2. The state of Queensland Health's systems

Queensland Health has a very broad role in improving the health of Queenslanders which includes its health promotion and illness prevention activities, primary health care through its network of community health centres, public hospitals, aged and palliative care services. At each stage in the service continuum there is interaction and overlap with the Commonwealth and local governments, other state government departments, and the non-government sector. Overall, Queensland Health is the principal provider of health services in Queensland and in some rural and remote areas the only health service provider.

Health services are delivered through 37 health service districts, 3 public health networks, the Mater Public Hospitals and around 1,100 non-government health care providers. Queensland Health has a network of 178 public hospitals and 277 primary and community health centres and a workforce equating to 43,785 full time equivalents (FTEs).

2.1 The current state based on performance reporting

The Interim Report highlighted significant health system issues and trends which must now be addressed. These issues are briefly summarised in this chapter and the Executive Summary of the Interim Report which is found in Appendix 1.5.

2.1.1 How healthy are Queenslanders?

There has been an unprecedented improvement in health and life expectancy in Australia through the 20th century. In the early part of the century these improvements were due to improved sanitation and living conditions, a reduction of maternal and infant mortality and the discovery of antibiotics. General improvements in socio-economic status, education levels, healthy lifestyles and continuous improvements in health care were responsible for health improvements in the later part of the century.

From an international perspective, Queenslanders currently enjoy good health as demonstrated in high life expectancy and low levels of infant mortality. However these outcomes are not enjoyed by all groups in the community and Aboriginal and Torres Strait Islander peoples in particular, experience worse health outcomes in almost all indicators measured. Those from socio-economically disadvantaged groups and some communities from non-English speaking backgrounds also have a disproportionate share of the burden of disease.

In 2005 chronic disease is the greatest cause of ill health in Queensland. This includes heart disease, stroke, cancer, mental illness, chronic respiratory diseases and diabetes. Many of these conditions are preventable or able to be better managed through healthy lifestyles and early detection and management.

Comparisons nationally and internationally identify suicide, ischaemic heart disease, transport accidents, some cancers and tobacco related conditions as the areas where there is the greatest potential for health gain for Queenslanders.

Queenslanders are more likely to smoke, consume alcohol at risky levels and be overweight or obese, all of which contribute to increased prevalence of chronic disease. It is estimated that 3,486[1] deaths could be avoided each year in Queensland through healthier lifestyles and improved prevention of disease. Prevention initiatives require partnership across a range of health providers as well as many government and non-government agencies, industry and community groups to address the broad spectrum of determinants of health (including public infrastructure, socio-economic status, education levels and the behaviour of individuals).

There is also significant potential for gain through improved detection and management of chronic conditions by non-hospital services (avoiding an estimated 1,496 deaths per year) and in hospital treatment (avoiding an estimated 1,380 deaths).

If governments comprehensively promote and support the community's obligations to healthier lifestyles, and more individuals accept their personal health responsibilities, pressure on the acute hospital system will ease and make hospital care more accessible for those with acute or emergent conditions.

It is for these reasons that Queensland Health must continue to direct investment to health promotion and prevention and primary health care activities as well as hospital activity. There is no reason why Queensland should not be able to at least achieve the performance of the other states by addressing these issues.

2.1.2 Health service activity in Queensland

Admitted patient services

Admitted patient services (721,013 admissions and 2.5 million patient days in 2003-04) account for over 50 percent of Queensland Health's budget[2].

Over the period 2000-01 and 2003-04 hospital admissions in Queensland have grown by 3.8 percent while population growth has been 4.7 percent.

Queensland treats a higher proportion of public patients (93.5 percent) in its public hospitals compared to the Australian average (91.6 percent)[3] but the public patient admission rate is 4 percent lower than Australia as a whole.

Despite lower levels of private health insurance, Queenslanders are higher end users of private hospitals for inpatient services (29 percent above the national average per capita). However, the rate of self funding or Department of Veterans' Affairs funded private hospital admissions is considerably higher and may explain some of this trend.

Queensland has a well developed private hospital network (in coastal areas) that reduces the duplication in services evident in other states. Even though a high proportion of public hospital services in Queensland are directed to public patients, fewer services per capita are being provided by public hospitals.

[1] Unpublished data Health Information Branch, Queensland Health
[2] Ministerial Portfolio Statement Minister for Health, State Budget 2005-06
[3] Department of Health & Aging, The state of our public hospitals, June 2005 report

Non-admitted hospital services

Queensland Health provides a range of hospital-based services on an outpatient basis.

Emergency department presentations

In 2003-04, there were 1.25 million emergency department presentations in Queensland public hospitals at a rate per capita that was 3.5 percent higher than the national average[4]. The Royal Brisbane Hospital and Gold Coast Hospital emergency departments are two of the three busiest emergency departments in Australia.

Over the period 1999 to 2005 presentations in the top 20 public hospital emergency departments increased by 14 percent compared to 12.9 percent population growth[5]. General practitioners services are an alternative for many of the less urgent cases seen in emergency departments. However, according to 2002-03 reporting, Queenslander's use of Medicare services is 4 percent lower per capita compared to national average[6].

There has been increasing pressure on emergency departments as presentation rates have increased rapidly in recent years. A geographically dispersed population and fewer general practitioners, particularly in rural and remote areas, are contributing factors.

Outpatient services provided in public hospitals

In 2003-04, Queensland Health provided 7,553,000 individual occasions of outpatient services.

To a greater extent than other states and territories, Queensland Health provides specialist outpatient clinics services to the public free of charge through the public hospital system. In recognition of this, the Commonwealth government has recently allowed Queensland specialists working in public hospitals to treat patients privately within certain guidelines and thereby access Medicare.

There have been disproportionate lower levels of utilisation of Medicare for public patients compared to other states which has disadvantaged Queenslanders and placed high levels of demand on outpatient services in Queensland's public hospitals.

Community health services

Despite the importance placed on health services delivered in the community for the management of chronic diseases, Queensland has a less developed community health sector than in other states.

Queensland also has slightly higher rates of preventable hospitalisations than the Australian average which suggests primary health care activities (general practice and community health) could be improved.

Currently there is limited data available to enable performance monitoring of community health services provided by Queensland Health at the local and aggregate level.

[4] Australian Hospital Statistics 2003-04
[5] Queensland Health, Emergency Department Information System
[6] The State of Health of the Queensland Population, Queensland Health, 2005

Queensland Health also coordinates the delivery of a range of health related services from 1,100 government and non-government (community and private sector) providers. These include a range of Home and Community Care (HACC) services for frail older people and younger people with moderate to severe disabilities.

