HEALTH CARE IN A NEWMAN QUEENSLAND

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INTRODUCTION

Since the Newman government came to power in March 2013, its huge majority in the parliament has meant that many changes have been implemented across Queensland with little opposition or even discussion. No-where has this been more visible than in the health care sector. The Newman government has attacked the Queensland health system with gusto, citing mistakes made in the past, under the previous Labor government, as the root cause of the problems within Queensland Health, and the need for severe cuts in spending. They cite the pay roll debacle (Ludlow 2013) which saw the total crash of a new electronic pay roll system immediately it was turned on (with no piloting and testing beforehand), resulting in people who did not receive their pay, or were paid thousands of dollars too much. They also cited fraud in the highest echelons of the Queensland Health finance offices when the yclept "Tahitian prince" defrauded the system of millions of dollars (Remekis 2013). While these problems certainly occurred on Labor's watch, the new Liberal-National Party (LNP) government, when giving reasons for draconian cuts in public spending, including health, ignored the effects of the disastrous natural disasters of Labor's last year in office, which saw 75% of Queensland under flood water, with the remaining 25% damaged in the biggest cyclone in recorded history. The costs to the state of reconstruction were enormous, but these rated little notice when the LNP laid blame.

So Queensland has had a raft of economy measures which have seen the loss of over 12,000 jobs across the public service (Moore 2013), and the health sector has been one of the hardest hit. In an attempt to create efficiencies, the LNP government has brought senior managers from overseas, largely the United Kingdom (UK), to implement changes across Queensland Health.

Australia has one of the best health care systems in the world. Its public-private partnership, in which about half the population pay private health insurance and use the

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private health system, means that the safety net of free health care for those who in need protected. It is just and fair that people who can afford to use the private system do so, thereby freeing up the public health system for those who need it. At the same time, all Australians can choose to use the free public system as required, and highly technological care, such as emergency care, transplants, intensive care and chemotherapy, is freely available to all. The standard of care across the two systems is the same – high quality, compassionate and efficient, with the person at the centre of decisions about care. Through the Medicare levy, the system is well resourced, and the health professionals who work in it are amongst the most highly educated in the world. Queensland Health fits within this framework of excellence.

This paper discusses some of the changes being implemented across Queensland Health and their ramifications for the state and the people of Queensland. A full examination of the changes brought in since 2012 is way beyond the scope of this brief paper, and so I have chosen to discuss four characteristics of the Newman government's health care, which I have entitled "Primary health care ", "Unforeseen consequences", "Rudderless ships", and "Beware the cultural cringe". The material under discussion is largely taken from the LNP government's "Blueprint for Better Healthcare in Queensland Report" (herein called *Blueprint*) which was published by Queensland Health on February 12, 2013. The main thrust of this paper is to discuss how some of the (sometimes) highly laudable aims in the report have affected the health care delivered to Queenslanders.

Characteristic 1: Primary health care

An understanding of primary health care eludes many politicians and health care policy makers, both state and federal. Much confusion about it exists, with those making policy believing it to be centred around doctors in general practice. In 1978, the World Health

Organization promulgated the Declaration of Alma Ata (World Health Organization (1978), which codified primary health care, and has become the cornerstone for this branch of care delivery. Its focus on promotion of health and prevention of disease has been further developed by a series of policies and directives since 1978, such as the Ottawa Charter for Health Promotion (1986). Australian governments confuse this with primary care, which means the first point of call for people accessing a health service, and in Australia, has come to mean general practitioners (GPs). There is a real difference between primary health care, which is delivered by a range of health professionals whose remit is to keep people healthy, and primary care, where the role of health professionals is curative. For a thorough examination of the differences between the two, see *Croakey*, of June 17, 2010. Australian policy makers have fallen into the trap of conflating the two philosophies, and under the COAG National Health Care Agreement of 2012 (Australian Government 2012), preventive services are paid for by the Federal government via Medicare Locals, meaning that all primary health care services are meant to be provided by GPs. This has given the Queensland government the opportunity for substantial cost shifting.

Page 17 of the *Blueprint* states:

> It is the government's role to keep people informed about what they can do to live longer, healthier lives and prevent ill-health. …There is a need to re-align the day-to-day delivery of preventative health services at the local level. … Increasingly, Medicare Locals will address this opportunity.

And on page 27:

> We will move away from complex and acute services, such as those delivered in hospitals, and provide balance by investing in sub-acute care and supporting preventative and intervention services.

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These two pronouncements are contradictory, and the second is certainly receiving little attention. In 2013, Queensland Health cut swathe through primary health care services. For example, all school nurse services were removed from Queensland state primary schools (Jabour 2013). These nurses play a vital role in screening children for health problems, and assessment is the foundation of their work. They provide mental health services and screening to young people, educate children about health behaviours and are an important health link between the families and the school, and community-based services. One wonders who will now find the conditions in primary school children that need medical examination, for example, poor hearing, or the beginnings of a mental illness. Surely having no school nurses to find such conditions will be to the detriment in the health of the children of Queensland.

