaide it had to go through the department to get an approval for a new position. We were constantly hearing that it took two years to get a new clerk or that if you had a clinician who wanted to work other than as a salaried clinician or in some well-understood traditional capacity that it was hard to do. But everyone in Health thought they were different and there were many differences to some other government departments, but there were others who were looking at it and saying, ‘Well, these things aren’t as different as people say’. And I think there was an awareness – and maybe it was part of the delay earlier on – that Bright was adamant that the health authority should not be a traditional government department but should be within the public sector. I know there were discussions about freeing up and having more flexible employment arrangements and the fear that salaries would run away and stuff like that, and they were difficult. But the belief was that this huge amount of voluntary work and the Commonwealth’s relationship with the State and all the high-order relationships between the component parts, sector components, weren’t going to work if it was a Health Department and not everyone was sure about and comfortable with going that far.

And the idea of steering and rowing, as it came up later on, wasn’t really in vogue then, but you get this sense of the Commission, that it ought to have this high-level policy and planning role and the detail – like the detailed staffing, the detailed funding, once the budgets had been sorted out – handed over to the operating areas. You’ve talked a bit about that, but was that the sort of foment going on about how we set this up and how we really get it working?

Yes, that is pretty close to the mark. But, just as an aside, I think on the small-p politics side of it you had the Queen Victoria Hospital and the Adelaide Children’s Hospital both thinking they were going to be losing power and independence, although it was a commission, a statutory authority, not a department. And I think that people in senior administration, both medical and lay, in the government hospitals would have been thinking that when they got a board of their own they
would have had a significant devolution of management and administration which would make them much more effective and flexible and able to deliver services. So there were going to be some winners and losers, I think.

**But some sort of a standard model, if you like, of the Commission, and then was it incorporated bodies, the others?**

Yes. The eight government hospitals weren’t legally incorporated prior to the creation of the health commission and they became incorporated under the Health Commission Act and given their own boards. That all took a couple of years. And then I think the process kind of got away from people a bit and they started incorporating two- or three-person community health centres and there were more and more things that kept appearing under the schedules, so they went from having a or a hundred and something-or-other hospitals, which included – the country hospitals that were all incorporated under the *Associations Incorporation Act* - and they were trying to bring them into the fold of the Health Commission Act, which was largely done by funding agreements and things. And then I think what happened was they went too far down the track of local autonomy, because there were too many small bodies, and the bit in the middle, which were the regions which had been created, which were meant to be pulling it together, they didn’t have enough legislative power. They were conceptually okay. But they weren’t strong and the centre kind of remained strong and the periphery proliferated and became more independent and the task of actually coordinating it, apart from the work that was going on in research, policy and planning, wasn’t effective.

**Interesting. Were there any other things going on before we get into the phase of the Commission being actually set up that you can recall?**

No, not that I’m aware of, no. Except that I should point out that what I was referring to above -- the incorporation of a large number of existing entities (ie country hospitals) and new entities (ie the new community health centres and services) -- was all happening in the first year or two of the new Health Commission.
So the Commission was finally established, my notes say by statute in December 1976, and they had a pretty broad role. I won’t go into all of those. But you mentioned earlier on one of the reasons for the establishment of the Commission at arm’s length, if you like, that’s not a department but a separate statutory body, was to get the voluntary organisations a bit more comfortable with the notion of working with a government body. How did that work in the end – – –?

And I think also doctors –

And doctors, right.

– and other bits that were independent or funded on a fee-for-service basis by the Commonwealth, a lot of them weren’t keen to have anything to do with a department -- and not sure that they were that much keener to have anything to do with the statutory authority, i.e. the Health Commission.

Can you remember how that worked initially? You were a member of the Planning Division – – –?

You mean when I went into the Commission?

Yes, when you went in.

Yes, I went into the Planning Department and initially I was in a Health Research Unit that was headed up by Dr Peter Last who I had got to know on the planning committee. But immediately – no, just before the Commission was created, when some of the flow-on work was happening in the health research unit, there was a Planning Division. One of the new full-time commissioners, John Blandford was a lawyer who had trained in hospital administration in England and he’d been a Health Services Commissioner in the ACT and he really had a wonderful understanding of policy and planning and what you needed to do to get different parts of a complex system to work together, and that was a major difference. And also it was a whole new area for recruiting. I think that most of the people who came into the new Planning Division were from outside health. Maybe we could have done with a few
more who had actually come from within health. But all of a sudden you had people with statistics, economics, and social policy backgrounds, and I used to look across at Education and every role in the Education Department, as far as I could see, was filled with a teacher – they were the accountants and the curriculum and everything else – and we had this sort of richness in the Health Commission of people from lots of different disciplines and backgrounds. It was good.