Given the importance of non-inpatient services in improving the health of people with chronic diseases, Queensland Health must invest in a coordinated approach to providing a range of community health services through both government and non-government providers and must establish mechanisms for monitoring the delivery of these services.

Aged care services

Queensland Health provides aged care services through community health services, as detailed above, and through 22 Residential Aged Care Facilities (which represents only 5.7 percent of the total residential care places in the state).

The Queensland Health model of care for the provision of residential aged care is more expensive than other models primarily due to salary arrangements. The appropriateness of Queensland Health as a provider of aged care facilities is questioned. Opportunities to sell these facilities to private sector providers with appropriate safeguards for residents and staff should be assessed and if favourable sold.

Jointly with the Commonwealth government, Queensland Health also provides 13 Multi Purpose Health Service centres in small rural communities. These services amalgamate acute hospital services, residential aged care services, and community health services including home and community care services.

Multi Purpose Health Centres are the preferred model of care for communities with small populations (ie less than 10,000).

Population health services

Population health is distinguished from other roles of the health system by its focus on protecting the health and wellbeing of populations, rather than individuals. Population health is not solely a public sector responsibility, nor is it exclusive to the health sector (public, private or non-government) therefore a strong partnership approach is essential to achieving public health outcomes.

We rely on Queensland Health to regulate and ensure health of populations especially in times of natural diaster or communicable disease outbreaks or pandemics. Where Public Health has been adequately resourced it has achieved national targets in the implementation of population health programs. Breast screening and immunisation programs (childhood and adult) are good examples of such programs where Queensland Health is performing as well if not better than the national average. However in other areas such as overweight and obesity we lag behind other states.

Population health activities must be strengthened to adequately address a range of health determinants such as overweight and obesity and we must ensure we are geared up to manage large scale threats to population health.

2.1.3 Queensland Health service expenditure and efficiency

The Queensland Health budget for 2005-06 is $5.4 billion and as at April 2005, Queensland Health's asset base was worth $6.3 billion (gross) and $3.5 billion (net).

The budget has grown by approximately $2.2 billion since 1997-98 (average annual growth rate of approximately 7 percent per annum). Over the same period Queensland's population has grown by an average of 1.9 percent per year[7]. In addition, health costs are estimated to have grown by an average of 3.5 percent[8] and 5.3 percent[9] per year. This suggests that the average annual budget increase for health of 7 percent has kept pace with growth in health care costs and population. However there are other indicators which suggest higher increases for non salary costs of 6 to 7 percent.

While expenditure has grown Queensland Health's (including some Commonwealth special purpose payments) relative recurrent expenditure in 2003-04[10] was $1,245 per person, $199 (or 14 percent) less per person lower than the national average of $1,444.

Compared to averages of Australian States and Territories, Queensland Health spends less per person on each of the categories listed in the following table:

	$ per capita		Difference	
	Queensland	Australia	$ per capita	%
Inpatient services	$604	$767	-$163	27% less
Non-inpatient & community services	$351	$375	-$24	7% less
Population and preventative health	$66	$68	-$2	4% less

Source: Commonwealth Grants Commission 2003-04

These figures represent an update on those that were available for the Interim Report.

Queensland also spends less per person on some key areas of health need such as mental health and Indigenous health as shown in the following table.

	$ per capita		Difference	
	Queensland	Australia	$ per capita	%
Mental health services [11]	$89	$100.50	-$11.50	11% less
Indigenous health [12]	$2,400	$2,749	-$349.00	13% less

[7] Population by Age and Sex, Australian States & Territories (time series spreadsheets), Australian Bureau of Statistics catalogue no. 3201.0 (released Dec 2004)
[8] 6401.0 Consumer Price Index, Australia TABLE 7F. CPI: Health, Weighted Average of Eight Capital Cities.
[9] Average Private Health Insurance Premium increase (1990-00 to 2004-05)
[10] Australian Bureau of Statistics data
[11] Productivity Commission , 2005
[12] Australian Institute of Health & Welfare, Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2001-02, 2005)

Compared to averages of Australian States and Territories, Queensland spends more per person on each of the categories listed in the following table:

	Percentage difference	$ per capita	
		Queensland	Australia
High level residential aged care[13]	44% more	$31.50	$22.00
Dental health[14]	78% more	$30.00	$16.70

By expenditure category, employee expenses account for approximately 60 percent of Queensland Health's total expenditure with supplies and services representing 22 percent. By service type, hospital expenditure (inpatient & outpatient) is the largest expenditure component and accounts for around 64 percent of the total Queensland Health budget.

The expenditure data also indicates that Queensland Health spends $9.40 (82 percent) more per person overall on health administration than other states[15]. However hospital administration costs per weighted separation are approximately 15.6 percent (or $66) lower than the national average[16]. The higher administration costs most likely reflect Queensland Health's more centralised structure with costs being recorded corporately rather than locally and some inconsistencies in how administrative staff are defined in different states.

This data is consistent with what has been observed in district visits and in Queensland Health Corporate Office. There are insufficient numbers of basic administrative support staff in hospitals resulting in clinicians being diverted inappropriately to administrative tasks. Corporate Office on the other hand has taken on a range of functions supported by administrative staff and projects officers that should not be performed by a central office and would be better performed closer to health service delivery.

Queensland hospitals operate very efficiently compared to averages of Australian States and Territories. Queensland[17]:

- has a similar number of public hospital beds per 1000 people (2.6 beds compared to 2.7 nationally)
- spent 11 percent less per casemix adjusted separation ($2929 compared to $3293) (an indication of the efficiency of Queensland hospitals which takes into account the complexity of the admission)
- has lower relative lengths of stay in hospital (0.94 compared to 0.99) (also having taken into consideration the average complexity of cases) and
- is achieving a similar rate of same day admissions (49 percent).

The key drivers for the lower cost include lower expenditure on nursing, allied health and medical services (staff numbers and average salaries) and lower relative stays than other States.

Queensland Health, unlike other states, also provides a statewide pathology service that supports clinical care in its hospitals. This centralised approach has been reported to provide a high quality and cost effective service across the state.

[13] Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)
[14] Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)
[15] Australian Institute of Health & Welfare, Health Expenditure Australia 2002-03 (2004)
[16] Australian Institute of Health & Welfare, Australian Hospital Statistics 200-04 (2005)
[17] Australian Institute of Health & Welfare, Australian Hospital Statistics 2004

Queensland Health should strive to maintain efficiency, but not at the expense of quality outcomes for patients and impacts on staff. Other priority aspects of service delivery performance should also be carefully monitored such as quality, safety, effectiveness and responsiveness.

Interstate comparisons suggest that expenditure needs to be boosted across the entire health system including population health, community health, mental health, Indigenous health and hospitals. However, the decisions a government should make about how and for what purposes finite health resources are allocated would ideally be informed by robust community debate.