Health promotion services in Queensland have been decimated, with clinics closed across the state. This, in an era of increasing rates of obesity and Type II diabetes, rigorous evidence about the role of prevention in cancer, concerns about immunization, and so forth, is unforgiveable. In a particularly concerning example, sexual health services have been severely reduced, despite a syphilis epidemic in North Queensland (Stephens 2013), which will have long term ramifications for not just current sufferers, but also infants born with congenital syphilis and all its negative outcomes.

A word needs to be said about services for Aboriginal and Torres Strait Islander people. The Federal Government covers the cost of most of these health services, and so they are, to a certain extent, protected from some of the Queensland Health cuts. However, given that 12% of the population of North Queensland is Aboriginal or Torres Strait Islander, Queensland Health still has a major obligation to provide their health services, and these, too, have been cut back.

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As per the COAG agreement (Australian Government 2012), Medicare Locals are to be the bodies that provide primary health care, but they are slow at picking up these services. This is not surprising, given the confusion over primary health care and primary care, and the fact that Medicare Locals are medically dominated (and may not understand the difference between the two). Primary health care is most often delivered by health professionals other than doctors, for example, nurses, health promotion and public health experts, etcetera. While we wait for the Medicare Locals to take up the services that Queensland Health have off-loaded, the health of Queenslanders will be jeopardised. Long term consequences will see expense over time as diseases such as type II diabetes and its myriad complications (such as blindness and limb amputations) develop, unchecked, in the population.

Unforeseen consequences

In years past, and similarly to other countries, the Australian public health system has had trouble dealing with the volume of people requiring elective surgery. In Queensland, this has meant, for some people, waiting up to a year for an operation (Australian Institute of Health and Welfare 2012). Such has been characteristic of Queensland Health under several different governments. The Newman government came in with a will to improve things in health, and in particular, cut waiting times. Of course, this aim is commendable, and the government is to be congratulated for its attempts to reduce waiting times. However, their solutions to this intractable problem have generated unforeseen consequences.

As a way to decrease waiting times and improve throughput in the health system, Queensland Health, similarly to other health departments in Australia, has borrowed from the UK's National Health Service (NHS). The NHS has devised targets which should be met, and tied these to funding, with bonuses to trusts (the name for health service districts in the NHS) for reaching targets in a prescribed time, and penalties for not doing so. Queensland Health

has transported targets from the NHS. One such is the National Emergency Access Target, or NEAT, which is defined in the *Blueprint* (2013) as "the proportion of patients who present to a public emergency department to be admitted, referred for treatment to another hospital or discharged within four hours" (p14). This has been colloquially called the "four-hour rule". Patients who present to an emergency department (ED) in any hospital in Queensland must be discharged from that ED, either home, or to a ward or unit, within four hours. Doctors have to see, diagnose and treat each patient, and nurses have to assess, advise and care for them, within that four hour window. Under normal circumstances and with patients with straightforward problems, this is possible, and, of course, desirable. Waiting times in ED have always posed problems, and across Australia, patients have been known to be lying on trolleys in ED for well over 12 hours, with ambulances waiting outside with patients who could not be brought in because all the beds/trolleys in ED were full of patients waiting to be seen (Hammond et. al 2012). By implementing this target, more patients can be seen, fewer have to wait, and the sick are not left lying around waiting for treatment. All of this is obviously a good thing. Australian, and Queensland, public health services have embraced the NEAT with gusto, and little critical assessment.

The NEAT has had consequences unforeseen by those who hoped to improve patient care with efficient throughput and decreased waiting times. The British Medical Association, in a 2005 reviewed target-driven health care, and found that 82% of EDs surveyed found that NEAT created threats to patient safety as a direct result of pressure to meet the target. Patients were discharged from ED before being fully assessed or stabilised; they were moved to inappropriate areas or wards just to clear them out of the ED. Staff could not adequately assess some patients within four hours, given that tests can often take longer than that to complete, and some patients required observation over longer periods of time. Consequently, the care of seriously ill or injured patients was compromised. Some NHS hospitals even

reported staff taking the wheels off trolleys so they could say the patient was on a "bed", that is, not left on a trolley for longer than the target time (Gulland 2003).

Other studies found that staff felt under pressure to avoid 'breaches' of the target; and staff described bullying and poor staff morale. Patients were being inappropriately and hurriedly re-designated or re-labelled so that they could be discharged from the ED early. The authors concluded that the four-hour rule led to target-led rather than needs-led care (Mason et. al 2010, Letham et. al 2012).