**What sort of projects were you involved in or research activities?**

Well, there was a lot of work going on with ageing, there was a lot of work happening with community health and community health principles relating to engagement with communities, and community development work to better understand the determinants of health and that’s a wonderful source of energy and information about communities managing their own health needs and diminishing their own personal requirements for health services by changing lifestyle and things like that. We set up a number of community health centres, women’s health and new services like that.

I was involved in a series of projects which initially astounded the hospitals. I went out to each of the major hospitals to do what was called a "role and functions study". I largely invented this myself, and I’d park myself out there in a given hospital and would talk to the heads of the clinical areas about what they were doing, and what they thought the future needs would be, and I would show them the demographics for the north-eastern suburbs, say it was Modbury Hospital, and say, you know, ‘You’re only doing so many – whatever the procedure was – now, but if you apply the international rate of x-operations or services per 1000 population aged 15–64 years (or whatever the relevant age group was that particular clinical service) then you’ll have this larger expected caseload in the future. So if you applied normative planning rates to current and future forecast population you could estimate what the future requirement for services and specialist staff might be. And nobody
had thought like that in the past, but once you provided them with the information
they accepted it as a more scientific and reliable approach to planning and funding
services than the previous approach which was pretty much just that the strongest or
the loudest voice got all the resources. Previously, you know, the heart surgeon or
cardiologist, would eventually get what they wanted because they were influential
and providing life-saving services. The patients died if the hospital and key
specialists didn't get the resources, so they tended to win out more often than not. In
a role and functions study we would go through every service in turn and we would
engage the staff and get them to have a better understanding of their colleagues’
needs as well as their own. And as part of role and functions studies we would link
inpatient services with discharge planning, aged care services, domiciliary care,
community health services and strategies to prevent avoidable admissions. It was
good.

But it wasn’t as effective as I would have liked, and what I found after about four
or five years was we’d written a lot of terrific plans, done a heap of research, we’d
done a lot of consultation and discussion which engaged people, and my take on it
was that very little was changing or that it was happening very slowly because
people were so busy in their roles and nothing was making them change. And so,
just to come back to my career, I decided after four or five years I didn’t want to
write plans that I couldn’t implement and they sent me off to Mount Eliza to the
Australian Administrative Staff College in 1983 and I did one of those executive
development courses there so that I would be able to move from planning to resource
allocation and management.

When I returned from Mount Eliza we started to move the Commission into a new
organisational guise, in which we created directorships of resources and planning so
that a director or an executive director, depending on which version of the structure
we had, had responsibility for overseeing and managing both finance and planning
staff within a defined geographical sector or region. This was actually a very
Michael FORWOOD

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effective structure as we were better able to apply limited resources to defined service objectives on a more rational basis.

Just in the earlier days, you mentioned this new approach notwithstanding people were too busy to pick it up, but was there a sense of a difference of an organisation? Now there’s a Health Commission and, seemingly, slightly out of the reaches of the Minister and Government, the rationale for setting up statutory authorities at arm's length.

To be honest I think not that much.

Not really?

I mean what you find, I think, when you’re sort of imbued with the spirit of a new way of doing things, is that you are operating within a different paradigm to the people you are working with and trying to influence. In retrospect I think that I thought that they were taking more on board than in fact they were. I don't think that some of us allowed sufficiently for the inherent conservatism of very busy people who were used to a particular way of doing things. So when I started a new project for example when I went down to the Children’s Hospital to work with them on their role and functions study, I think I underestimated their prejudices against the central authority (whether it was a statutory authority or a traditional government department) and overestimated the ability of people to plan and manage in a different way to the way to which they were accustomed. Deep down I think that a lot of people just thought it was business as usual and a different name for what was still effectively a department until you actually demonstrated to them that it was different.

On the other hand I think, without a doubt, that the Health Commission was a far more professional and competent organisation than its predecessors. It brought fresh intelligence and new energy to health system planning, resourcing and delivery especially in the first four to five years. And this probably had a positive legacy for another five years or so after that. Where it failed was in creating too many incorporated bodies and in not developing an effective regional structure for the
coordination of services. It also ended up being somewhat estranged from the central agencies (Premier & Cabinet, Treasury, the Public Service Board and Attorney-General’s Departments) as it was just not in the ‘inner circles’ of Government.

