RESEARCH REPORT NO 22

HEALTH CARE IN A 'NEW' QUEENSLAND[1]

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At the launch of the TJRyan Foundation in February 2014, I presented a paper entitled 'Healthcare in a Newman Queensland' (http://www.tjryanfoundation.org.au/_dbase_upl/Health_care_in_the_new_Queensland.pdf). With the recent election which has seen the overthrow of Campbell Newman's government, I call this current paper 'Healthcare in a "new" Queensland'.

The previous Liberal-National Party (LNP) government planned ambitious changes for Queensland Health, which, as one of the largest of the government departments, was in need of an overhaul. Their aims were laudable, and included reducing bureaucracy; reducing waiting times for admission to hospital, specialist consultation and routine surgery; ensuring patients were seen by medical specialists and received required surgery within reasonable timeframes, and a more efficient Queensland Health.

Methods for making these changes included decentralising the system by creating autonomous health regions with their own boards of directors who had the power to control everything locally. Membership of these boards was by direct ministerial appointment, and they were expected to use an efficient business model. Because Queensland Health, as one of the biggest employers in Queensland, was notoriously cumbersome, the new boards were expected to cut staff and implement targets, the achievement of which became the driving force behind facilitation of many of the proposed changes. All this was put in place between 2012 and 2015, the three years of the LNP government.

The changes wrought by the Newman government have had significant negative effects on the health system, and a full and formal evaluation is now required to assess if there were indeed any real efficiencies achieved.

The staff cuts were the most visible and most important modifications. A total of 4,820 positions were removed from the Queensland Health workforce, and of those, 1,800 were nurses and midwives.[3] While Lawrence Springborg, the health minister of the time, continued to proclaim that

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[1] A special thanks to Ms Beth Mohle, Dr Liz Todhunter and all the staff and members of the Queensland Nurses' Union of Employees, firstly for help in providing details for this paper, and secondly, but most importantly, for the terrific support and help they have been to the nurses and midwives of Queensland over the last three years.

[2] Paper presented at the 1st Anniversary of the TJ Ryan Foundation on 20 February 2015, Brisbane by TJRyan Foundation Board Member, Professor Linda Shields MD, PhD, FACN.

[3] Queensland Nurses' Union. (2014). 'News: Public hospitals at breaking point', September 2011, http://www.qnu.org.au/news/press-releases/current-releases/public-hospitals-at-breaking-point

none of the lost positions were in front line services[4], this was patently not true, and many of the nursing and midwifery positions were from wards and units. Many employees had to apply for their own jobs, setting them up in competition with their co-workers, and staff cuts were so extensive that entire important services such as primary health care disappeared across Queensland. The substantial job losses caused a significant brain drain to other Australian states. To meet service needs with a reduced workforce, overtime has increased dramatically[5] and patients are pushed through the system in factory style healthcare delivery. With the diminished workforce, there are now not enough staff to safely and appropriately care for patients. Burnout amongst staff is rising with further job losses[6] and the difficulty of attracting people to work in rural and remote areas has increased. Consequently, continuity of care has been compromised, meaning that patients/clients of the health system do not receive the seamless ongoing efficiency needed for effective clinical care.

Another aspect of the staff cuts is less well recognised. Across Queensland, many staff have come from overseas and are employed on 457 visas.[7] This is not necessarily a problem in itself, but when one considers that in Australia there are new graduate nurses who cannot get positions[8], it seems a ludicrous situation, and one that is detrimental to the nursing profession. These young people are leaving nursing after three years of study as they cannot find work. In April 2012 Health Workforce Australia predicted that 'By 2016, there will be insufficient specialist training places for medical graduates' and 'The short-term supply of nurses is stable, but by 2025 there will be a significant shortfall'.[9] Yet we are losing these nurses before they even begin.

While the staff cuts have been the most visible changes to Queensland Health, another trend is easy to see. As I outlined in my paper in 2014[10], many senior management positions in Queensland Health were given to appointees from the National Health Service (NHS) in the United Kingdom (UK). While bringing fresh ideas from other countries and other systems is healthy, the preponderance of senior positions being from the NHS has been concerning, as the NHS has major problems of its own. The NHS over the last decade has promoted target driven health care, which research is showing has created a raft of unexpected problems.[11]

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[4] ABC Staff. (2012). 'Queensland Health axes over 2,700 jobs', ABC Capricornia, 7 September. http://www.abc.net.au/local/stories/2012/09/07/3585327.htm

[5] Mohle B. (2015). 'Letter to editor: job cuts', 15 January. Queensland Nurses Union of Employees website: http://www.qnu.org.au/news/news/current-releases/lte-210115

[6] Hegney D, Francis, K., Eley, R. (2014) 'Your Work, Your Time, Your Life 2013 Report'. Unpublished Report to Queensland Nurses Union.

[7] The Temporary Work (Skilled) visa (subclass 457) allows skilled workers to come to Australia and work for an approved business for up to four years.