2.1.4 Workforce planning and management

Queensland Health spends 60 percent of its budget on staffing and employs staff equating 43,785 (FTE)[18] positions. In an environment of workforce shortage and increasing focus on quality and safety, workforce management (attracting, retaining and effectively using staff) and workforce planning (preparing an appropriate workforce to meet future organisational requirements) is critical[19].

Clinical staff (doctors, nurses and professional staff) represent 60 percent of Queensland Health's full time equivalent employees. The current profile of Queensland Health staff and workforce growth rates for the last 10 years are shown in the table below.

Staff category	FTEs	Percent of total FTEs	FTE growth since 1996-97
Doctors (including visiting medical officers)	3,674	8%	51%
Nurses	16,943	39%	12%
Professional staff (including allied health)	4,961	11%	59%
Operational staff (wards persons, food, linen and cleaning)	8,414	19%	8%
Managerial and administrative	8,433	19%	84%
Technical, trade and artisan	1,360	3%	0%
Total Queensland Health	**43,785**	**100%**	**27%**

Source: *Queensland Health Human Resource Management Information System*
Note these figures are based on FTEs not headcounts as in some data in Chapter 10

Queensland has a lower than average proportion of doctors in the population; 333 per 100,000 persons compared with 381 nationally[20]. However, Australia as a whole has maintained higher numbers of doctors and nurses than the United States, Canada, the United Kingdom and New Zealand[21].

One in five of the 3,433 full time equivalent doctors (excluding visiting medical officers) employed by Queensland Health have provisional registration[22] under the area of need provisions in the *Medical Practitioners Registration Act 2001*. Queensland Health is heavily reliant on these doctors who are generally overseas trained and recruited. Any changes to these arrangements would have a significant impact on service delivery

[18] Queensland Health March 2005 estimate
[19] Australian Health Ministers' Advisory Council (AHMAC)(2005), Submission to the Productivity Commission Health Workforce Study
[20] based on registration of medical practitioners
[21] OECD, 2005
[22] Queensland Health unpublished data (2005)

particularly in non-metropolitan areas where higher proportions of doctors with provisional registration are practicing.

Contrary to popular myth, this Review can confirm that managerial and administrative staff make up 17 percent of all staff. Compared to other states Queensland Health has fewer administrative staff in public hospitals and more in Corporate Office due to its more centralised service delivery system. This Review addresses this imbalance.

Queensland also has the lowest number of nurses per capita of any state in Australia (except Tasmania) and has a critical shortage of nurses. With both the nursing and medical workforce there has been a trend to reduce working hours and do part-time work to achieve a work/life balance.

In the public hospital setting, approximately 70 percent of the total costs (excluding capital costs) are related to staffing. Compared to the Australian averages, Queensland:

- employs 11 percent fewer public hospital staff per 1000 people[23] and
- pays 5.6 percent less in average salaries for public hospital staff (Queensland's general average weekly earnings are the lowest in Australia at between 6 and 7 percent below the national average)[24].

Compared to the Queensland public sector, Queensland Health employees have higher rates of absenteeism particularly due to sick leave and a higher percentage of employees taking work cover leave[25]. These are often indicators of workplaces where staff are experiencing work stress and pressure. It should also be appreciated that health staff are exposed to potentially higher levels of communicable disease than the rest of the community.

In an environment of global health workforce shortage and an increasing requirement to focus on quality and safety, Queensland Health needs to monitor and analyse workforce dynamics, and take effective action to deal with immediate and longer term problems of workforce shortage.

2.1.5 Quality and safety of health services

Health services that adhere to established standards for clinical care and have processes in place to minimise harm, are more likely to deliver quality health services for patients and communities.

Queensland Health services (inpatient and non-inpatient) have embraced health service accreditation by an external third party aimed at ensuring that processes and standards are in place to deliver quality health services[26]. The proportion of public hospitals accredited in Queensland (89 percent) is higher than the national average (84 percent)[27]. While accreditation is a necessary starting point, it is not sufficient on its own to ensure the quality of services provided by facilities. This has been demonstrated in Australia and overseas where major inquiries into adverse events (including Bundaberg Hospital) have occurred in quality accredited facilities.

[23] Productivity Commission 2005
[24] Australian Institute of Health & Welfare
[25] Department of Industrial Relations March 2005 data
[26] Australian Institute of Health & Welfare, Australian Hospital Statistics 2003-04, 2005
[27] Australian Institute of Health and Welfare, Australian Hospital Statistics 2003-04, 2005

Using indirect measures of quality, Queensland public hospitals on average appear to perform as well as other public hospitals elsewhere in Australia for most measures. However there is considerable variation between hospitals within Queensland.

For selected conditions small groups of clinicians in some Queensland public hospitals (known as collaboratives) have been collecting data to establish how closely evidence based guidelines for treatment are being followed. Such measurement and feedback has been shown to be an effective strategy in improving the quality of health service delivery. Queensland Health is beginning to expand this type of monitoring for a range of high volume conditions but this process is not yet systematic across all procedures and services or state-wide.

It is estimated that one in ten patients that are admitted to Australian hospitals are harmed as a result of the health care that they receive and that approximately half of this harm is potentially preventable[28]. Much of the avoidable harm can be accounted for by falls, pressure ulcers, poor medication management, surgical complications and hospital acquired infections. Local systems are being developed and implemented to monitor these events but they are not yet able to report meaningfully on incidence on a statewide level.

Queensland Health as a high priority must continue to develop statewide clinician supported systems that support improved quality and safety and enable quality improvement activities to be monitored and evaluated.

2.1.6 Queensland Health responsiveness to the needs of patients and communities

Queenslanders need to be able to access treatment in a timely manner. Currently this is monitored and reported only for selected services described below. Such a focus potentially gives priority to these services over other equally important services (for example cancer treatment services or community health services).

Emergency department admissions

Waiting times for emergency departments in Queensland public hospitals met national targets for resuscitation cases but not for emergency, urgent, semi-urgent and non-urgent presentations [29]. In Queensland only 60 percent of emergency department presentations over all categories are seen on time.

Outpatient appointment waiting times

All states, in both the public and private sector have waiting times between referral from a general practitioner and the date for an appointment with a specialist. These waiting times are not systematically measured but have been the subject of much reported criticism recently in Queensland as well as in some other states which have problems of the same scale as Queensland.

[28] Wilson RM, Runciman WB et al, The Quality in Australian Health Care Study, Med J Aust 1995;163:458
[29] Australian Hospital Statistics 2003-04, AIHW

Elective surgery waiting lists

Queensland has the second highest rates (30 patients per 1,000 population) of elective surgery in Australia (national average 26 patients per 1,000 population). The proportion of elective surgery cases seen on time has declined since 1998-99 but Queensland is reported as second highest (90 percent of patients seen on time) compared to the other states (84 percent)[30].