And what was the staffing establishment, was there a significant increase because of this approach, this coordination?

I didn’t know much about the staffing numbers, but there has to have been an increase in the total staff. There was certainly a considerable number of new and different personnel in the head office and I doubt there were many, if any, reductions at the hospital/health unit level. I remember there were people who were in the old Hospitals Department who, with the incorporation of the government hospitals, were packed off to do their finance, administration and HR jobs at The Queen Elizabeth or the Royal Adelaide Hospitals and so on, so there were people who went out from the head office; but there were quite a lot of new people coming into the head office, and I really don't know what the net effect was.

Yes, you’d study the net differences, I suppose. Did you pick up any difference in relationships with some of the major employee blocs, like the doctors, the nurses?

It's difficult to say. The commissioning of Flinders Medical Centre in 1974 as a major teaching hospital in the southern suburbs clearly led to a steady increase in staffed and available beds and doctors and nurses. There was also a continuing expansion of specialist and sub specialist medical services within medicine, surgery, obstetrics and gynaecology and the other major, so-called, general specialties. There were many changes occurring in health care that were quite independent of the new health services planning and administrative arrangements of the Health Commission. In terms of industrial relations and related matters it was not until the mid-'80s that I had much to do with them and had any appreciation of how they impacted on change and reforms. It’s very hard, because there’s so many factors at play, to know how much, if at all, the new structure was an element and how much it was simply that their employment arrangements had changed so much from working as honorary
medical staff back in the ’50s and ’60s to working as a part-time specialist doctors or full-time salaried medical staff. As I said earlier there was increasing specialisation in medical care. There were some hospitals that had significant numbers of full-time, salaried medical staff and there were issues about pay and conditions already emerging between them and those who were fifty per cent in the private sector and working in private hospitals – and I’m talking particularly the hospital doctors – and were doing paid sessions, and so there were tensions within the profession about different modes of employment and there was a push for more money because they could earn so much more in their private capacities. But a lot of them really wanted to have a teaching hospital appointment because of partly altruism and, secondly, the buzz and it’s where the prestige was.

But I mean I’m not sure how much the Health Commission being a statutory authority was significant to many of the people who Bright and the committee thought it would be significant for; and yet the other part of me, because I’m very longwinded about this, says that I think if we’d just been a Hospitals Department it would have been much harder to get some of the discussions going and the things happening.

What about the central agencies, did you notice any changes there? Like the Premier’s Department – – –.

When I left the Premier's Department and joined the South Australian Health Commission I immediately became a line agency man (laughs) fighting for our share of the cake. Look, as you know, the government changed soon after the creation of the Commission and the new Liberal Government immediately implemented two per cent per annum cuts for the next couple of years. I don't think that being a statutory authority protected us from this in any way at all.

This is ’79.
Michael FORWOOD

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Yes. And then we had John Cornwall as our Minister for a period of time and that was very exciting again.

That was under Bannon.

That was under Bannon, yes, the Bannon Government. Cornwall was a strong and passionate minister and they were exciting times. I was thinking also that – I don’t know, you’re always, when you’ve got a history background, thinking how much a personality is important and how much is it the prevailing social and economic issues of the day, but the first chair of the Commission was Brian Shea and he was good and it was building and it was organisational change, but there wasn’t I think a rush of immediate implementation of the new ideas, but they were being fostered and they were happening although there was some resistance. But he was a very powerful figure and very adept politically and administratively. Then he was succeeded as Chairman by Bernie Mackay, which was when Jennifer Adamson was Health Minister during the Tonkin Government, and he was a very smart cookie and he took the Bright vision – not in exactly the template form – and things moved ahead with another significant surge. But he left to be the head of Health in New South Wales and subsequently to Canberra, and I think he was only with us about two and a half years or so. And then we had Gary Andrews, who was a professor of geriatrics, and I think that he didn’t work with the mandarins in the central agencies. Anyway, he was different and I think we were weaker there. I’m not sure when the budget overruns started to happen; but Bruce Guerin from the Premier’s Department was sent in as Executive Commissioner for a time and we were weaker still.

Yes, that was under the Corcoran Government.

Okay. And then we had – after Gary Andrews and Bruce Guerin – Dr David Blaikie (a dentist and an active member of the Labor Party, the influential Prospect Branch I believe), who was very, very politically sensitive – and, to my mind, too pre-occupied with what the Premier and central agencies wanted, too much of the time –
and after that Dr Bill McCoy a medico and former superintendent of the Children’s Hospital who was not a strong leader. What am I saying here? I think it’s that the effectiveness of the Commission was significantly influenced in the first ten to fifteen years by who was leading it.