[8] Stewart J. (2014). 'Thousands of nursing graduates unable to find work in Australian hospitals: union'. http://www.abc.net.au/news/2014-05-24/thousands-of-nursing-graduates-unable-to-find-work/5475320

[9] Gordon S, Mendenhall P, O'Connor BB. (2013) *Beyond the checklist: what else health care can learn from aviation teamwork and safety*. Cornell University Press, New York.
Health Workforce Australia. (2012). *Health Workforce 2025 - Doctors, Nurses and Midwives*. https://www.hwa.gov.au/our-work/health-workforce-planning/health-workforce-2025-doctors-nurses-and-midwives

[10] Shields, L, 'Healthcare in a Newman Queensland' (http://www.tjryanfoundation.org.au/_dbase_upl/Health_care_in_the_new_Queensland.pdf).

[11] British Medical Association (2005). *BMA survey of A&E waiting times*. British Medical Association, London; Mason S, Nicholl J, Locker T. (2010). 'Four hour emergency target: targets still lead care in emergency departments'. BMJ;341:61; Mears A. (2014). 'Gaming and Targets in the English NHS'. *Universal Journal of Management* 2(7): 293-301. DOI: 10.13189/ujm.2014.020705

While the aims of Queensland Health's 'Blueprint for better health care in Queensland'[12] which was developed by the LNP government as a framework for change sounded good, they were flawed, as they were based on the target model that at the time was being shown to be problematic.[13] Nonetheless, the LNP government pressed on with the changes, despite organizations such as the TJRyan Foundation and the Queensland Nurses' Union of Employees (QNU) ringing warning bells. Consequences of the changes put in place are having far reaching, deleterious effects.

Trying to meet targets such as the 'four hour rule' in Emergency Departments (formally called NEAT - National Emergency Access Target) and targets for the percentage of elective surgery patients seen within the clinically recommended time (NEST: National Elective Surgery Target) have had, as I predicted in 2014, some unforeseen negative results.

In some hospitals, four to five patients pass through one bed in one day. Nurses who have to admit the patients, who have to care for them in the few hours they occupy the bed and who then discharge them, report not being able to get to know their patients, and feeling as though they are working in a factory. If the nurse cannot know his or her patient, how can he or she possibly see when something goes wrong with the patient, or pick up changes in the person's clinical condition? The 'four hour rule' sees patients admitted to inappropriate wards because once the four hours is up in the Emergency Department they must be sent somewhere so that the target can be met, and they may not be sent to the ward/unit where the most appropriate care is to be had.

For example, a person with a suspected cardiac condition may be sent to a surgical ward until a bed becomes available in a medical ward. Staff in the surgical ward do a terrific job caring for people who have surgery, but may not have the specialist skills necessary to care for a patient with heart trouble. In another ruse to meet the 'four hour rule', holding wards have been set up in some places, so that patients can be sent out of the Emergency Department to make the 'four hour rule' lists look good. As a result of these 'holding patterns' patients are moved from one ward to others, thereby breaking the important thing we call 'continuity of care' which means that cohesive care is given by a team of health professionals that remains essentially the same throughout a person's admission. In this way, the staff become acquainted with the person, why he or she has been admitted, or requires care, and can give seamless care.

Entry into hospital has also been the subject of targets. Ambulances are not meant to queue outside Emergency Departments – the patient is meant to be brought inside for care as soon as possible after arrival. However, Emergency Departments are often so full (and often understaffed as well) that beds are not immediately available, so the ambulance has little choice but to wait. To meet the target of the set time period before admission Emergency, administration staff are going out to do paperwork in ambulance bays so that the admission time is recorded. This does not, however, have any real effect – patients still have to wait, but at least the paperwork and the targets look good.

The end result of these changes has not been the efficiencies that LNP health minister Springborg wanted. Instead, health services, nurses, doctors, allied health and administration staff are all doing more with less. Overtime has greatly increased, as has staff burnout.[14] To try to make the changes work, some health service managements have resorted to emotional blackmail and intimidation.

Imagine this: a nurse in the operating theatre has worked a 10-hour shift. Towards the end of the shift, he is asked to stay on and work another two hours to complete a surgery list so that the target can be met for that day. He says he can't do it, as he is fatigued and would be unsafe if he

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[12] Queensland Health. (2013, February). *Blueprint for better healthcare in Queensland* http://www.health.qld.gov.au/blueprint/docs/spreads.pdf

[13] British Medical Association (2005). *BMA survey of A&E waiting times*. British Medical Association, London; Mason S, Nicholl J, Locker T. (2010). Four hour emergency target: targets still lead care in emergency departments. BMJ;341:61;

[14] Hegney D, Francis, K., Eley, R. (2014) 'Your Work, Your Time, Your Life 2013 Report'. Unpublished Report to Queensland Nurses Union.

continued working. The manager of the unit tells him that the patients would miss out if they can't get their operations that day, that there are no other nurses available to do the shift, and that the manager and all the staff will be in trouble if the target is not met. The nurse is made feel morally obliged to do the overtime, despite the obvious safety issues for both nurse and patients. I give this as an example, but it is a very real situation which is replicated in many wards and units across Queensland Health. Basically, nurses want to help people, and are often coerced with this sort of language even though they are fatigued and the patients' and the nurse's safety will be compromised. Such emotional blackmail is all too common, and is completely unacceptable. The Queensland Nurses Union has been very active in protesting about such behaviour. The result is an all-pervading culture of fear throughout the Queensland Health workforce. Of course, such a climate can have only negative effects on patient care.