The number of elective surgery cases increased from 87,050 in 2000-01 to 92,491 in 2004-05.

Oral health

Queensland provides the largest and most comprehensive oral health service in Australia in both proportionate and absolute terms but continues to face heavy demand (resulting in long waiting times) for dental services particularly for aged, chronically ill and disadvantaged adults. Free oral health services are restricted to school children up to year 10 and holders of Commonwealth Health Care cards. The demand for public dental services in Queensland is much higher than some other jurisdictions due to a lack of widespread fluoridation in local communities in comparison with the rest of Australia.

Public and private hospital funding

Waiting lists for public health services in comparison to private health services are impacted by some major differences in the way public and private hospitals are funded. The private sector is motivated to increase patient throughput because revenue is attached to the number of patients seen and the type of care provided. In contrast, the public sector receives a fixed grant to provide a range of medical and surgical services. Therefore if the level of activity increases beyond the level planned, it can only be managed by:

- Increasing the cost efficiency per patient to increase throughput (ie reduce length of stay and bed numbers or reduce staffing)
- Prioritise access via a waiting list with priority given to urgent cases or diverting resources for other services to acute services.

Queensland's public health services use all of these demand management measures.

Potential opportunities for reducing waiting times:

- improved primary care and linkages between general practitioners and hospitals
- redesign of work practices and workforce reforms that improve patient flow through health services
- stronger partnerships with community health services and non-government organisations to deliver step down facilities for patient care.

Patient satisfaction

Overall most patients (89 percent) have indicated satisfaction with their hospital stay[31]. The areas requiring improvement all related to systems in hospitals associated with admissions and discharges, provision of information, and management of patient

[30] State of our Hospitals Report, 2005, Australian Government
[31] Queensland Health, Queensland Hospitals in the Twenty-first Century, 2003

complaints. Patients however were not asked in these surveys to what extent their health problem was resolved as a result of their hospital treatment.

Inequities in responsiveness

Mental health patients and patients from non-English speaking backgrounds had lower levels of satisfaction with Queensland hospitals. On a number of indicators Indigenous peoples' access to health services is less than non-Indigenous peoples' despite their experiencing a significantly larger burden of disease.

Consumer and carer input into services

For mental health services, it is desirable to have a person appointed to represent the interests of consumers and carers to advise on all aspects of service delivery. Half of the health service districts in Queensland met this goal in 2003[32]. Consumer or carer input into the delivery of other health services is not well developed.

Where resources are the barrier to timely service delivery, this should be clearly communicated not only to affected patients but to the leaders of Queensland Health and the government.

The provision of culturally safe and accessible health services for Indigenous Queenslanders (including urban communities) and people from non-English speaking backgrounds must be a high priority for Queensland Health.

2.1.7 Queensland Health effectiveness in achieving the desired results for patients and the community

Health services at a state level should result in the prevention of illness and improved health for communities and improved functioning and survival for individuals with specific conditions. These results are achieved through the full range of services including population health, primary care and hospital services.

Currently for the vast majority of Queensland Health services (and health services in other jurisdictions) there is limited monitoring in a systematic way to inform whether patients and communities are benefiting. A notable exception is survival for Queenslanders diagnosed with cancer (an outcome that is impacted by a range of services) which is equivalent to that achieved overseas and in other Australian states[33].

Assessment of health status before and after undergoing procedures in hospital provides a very direct measure of the effective performance of a health service. This approach is not routinely used by Queensland Health but has been piloted at The Prince Charles Hospital among patients admitted for selected surgical procedures. Significant improvements in physical and mental functioning, comparable to some of the best results achieved internationally were demonstrated. This model of assessment of the effectiveness of services delivered by Queensland Health should be incorporated in routine evaluation.

Measurement of the effectiveness of Queensland Health's delivery of programs and services should be part of a culture of evaluation, learning and improvement across the whole range of service types. Such monitoring is a strong motivator for seeking to achieve the optimal performance of health services.

[32] Productivity Commission, Report on Government Services, 2005
[33] Queensland Health & The Queensland Cancer Fund, Cancer survival in Queensland 2002, 2005

2.1.8 Are services delivered in a sustainable way?

Continuity and sustainability are critical issues for any health system and key themes to consider are as follows:

Coordination of health programs and services with other providers

The average health consumer in Australia faces a complex array of health providers in a system that has been largely shaped by funding mechanisms rather than a focus on consumer and community needs. In fact these funding mechanisms have often created conflicting priorities. For example the Commonwealth government funds general practitioner and private specialist services and the state government (with contributions from the Commonwealth) funds public hospitals.

A broad range of stakeholders have a legitimate interest in and contribute directly or indirectly to attaining health outcomes for Queenslanders. Partnerships with these stakeholders are essential to optimise the collective effectiveness in improving health services for all Queenslanders.

The most significant opportunity in the medium term for achieving a more consumer and community focused and cost effective health system would be to simplify and reorganise the health funding, policy and regulatory roles of the different levels of government.

Creating a culture of learning and excellence

In health service delivery settings, health and medical research contributes to a culture of excellence and learning and is important for attracting and retaining good clinicians. In turn, the community in Queensland derives a direct benefit from improved quality of care particularly from research with a focus on delivery of health services and quality and safety. On a per capita basis Queensland invests significantly less on health and medical research than most other states. This is quite concerning in an environment of workforce shortage and global competition for clinicians.

Efforts to re-establish a research culture within Queensland Health could contribute to attracting and retaining clinicians and fostering an environment where evaluation and learning is highly valued.

Capacity to deal with emerging issues

There are a number of conditions which are likely to increase in incidence and prevalence in Queensland Health in the twenty first century (including chronic disease, mental illness, dementia and hepatitis C). Based on projected numbers of cases of these conditions the current health model, with a focus mainly on treatment rather than prevention, will be unable to meet these challenges in the medium to long term.

At a population level, emerging threats such as bio-terrorism and infectious disease outbreaks need to be addressed. Should one or both of these threats eventuate, there would be significant demand on workforce with the knowledge and skills required to effectively respond to the threat, and on health infrastructures.

Maintaining a watching brief on emerging issues and innovative approaches to dealing with these issues are critical to the sustainability of the health system in Queensland.

2.2 The current state based on the consultation processes

The Interim Report (based on consultation with health service districts and preliminary research) provided an overview of the current Queensland Health systems and culture including an analysis of how well these systems are performing to deliver health services and improved health outcomes for Queenslanders. A summary of the key findings of the Interim Report is provided below.