The relationships – – –.

Yes. And I think that there was a problem with central agency relationships and with some internal relationships within the system eg between head office and one or two of the major teaching hospitals. There was a problem I learnt about later when I got into the very senior executive ranks of the Commission was that we were perceived as being not one of them, even when we weren’t aware of it, that we were seen to make our own rules, behave our own way, think we were different and more complicated than we were, and not to be sufficiently attuned to the Public Service Commission, Treasury and Attorney-General’s views of things. (break in recording)

Another area I was going to ask about: some papers I came across which recommended the establishment of a lot of advisory groups. Can you recall what they were supposed to do and whether they were effective or not?

That was an important one in the legislation, a ‘representative committee called the Health Services Advisory Committee, that had a doctor, a dentist, a nurse, an allied health professional, a member of a leading voluntary organisation and others drawn from different sectors and different backgrounds. I don’t think that it was ever able to work effectively because they really had no common interests and it was kind of one person talking at a time. And I think some of the other advisory committees, they didn’t deliver what people might have thought because the directions were pretty well-known so there wasn’t a lot of general policy advice needed and it was not time for more planning.

And the community was engaged how? There were the five part-time commissioners for a while until, I think under the Tonkin Government, the Commission was rationalised.
I can’t remember when it happened, but I think that if not before John Cornwall’s time in the Bannon Government we had various health services advisory committees at the regional and district levels. In the Adelaide metropolitan area there were northern, eastern, western and southern advisory committees, and they had people who were drawn from local communities and community interest groups – no, actually I can remember that was before even Jennifer Adamson’s time, so they were fairly early on. And they had some influence, but they didn’t know how to behave themselves and so were a mixed blessing for government. They didn’t concern the Commission, I think, as much as they did the Government, because they could get very outspoken about what their local communities wanted, needed and didn’t have. (laughs)

Right, interesting. And you had the boards, of course, once they were set up, the boards of the various institutions, the hospitals and others, with a number of those people being from the community, notwithstanding the legal responsibilities of board members.

Yes, they had a mix, although a lot of them, even in those days, were based on business skills, so you had a lawyer and an accountant and an academic and a this, that and the other. I think they added quite a bit.

Just by way of rounding up our discussion, was there anything you wanted to add in terms of just major achievements that you saw the Commission getting to – in its early years, anyway, the sort of timeframe we’re looking at – and any particular reasons why some things worked and some didn’t?

Yes, thank you. Well, I’m not sure that there’s been all that positive a flavour in what I’ve been saying. But it was an incredible time. From 1977 through until ’86, ’87, towards the latter half of the ’80s there was a terrific buzz. There were new people, there were new skills; the policy and planning side of things were very, very effective. The community health movement in South Australia which came out of the Bright Committee was a leader in Australia for many years. We did great things in health promotion and primary prevention. New links were forged between hospital
services and community based services – but not really to the extent that it made a real difference I’m afraid. A number of women of great ability came up through women’s health and community health and public health and ended up in positions of great influence around Australia, bringing community health principles into acute care and forward planning. They included Judith Dwyer, who ended up head of the Monash Health Service and Flinders Medical Centre before that came through the Women’s Health Movement; Liz Furler, who went up to Canberra and became a highly influential Divisional head; Kathy Alexander who was deputy at the new Women’s & Children’s and became CEO of the Royal Children’s Hospital in Melbourne. And there was a lot that was done that was better-informed than it had ever been before. But while there was a far better understanding of what was fundamental to real change in the health of the community, it was always difficult to fund the new initiatives with the growing population demand acute hospital services ie just more and more hospital admissions and procedures. The technical side was getting more and more expensive as well, with hip replacements and new scans and all those things, and they consumed more and more resources, where the plan was to do a lot more at the community level and to prevent ill health and hospital admissions. We did great things at the community level, but it didn’t ever get resourced to the extent that everyone would have liked.

Did you have any experience with the issues of Aboriginal health?

I had a bit later on. That was more in the ’90s, and I think that our learning there was that however much planning, however much we consulted with Indigenous communities, it was very, very hard to get effective implementation.

I’ve enjoyed it, thanks.

Well, thanks very much, Michael, that’s been a good roundup of the early years of the enquiry and the establishment of the Health Commission. Thanks.
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END OF INTERVIEW