Nonetheless, care is good in most Queensland Health facilities, and the public should celebrate this fact. However, it is often brought about by health professionals and other staff who make the good care happen despite the demands on them of, in some places, autocratic management styles, bullying, and other less than optimal management practices. It is little wonder that the brain drain to other Australian states, or out of Queensland Health to other sectors, continues.
The underlying premise of the LNP government was cost, and it is undeniable that the cost of health is an ethical issue.[15] The LNP government was all about reducing cost of government, but to impose a business model on health care administration in a publicly funded health system is not the best way to ensure good care is delivered.

Public health care is not a business, but if one wishes to perceive it that way, then a case can be argued. In a business model for a publicly funded health service, the shareholders are the taxpayers, and the 'business' – the health system, has a duty to provide best possible health care to its 'shareholders'. While the 'business' has a responsibility to run services efficiently, it cannot be run on business principles alone because there is a public good to be met (equal health care for all), and it is not ethical to expect to make a profit as would be expected and ethical in a private business (or health system). Indeed, it would be unethical for a private hospital not to make a profit, but the argument here is about a public health system funded by taxation. The ethics of running the public health system as a business could provide a framework to assess how Queensland Health is working after three years of LNP cost cuttings and business model health delivery.

A top level review of Queensland Health is urgently needed. Three years of LNP government and health boards is a broad enough timeframe from which changes and effects can be assessed. All would agree that in Queensland Health there is a need for a revision of bureaucratic processes. The implementation of health boards requires assessment – was this a good or bad move? Are the health boards improving the efficient running of Queensland Health, or are they making it worse? Are the boards themselves efficient? Are their workings transparent? Functioning and results of the decentralised model and purported efficiencies should be examined to determine if they are real, or if they are driven by a possibly inappropriate business model. Urgent attention needs to be given to staff losses and replacements, in particular, the effect of the employment of senior staff from the UK National Health Service, and the models implemented by them, with particular consideration given to the effects of the application of flawed NHS practices.

The review must be independent, but must seek advice from the Queensland Nurses Union (which has been an important advocate not just for nurses and midwives but also for the people of Queensland during the crises of the last three years) and the Australian Medical Association. Importantly, patient 'consumer' groups must be involved at every level – after all, the care which Queensland Health delivers is to the people of Queensland, who, after all, are the 'shareholders' in this 'business.

The most important job for those who undertake the review is to investigate, ameliorate and repair the culture of fear that can be found across Queensland Health today. An independent review must make sure people are not afraid to speak openly and honestly. The culture of fear must be

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[15] Baily, M. A. (2011). 'Futility, Autonomy, and Cost in End-of-Life Care'. *The Journal of Law, Medicine & Ethics*, 39(2), 172-182. doi: 10.1111/j.1748-720X.2011.00586.x

replaced with one of trust. Indeed there is such a lack of trust at present that staff will need much convincing that things are going to improve - they have to know that they can speak without prejudice. The culture of fear is worse in rural areas where people have a limited ability to change employers and so regional, rural and remote areas need special attention.

The Queensland Nurses Union has been working to have nurse-patient ratios mandated in Queensland, as they have been most successfully applied in Victoria, and this was one of the election promises of the incoming Labor government. Another promise was an increase in nursing staff numbers. It has been well proven that for every extra nursing position, mortality and adverse events in hospitals decline.[16]

Suggestions have been made that the airline industry has the answer for the health industry.[17] Over the last 20 years, the airline industry has successfully implemented a model of equality amongst its workforce, with the most junior employee encouraged to speak if he or she sees something that has a potential impact upon safety. The results of catastrophes in both the health and airline industries are the same – death of people. It is incumbent on all health professionals, health service staff, and importantly health service users to work with the new Palaszczuk Labor government to ensure Queensland Health reaches its real potential as a safe and efficient health system providing the best possible care to Queenslanders.

[16] Aiken LH, Sloane DM, Bruyneel L,Van den Heede K, Griffiths P, Busse R, Diomidous M, Kinnunen J, Kózka M, Lesaffre E, McHugh MD, Moreno-Casbas MT, Rafferty AM, Schwendimann R, Scott PA, Tishelman C, van Achterberg T, Sermeus W. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. The Lancet. doi:10.1016/S0140-6736(13)62631-8; Jarrín O, Flynn L, Lake E., Aiken, LH. (2014). Home Health Agency Work Environments and Hospitalizations. Medical care, 52(10), 877.

[17] Gordon S, Mendenhall P, O'Connor BB. (2013) Beyond the checklist: what else health care can learn from aviation teamwork and safety. Cornell University Press, New York.