2.2.1 Overview

- Queensland Health has a dedicated and professional workforce. District visits confirmed through wide ranging discussion and observation of elements of work practice across the occupations, that staff are committed to delivering high standards of services for those in their care.
- The public health system in Queensland depends not only upon permanent public sector employees, but a broad range of staff from the private and non-government sectors as well, who also contribute significantly to the delivery of public health services throughout the State.
- Clinical outcomes being achieved in Queensland's public hospitals are comparable to the outcomes in other Australian states. However, there is variability in clinical outcomes within Queensland Health, particularly between the larger tertiary hospitals and the regional centres, with regional and smaller centres not achieving the results of the large hospitals.
- Staff, infrastructure and financial resources in Queensland Health are stretched very thinly, and are not keeping pace with demand. This is an urgent and significant problem particularly in high population growth areas.
- From a patient perspective, patients and the community are expressing concern and anger about the excessive delays for accessing specialists in outpatient clinics at public hospitals after receiving a referral from a general practitioner, and for elective surgery.
- Patients who considered they had not received adequate care or suffered due to procedural failures were resentful and angry that the avenues of complaint through the local health service, Crime and Misconduct Commission, Ombudsman, and Health Rights Commission, had failed them.
- Patients have also expressed a strong need for improved communication with health professionals, including being advised of expected waiting times for receiving a service, whether it be in an emergency department or on an elective surgery waiting list. In some cases, patients advised they had received little acknowledgement, explanation or information about their medical or surgical procedures or when medical care had gone wrong.
- Improving the patient experience with the health system, including strengthening the continuum of care between Queensland Health's services and other health providers is an ongoing issue. Within Queensland Health, patients have expressed the need to

build a consistent relationship with individual health professionals, with concern about high levels of turnover within the system and lack of coordination of their care.

- Insufficient mental health services, both in acute settings and in community settings has been one of the most consistent themes raised with the Review, from both patients and Queensland Health staff. The accounts of systemic failure leading often to untimely death of young adults are particularly distressing.
- In rural and remote areas, patients expressed the need for improved planning of services, including the need to have access to appropriate transport and accommodation arrangements where services could not be provided locally.
- Aboriginal and Torres Strait Islander people have significantly poorer health outcomes and experience social and lifestyle factors which contribute to a high burden of disease. Significant added resources across the government and Indigenous community support spectrum will be required for programs from prevention, community education, support and services, through to acute services over a number of years.

These issues have been noted by the Review to ensure recommended system improvements within Queensland Health will help to achieve improved patient outcomes for all Queenslanders.

2.2.2 District and corporate organisational structures and layers of decision making

- Compared to health departments in other states, Queensland Health is highly centralised, and has operated as a single department for a number of years, with a brief period of regionalisation in the 1990s.
- The centralised delivery of health services has provided a number of benefits for Queensland, including districts operating with a level of collaboration across a large geographic area at a time when health service resource shortages are so critical. Queensland Health has also used its centralised structure to support consistent information technology arrangements, drive bulk purchasing and coordinate approaches to new initiatives.
- The centralised structure has however diluted levels of authority at the local service delivery levels. Queensland Health is perceived as having become a cumbersome bureaucracy with too many layers to make decisions quickly. Corporate Office has become sizeable and heavily involved in operational activities and service rather than providing the strategic direction, resource support and performance overview. At the district level Corporate Office is seen as being detached from the day-to-day service delivery functions it is intended to support.
- Queensland Health's three zones were established in 1999. The zonal staffing structures are relatively small in size compared to similar arrangements in New South Wales which has recently established area health services of approximately one million population. From a decision making perspective, it is Corporate Office rather than the zones making decisions about planning, budget allocations and policy direction which need to be made closer to service delivery.
- District Managers have wide delegations to allow timely decisions. However, the department's centralised structure, combined with tight budgetary conditions and

growing demand for health care services have strongly influenced where decisions are being made in the organisation and impact on the capacity of districts to make decisions locally.

- Local communities and district staff have strong attachments and identification with their local districts including their particular hospital. However, it is evident that some rural and regional districts do not have adequate infrastructure or capacity to fully support their expected roles including clinical governance, training and support services.
- District Health Councils were created in 1996 to provide local community input into health services. The current model is ineffective in enabling meaningful community input into health service delivery and must be strengthened.
- In December 2003, a Shared Service Provider was established to consolidate the corporate services functions (including finance, procurement and human resource management) within Queensland Health. This structure is intended to produce longer term administrative savings. However, there has been considerable concern expressed about the performance of the Shared Service Provider to date especially human resource services.

2.2.3 Corporate planning and budgeting systems

- Queensland Health faces significant challenges in future years to address a range of issues in the health sector, including meeting growing demand for services due to an ageing and growing population, an increasing prevalence of chronic disease and medical advances increasing health options. Queensland Health faces workforce shortages, a need to change the way health services are delivered to address the future challenges and overcome integration issues caused by the fragmented Commonwealth/State health care systems.
- Service planning (including clinical, infrastructure and workforce) within Queensland Health has been limited. Current planning efforts are not sufficient to provide information necessary to inform longer term service capacity needs. This is now a grave concern for both workforce and infrastructure planning particularly in South East Queensland.
- Clinicians and the community have expressed a strong need to be more heavily involved in health and clinical planning in Queensland as well as provide input into how resources are allocated.
- Internally, budgets are allocated based on historical budgets and are adjusted annually for enterprise bargaining costs and non-labour escalation. Funding for new initiatives at the local level is determined by Corporate Office, either through the allocation of growth funding or direction through new initiatives considered as part of the overall State Government budget process and regional demands.
- District budgets are not automatically adjusted to reflect changing demand or community expectations. A review of funding allocations based on a regional allocation formula shows an inequitable allocation of resources across the districts, particularly in high growth areas. The historical funding arrangements are no longer considered to meet the needs of the department in delivery of services.

2.2.4 Cost effectiveness of services compared to relevant jurisdictions

- Queensland is more cost efficient in the delivery of acute care services than other states. Queensland's cost per casemix weighted separation is approximately 11 percent lower than the national average, with at least part of this due to Queensland's lower wages structure. There is a concern from staff, patients and the community that efficiency should not compromise quality and safety for patients or be at the expense of not providing adequately for Queensland health staff.
- Staff generally reported the health system as being under significant pressure, with insufficient resources to meet increasing demand.
- The Review has identified opportunities for service improvement including improving patient flows in the acute care settings and strengthening service integration between acute and community services.
- A number of clinicians identified the need to improve the interface between general practitioners and outpatients. In a number of hospitals, clinicians identified opportunities to redesign: the process for admission; improved access and planning for theatres and intensive care unit beds; discharge arrangements (including patient transport post discharge); and step down care facilities and services.
- A number of the barriers to improving patient care and the improved function of the system involve the interface between the State and Commonwealth funded services.
- External providers including non-government organisations and the private sector indicated that they may be able to provide some services more cost effectively than Queensland Health. However, they indicated Queensland Health would need to more clearly define its role in service provision and how it operated with external partners.