"NEST" is another target which is based on a good idea, but has had unforeseen consequences. The National Elective Surgery Target "requires an increase in the percentage of elective surgery patients seen within the clinically recommended time" (*Blueprint:* p15). One could hardly argue with its aim of, by 2015, 100% of elective surgery patients being seen within the clinically recommended time, which, for Category 1 (the most severe) patients is 30 days, Category 2 is 90 days, and Category 3 is 365 days. If one was in pain waiting for a, for example, hip replacement, one would regard even 30 days as a very long time. In some places, these goals are being met, and this is a good thing.

I argue, though, that like Mickey Mouse and the sorcerer's buckets (Disney 1940), care must be taken that the drivers for targets such as this do not take over. In England, scandals are emerging constantly about poor care, and nowhere has this been more publicly demonstrated that in the Mid Staffordshire Trust, where hospital death rates much higher than the national average were investigated (Health Care Commission 2009, Francs 2013). The causes were found to be the chasing of targets to the exclusion of good patient care.

Australia has had a similar (though smaller) scandal with Dr Jayant Patel in Bundaberg (Thomas 2007). The managers of the health district were very pleased because Dr Patel's approach to surgery meant that, by increasing throughput, they met the Queensland Health surgery waiting list targets in record time, thus saving large amounts of money and

enhancing reutations. It is now well known that Dr Patel carried out inappropriate surgery way beyond his skill and ability. When nurses and others reported their increasing concerns, the hospital administration bullied them because they saw Patel as meeting Queensland Health's targets, making the administrators look very good. To quote Hedley Thomas, whose book, "Sick to Death" tells the story of the Bundaberg scandal: "The waiting lists were held up by the media, the politicians and the patients as proof of either maladministration or well-oiled efficiency. By meeting the targets in surgery he (Patel) would make the hospital look good." (Thomas, 2007, L 97). Such poor judgement could easily emerge from the well-intentioned, target driven health care which characterises Queensland Health now.

Rudderless ships

In an attempt to improve the management of the most unwieldy of Queensland government departments, health, it was decided to decentralise administration within Queensland Health, and in 2011 the Hospital and Health Boards Act was passed *(Blueprint* 2013). Seventeen health boards were set up, with people drawn from their local communities, to oversee health care in each region. Each board (which, by law, has to include a nurse and a medical doctor) has the power to appoint to its positions, and in the ensuing year, two health boards decided to save money by removing their executive directors of both nursing and medicine and having those professions answer to a corporate manager. (Shields 2013) Another service has removed its director of nursing (Calcino 2013). While the nursing, midwifery and medical professions campaigned against this, the trend is possibly going to develop further across the state. Solid evidence exists demonstrating the value of having professions answerable to their own profession, a fact that would seem obvious (Wong, Cummins & Ducharme 2013). How can a generic, corporate manager understand the clinical complexities of medicine, nursing and midwifery? If, for example, surgery goes wrong, and a

patient dies, how can a manager who is not a doctor understand fully what has happened and put in place effective ways of ensuring it does not occur again? Or, if a child needs extensive nursing support for a long admission with a chronic illness, how could a manager who is not a nurse make decisions about the level of care required, and its cost allocation? There are many such examples that can be brought to mind, but overall, the professions will be left to wander managerially unsupported in unknown seas, with no-one at the professional rudder. Of course, this translates to potential adverse outcomes for patients.

There is another aspect of this that is concerning, particularly for the nursing profession, (and for patients). In several countries, nurses are being encouraged to take on extended roles. This can be good, for example, nurse practitioners who can legally diagnose and prescribe can make a difference to the care of patients who may not be able to access busy GPs. Nurse practitioners have the ability and specialist education to spend long periods of time with patients, and use detailed assessment techniques and excellent communication skills to ensure the patient receives holistic care. General practitioners, on the other hand, are trained to diagnose and treat, but may not have the time, nor the enhanced communication and assessment skills, to be able to give the patient the same type of care.

Worryingly, though, some health services are employing nurses to do roles that exceed a nurse's scope of practice. In the UK, some nurses are being employed to perform varicose vein surgery, or endoscopies (BBC News 2004). Such procedures are within the scope of medical practitioners, not nurses, meaning that nurses are being enjoined to work outside their scope of practice, and this is illegal. Indubitably, nurses are less expensive to employ than doctors, but if damage is done to a patient, then where does the legal responsibility lie? Certainly any nurse working outside his or her scope of practice would be liable. Queensland Health is buying into this. The Blueprint for Health says "Appropriately trained nurses can be employed in procedures, such as endoscopy, to help reduce waiting lists

for patients" (p36). It is not surprising that with rudderless ships increasing on Queensland Health's seas, decisions about employing people to work outside their scope of practice could become commonplace, as generic managers with no or little knowledge of the professions involved will see only the potential cost savings.