2.2.5 Organisation and delivery of clinical support services

- Pathology, radiology and pharmacy services are all indicating significant difficulties recruiting and retaining qualified staff. In January 2005, pharmacy was reporting 16 percent vacancies. All services are indicating staff shortages which are impacting on service delivery capacity and the workloads of the remaining staff.
- The lack of specialist staff is impacting on service quality, particularly in radiology. Some doctors indicated concern that inadequate access to radiology services was impacting on diagnostic capabilities particularly after-hours and on weekends. Some districts are also reporting that waiting times for radiology are increasing.
- The public sector is seen to pay less than the private sector for all three disciplines, with continual competition for quality staff. On the other hand, the public sector is seen as offering wider experience and more interesting work than the private sector.
- Insufficient administrative support for clinicians has been raised as a consistent theme. Clinicians in all sectors expressed concern about the increasing levels of administration work required in their day to day work, impacting on clinical time.

2.2.6 Clinical audit and governance systems

- Queensland Health has a range of clinical governance systems that should theoretically have detected the events in Bundaberg Hospital. Their failure to do this reinforces that systems and committees alone will not of themselves ensure that a chain of adverse events is quickly identified and addressed. Clinical governance and quality and safety programs have been in place for many years including:
  - all districts have arrangements in place for the credentialing and privileging of doctors, although their capacity to undertake this assessment rigorously varies from district to district, being dependent largely on size
  - in some districts, committees exist which routinely look at morbidity and mortality. However, there are no formal requirements for these reviews to take place or requirement to share the findings with other staff.
  - there have been few clinical audits conducted by the Office of the Chief Health Officer and no statewide training for clinicians on clinical audit processes.
- Queensland Health does not have the systems to adequately support or encourage clinicians (ranging across the professions) to report concerns about the competence and decisions of another clinician. Identification of declining or questionable clinical competence is hampered by inadequate clinical data collections and insufficient involvement of clinical leaders.

Quality and safety

- Quality and safety systems are being implemented but are still immature. Most districts have some form of quality committee. There is a wide range of variation in the level of consideration given to quality committee reports and feedback provided.
- Quality and safety systems have focused on issues such as falls prevention, medication errors, incident reporting and workplace health and safety issues to date.
- In many districts, the quality system has become synonymous with the accreditation process. The quality process is not seen by staff to be a part of normal practice. Accreditation alone is not an adequate measure of the quality and safety of services.

Risk management

- Risk management development is still in its infancy in Queensland Health and to some extent is still being seen as a legislative compliance issue rather than a tool for managing and ensuring good patient outcomes.
- All districts have risk registers, but they do not roll up to a corporate risk register. The quality of the risk registers vary markedly between districts as does the link between the risks identified and evidence of strategies to manage the risks.
- In the main, risk management in the districts is reactive, rather than proactive. There is a belief by some staff that the informal system of risk management works well and lack of time due to patient load does not permit them to value or use the formal systems.

Complaints management

- Public forums and many submissions received by the Review raised consistent concerns with Queensland Health's ability to adequately deal with complaints, whether from patients or staff.
- There is an inconsistent approach across the State for dealing with the various complaint categories. Complaints management within Queensland Health is not sufficiently coordinated and in many cases ineffectual. In some districts local resolution of patient complaints appears to be working well, although in a number of districts patient complaints are being escalated directly to the Minister for resolution or external legal avenues are being pursued because of the difficulty in gaining local resolution.
- The public does not have satisfactory complaints systems upon which to rely, nor are there sufficient patient support mechanisms or checks and balances. There was some concern by rural communities that people were not lodging complaints in the fear that services would be closed. Some staff advised that little regard has been paid to workplace, health and safety systems and views of district staff are that the grievance system, as a means of resolving workplace issues, is an abject failure.
- A great deal of dissatisfaction was expressed about the delays and lack of effective complaint resolution by bodies such as the Ombudsman and the Health Rights Commission.

2.2.7 Workforce management systems

- Queensland Health is the largest employer of health professionals in Queensland. Its role includes recruitment, placement, supervising, training and mentoring the health workforce of the future.
- Queensland Health is competing in a global market for the health workforce where there are growing shortages across the medical, nursing and allied health professions.
- In the context of critical health workforce shortages, it is important that Queensland Health's workforce management systems support clinicians to deliver services and assist in attracting and retaining the best and most highly skilled practitioners in the State's public health system.
- An effective workforce management system would be expected to include long term workforce planning, effective recruitment and retention processes, appropriate remuneration and employment conditions, a fair and transparent staff complaints system, quality controls including credentialing and periodic reassessment of skills, access to training and professional development, mechanisms for allocating staff, and up to date workplace health and safety management systems.
- Most importantly, the workforce management system as a whole should support, value and nurture staff. Health professionals are working in increasingly complex and stressful environments characterised by rising workloads, sicker patients, more demanding and at times physically violent patients, rapid technological advances and growing community expectations about what health services can deliver.

A range of workforce management systems are used within Queensland Health. Broadly, the major systems include:

- Human Resource information management systems such as LATTICE, which provide data about the Queensland Health workforce including trends over time
- workforce planning in some districts or zones and a corporately developed Queensland Health Workforce Strategic Plan 2005-10
- representation on national workforce planning forums [the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Officials Committee (AHWOC)]
- recruitment processes based on whole of government merit selection and vacancy advertising requirements as well as use of recruiting agencies
- a range of systems to cover temporary vacancies including: use of private agency staff for nurses; deployment of junior doctors to cover leave taken by medical staff in rural and remote areas; internal relief arrangements in some districts
- credentialing and clinical privileging policies and procedures, with final responsibility resting with District Managers
- a fragmented and complex award based system of remuneration and conditions for professional groups, determined through whole of government enterprise bargaining processes
- a range of retention strategies including: study leave, motor vehicle entitlements and private practice arrangements for medical staff, rural and remote allowances and rental assistance for some staff; limited qualification allowances for nursing staff; and a Clinical Advancement Scheme for allied health professionals
- a hospital based postgraduate and vocational training system for doctors which operates in partnership with universities, the Medical Board and Australian medical colleges
- clinical placements for nursing and allied health students in partnership with universities, to support education of future clinicians
- training and professional development arrangements including mandatory corporate training for all staff (eg fire safety, aggression management, cross-cultural training) and varied arrangements for clinical skills development for doctors, nurses and allied health professionals
- rostering systems for nurses including ESP and the Business Planning Framework
- grievance processes to manage staff complaints and disputes.

Queensland Health's workforce systems are working imperfectly overall despite its ability to sustain steady increases in its clinical workforce over the past decade. However, there is room for improvement, with key findings outlined below.

Monitoring of key workforce trends

- The Review appreciated the significant efforts undertaken by Queensland Health to provide data on the workforce in terms of numbers, trends over time, vacancy rates,

areas of key workforce pressure and turnover and wastage rates. However, the difficulties in providing this data highlight a failure within the organisation to systematically monitor and analyse workforce data, including identification of key trends and areas of concern.

- In terms of monitoring staff morale, the Review accessed surveys occurring on an ad hoc, district by district basis, but could not identify any statewide staff satisfaction survey activity.
- More comprehensive monitoring and analysis of workforce trends would be useful to inform statewide workforce planning.

Workforce planning

- Plans were available in some districts and zones. There was no comprehensive plan which modelled future workforce needs and scenarios, options to meet future demand which included specific targets, strategies and timeframes.
- Queensland Health contributes to national workforce planning activities which are most developed in the area of medical and nursing workforce but underdeveloped in respect of allied health. Additionally, national workforce planning activities are based on current models of care and workforce trends.
- National work to examine alternative workforce scenarios or models would be desirable, given the widespread agreement that the existing workforce model cannot be sustained in the context of a shrinking and ageing workforce. The advantage of national planning is the opportunity to engage the Commonwealth government given its critical roles in funding student university places, private medical activity, primary health care and aged care.

Recruitment systems

- The Interim Report identified the need for more flexibility in recruiting clinicians and the limits of whole of government merit selection processes in identifying the best clinicians to fill a vacancy, especially the nursing workforce. There is a need for more flexibility in advertising positions, timely placement of requested advertisements, and the need for improved recruitment systems in selecting OTDs with special purpose registration.
- A degree of casualisation was observed in the nursing workforce, with a high reliance on agency staff to regularly cover nursing vacancies at short notice.
- The Review was told that many clinicians are awaiting the outcome of the Bundaberg Commission of Inquiry and the Queensland Health Systems Review before determining whether they will remain in the public sector. This, combined with damage to Queensland Health's reputation as an employer following events at Bundaberg Hospital, suggests that intensive efforts are needed immediately to improve recruitment and conditions resulting in greater retention of employment of Queensland Health's current and future clinical workforce.
- These issues may be partly addressed by the Queensland Government's announcement on 2 August 2005 to give Queensland Health more flexibility than other departments in its recruitment techniques.

Credentialing and clinical privileging

- Queensland Health has in place credentialing and clinical privileging policies and procedures. However, events in Bundaberg Hospital have clearly raised questions about the adequacy of implementation of these systems.

Remuneration and entitlements

- Clinical staff identified a range of issues impacting on retention. This included a perception that Queensland clinical staff earn less than their interstate counterparts. However, non-salary issues were clearly presented as being more significant in determining whether to remain in the public sector. The Interim Report highlighted these issues in detail. Broadly, clinicians reported feeling undervalued and marginalised from a system with unmanageable workloads, lack of management support, lack of clinical input into decision making including budget allocations, insufficient time for teaching, research and professional development, budget constraints impacting on quality of clinical care, limited opportunities to develop collegiate networks within and across professional groups and poor organisational culture.
- Remuneration and entitlements are determined through whole of government enterprise bargaining processes. Often enterprise negotiations are escalated to the highest levels in government, thus diminishing the worth of the enterprise concept. Such arrangements leave very limited discretion within Queensland Health and at the district level to negotiate individual employment arrangements. To some extent, standardised entitlements are helpful in that they contain uncontrolled escalation of salary costs through competition between districts.
- It is important for remuneration and entitlements to be fair and just and competitive with other states to position Queensland Health as an attractive employer. This is not presently the case.

Retention strategies

- District staff identified a range of issues impacting on retention. However, many other system improvements, particularly in the areas of workload, budgeting, service planning and information systems, will also be critical in improving work conditions and ensuring clinical staff feel valued and supported.

Education and training

- Queensland Health is unable to provide essential teaching, education and training as it struggles to cope with increasing demands for services. Across all professional groups, the Review heard from senior clinicians who were concerned that they did not have time to adequately support, supervise and mentor junior clinicians due to high clinical workloads. In turn, many junior clinicians felt exposed due to insufficient supervision and support.
- Senior medical staff – including full time and visiting medical officers – have an entitlement as part of their conditions of employment, to study or take professional development leave. However, doctors consistently reported major frustrations with the convoluted and mean spirited approval processes required for them to attend overseas conferences and to take study leave.

- Junior doctors and registrars are employed in public hospitals in both a service delivery role and to meet training requirements under what could best be characterised as the medical apprenticeship training model. Junior doctors and registrars reported not receiving adequate support or supervision due to high clinical workloads of senior doctors.
- The supply of medical graduates into the system is expected to double by 2010 with the expansion of medical courses across the State's universities. This will pose major challenges to Queensland's public hospital system in terms of the need for additional training positions and the extra demands for supervision which will be placed on already stretched senior specialist staff.
- This has led to questions around the continued suitability of the current traditional time-based medical training system which is based on an apprentice type model and undertaken predominantly in metropolitan and regional public teaching hospitals. If increasing graduate numbers are accompanied by worsening senior medical staff shortages then this model may be difficult to sustain.
- There are numerous players involved in medical training including the Commonwealth and State Governments, universities, colleges, registration boards, professional associations, and the private sector. The multiplicity of players and their differing objectives makes long term coordinated planning critical in addressing future medical training needs.
- Queensland Health has implemented a number of strategies to improve training and education for the nursing profession including the development of a Statewide Nursing Staff Development Framework to provide a coordinated direction for training across the State. Nurse educators are employed in most of the medium and larger sized facilities and there has been a major emphasis on developing transition programs for new graduate nurses and nurses re-entering the workforce. Special programs for nurses working in rural and remote areas have also been developed.
- Notwithstanding these efforts, there is considerable variation in the delivery and quality of training undertaken across the districts. Generally, access to training is restricted in rural and remote areas and there can be disparities in availability between community and acute settings. Some districts have put in place a range of training programs including specific skills development programs for emergency department and intensive care nurses while in other facilities, there are limited specific training or education programs available.
- Often the workload has prohibited staff from attending training due to the lack of backfill available.
- Clinical practice differences can be attributed to infrastructure, availability of nurse educators, and the level of staff and organisational commitment to training and professional development. The increasing casualisation of the nursing workforce also presents challenges for training as resources are usually allocated on the basis of the number of full time equivalent staff employed.
- Nurses were also concerned at the focus on administrative mandatory training, frequently emanating from Corporate Office, which is not risk based or appropriately targeted, is seen as of little value by staff and is not related to higher priority clinical requirements.
- Allied health comprises a diverse range of professionals with different training needs and requirements. While Queensland Health has recognised the need for improved

training for allied health professionals, as with nurses, the application of training strategies can be variable across the State. The relatively smaller numbers of each professional group within the allied health profession makes mentoring support difficult particularly in the smaller health service districts where there may be only one or two practitioners.

- Concerns commonly raised by allied health staff included increasing patient demands which limits time available to support junior staff, inability to backfill positions and attend training, and difficulties associated with meeting specific registration board requirements regarding supervised practice. The Review also noted the industrial action which occurred in 2004 where allied health staff withdrew supervision for clinical placements due to concerns about lack of resourcing to support supervision.
- Allied health staff also report dissatisfaction with their preparation for the work environment and a lack of support and preparation for working in rural and remote areas. The majority of professional development undertaken by allied health employees is self-funded which also acts as a major disincentive for professionals to keep their skills up to date.

In summary, the dearth of teaching and training is one of the most serious, if not the most serious, problem identified.

Grievance processes to manage staff complaints and disputes

The Review heard from many Queensland Health staff that existing grievance systems are not resolving concerns for aggrieved staff or resolving workplace conflict. Whilst grievance procedures are a key workforce management strategy, the process:

- Removes responsibility for workplace harmony from management/supervisors
- Takes an inordinate amount of time
- Resolves little and often escalates conflict and resentment.

Workforce information systems

- District visits highlighted the administrative burden imposed on clinicians in managing workforce information and rostering systems. There was a consistent view expressed by clinicians in districts that these systems could be far more efficient and that management of some of these systems might be more appropriately performed by administrative support officers to increase availability of clinicians to perform clinical work.

2.2.8 Asset management and capital works

- There has been considerable modernisation of Queensland Health's asset base over the last 10 years, particularly following the completion of the $2.8 billion Statewide Health Rebuilding Program. However health planning input was deficient and all major facilities rebuilt have insufficient beds for today's demand and future growth. There has been a tendency over many years for government to impose their view on where health services should be located. This should be addressed.
- Improving the link between health service planning and capital works planning has been identified as an ongoing issue for Queensland Health. There has been limited

routine service planning in Queensland Health for a number of years, with no effective link between health service planning and capital works or asset strategic planning.

- A number of districts have indicated a gap in sub-acute capacity, for both acute and mental health conditions. Many considered that investment in these areas would ease pressure on acute facilities and improve continuity of care.
- Budget setting for new capital works projects has been an ongoing challenge for Queensland Health, partly due to insufficient planning prior to project announcement, inadequate scope definition and insufficient total funding.
- Districts have indicated a gap between their asset needs and the annual capital works plan, with limited involvement of the districts in the overall capital planning and prioritisation arrangements. Funding for asset replacement, refurbishment, maintenance and building operations continues to be an issue for the department.

2.2.9 Information management

- Information is a key enabler in the delivery of health outcomes within Queensland. Information technology and management services Queensland Health is governed and delivered at the corporately. This centralised approach is viewed by other states as providing significant information management benefits.
- Queensland Health has many information systems providing a wealth of data yet information has tended to concentrate on financial performance, hospital activity and, far less perfectly, human resource systems. Queensland Health does not have information systems for all of its major service delivery functions eg. community health or allied health services. Information management to support clinical processes and outcome monitoring have not been a focus of the organisation to date.
- At the operational level, issues raised by staff regarding information technology and information management include inadequate access to information technology infrastructure, the need for information systems to be considered in their totality, including the impact on clinical staff of a number of systems and improving system integration to minimise time spent entering data into different systems.
- From a corporate perspective, there is a strong need for a systematic review of the administrative processes across the department commencing with human resource systems to minimise the overall administrative burden which has become cumbersome and time consuming.

2.2.10 Performance monitoring and reporting of health system outcomes

- Queensland Health provides a range of performance measurement data publicly to meet the requirements of the both the State and Commonwealth Governments, and participates in a range of benchmarking activities with national bodies including the Australian Institute of Health and Welfare and the Productivity Commission.
- External health outcome reporting by Queensland Health has been a combination of annual input into the Queensland Government's Priorities in Progress report and through the *State of Health of the Queensland Population series*. The latter reports in

identify the burden of disease for Queensland and highlight areas of potential health improvement.

- Public performance measurement and reporting of the health system has focused heavily on hospital based services, particularly activity, access and expenditure. Queensland Health reports publicly on waiting times for elective surgery on a quarterly basis. However routine public reporting of quality, safety and clinical outcomes does not occur.
- Internal reporting within Queensland Health is based traditionally around activity levels and financial monitoring. The Measured Quality Program was the first corporate attempt to measure quality and safety across the hospital system.
- Compared to New South Wales and Victoria, Queensland Health provides less routine public information about a range of health services including access and quality of health services.

2.2.11 Culture

- Queensland Health has a positive culture of dedication towards patient care and wellbeing which was also very strongly evident during district visits. The general commitment of Queensland Health staff to providing quality care in some times difficult circumstances is commendable. Queensland Health has also had a culture of clinical innovation in a number of specialities, considered a world leader in a number of areas.
- However it has also been widely reported in the media, to the Review through its district visits and submissions, that an entrenched and negative feature of the Queensland Health culture is one of bullying, threat, intimidation, coercion and retribution on the one hand, and of secrecy, blaming and avoiding responsibility on the other. These values, attitudes and behaviours are not conducive to a cohesive staff environment or good patient care.
- There is a strong culture of budget containment which has developed within Queensland Health. There has been a clear message from the highest levels of all Governments over the last decade that failure to perform to budget will not be tolerated. Staff concede budget management is important, but feel that the manner in which cost consciousness and budget efficiency have been driven, has been responsible for exacerbating the incidence of bullying and intimidation.
- There is also a culture of secrecy and cover-up where it is argued protection of patient rights is used to avoid release of information in the public interest.
- There is a need to improve the commitment and skills of leaders, managers and supervisors to deal with difficult and complex problems, engaging effectively with staff and encouraging staff contribution to the resolution of problems.
- All too frequently staff report that problems are addressed through processes where verbal instruction evoked antagonism and formal processes involving lengthy written correspondence with no response or follow up. The lodgement of formal grievances and lengthy investigations with inconclusive outcomes was a commonly reported feature.