Beware the cultural cringe

The final characteristic of the Newman government's health programmes is influenced by a common Australian attribute. Australians are not good at recognising their achievements, and look overseas, largely to the UK, the "mother country". First coined in 1958 (Phillips 1958), the term "cultural cringe" describes failing to recognise the wealth of talent and expertise available in Australia, and looking outside, believing anything from without is better than anything from within. Under the new government, this fits Queensland Health well. In at least six health districts across Queensland, executive and management level appointments have been filled with people brought from the UK's National Health Service (NHS). Clearly, parochialism has no place in developing a fine health system, and ideas and experience from another place can contribute richly to a service. Nevertheless, if we are to bring expertise from overseas, Queensland would do well to cast its net more widely.

The NHS began in 1948, with the admirable aim of providing free health care to all, paid for out of taxation (National Health Service, 2013). At the time, the burgeoning of technology and costs of treatment could never have been predicted. Now the NHS is in crisis, and breaking apart (Sell 2011, Donnelly & Swinford 2013). Some reports indicate that nurse to patient ratios are 1:22 in some places (Donnelly 2014), in other words, on average, each nurse on a shift has 22 people for whom he or she has to provide care. (In most places in Australia, the most common ratio is one nurse to four patients (NSW Nurses and Midwives

Association 2014)). Health care costs have rendered the NHS unsustainable, and a raft of scandals have been rocking it for years. The most notable was the Mid Staffordshire Trust (mentioned above) which resulted in four major inquiries (Health Care Commission 2009, Alberti 2009, Colin-Thome 2009, Francis 2010, 2013), which all concluded that the trust failed because meeting targets was more important than patient care, there was too much focus on finances to the detriment of clinical care; there was little or no attention to clinical outcomes, inadequate supervision of services by the Trust Board, poor clinical engagement, and understaffing (Francis 2013, Shields 2014). Certainly, Queensland has had the Bundaberg outrage to deal with, interestingly caused by the same target driven management systems. Nonetheless, the Australian health care systems overall are very different to the NHS. In many ways, things are much better here (Watson & Shields 2009). Australia's two tier system of health care means that those able to pay for health care do so, ensuring a strong and healthy safety net is in place to support those who cannot. At the same time, all Australians can access the free health service as required, and certainly when highly technological and costly services are needed, for example chemotherapy, transplants, or intensive care, these are readily available to all.

The level of education of nurses in Australia is much higher than in England (Scotland and Wales require a Bachelor's degree for registration as a nurse) (Shields & Watson 2007, 2008, Watson & Shields 2009). Registered nurses in Australia require a Bachelor's degree for registration, while until 2013, only a diploma was required in England. Until recently, less than 10% of British nurses held degrees (Sastry 2005), though the number with degrees will steadily grow now their registration requirements have been lifted (NHSCareers, no date). Entry requirements to the diploma programmes were the equivalent of five Grade 10 passes in Australia, and so the education level of nurses has been very poor. There is much rigorous evidence that a workforce of primarily degree educated nurses

reduces mortality and adverse events in hospitals, (Aiken et. al 2014) and the recent raising of standards in the UK will have beneficial effects.

Bringing ideas and expertise from overseas means a fresh approach, innovative and positive ideas, exciting new ways of doing things. Parochialism has no place in this global world, and health care benefits from importing thinking, concepts and mind-sets from another country and culture. Nevertheless, care should be taken when choosing those ideas. The NHS has some very good things that could well be translated into Queensland Health. The position of health visitor is a good example. Health visitors are nurses with a highly specialised degree which encompasses community nursing and primary health care, including health promotion. (In about 2006, the health visitors were almost wiped out in England because of budget cuts, but now they are being re-employed, as their worth was truly felt when they were not there). Queensland Health could well do with health visitors, as this whole primary health care area has been neglected in Queensland, and, as described above, is now almost obliterated (*Blueprint* 2013). Other "goods" from the NHS include the highly developed way children are cared for in hospitals. Since the revolution in paediatric care which followed the publication of the Platt Report in 1959, which saw parents as partners in the care of their children (Jolley & Shields 2009), the psychosocial care of children in hospitals in the UK has had few peers. Across Australia, the psychosocial care of children in hospitals is often overlooked, and Queensland Health could learn much from the NHS about how this can be done for the betterment of children and their families.

Having said that, I make the points that A. we should think critically about what people from other countries can bring. The NHS is very different to Australian health care, and anyone coming to work in Queensland Health should be given a thorough orientation to the Australian and Queensland health care systems. Just because something has been implemented in the NHS does not mean it is appropriate for, or will work, in Queensland

Health. Queensland should target people for the good things that could be brought, for example, health visitors could help re-start primary health care services (or be employed by the Medicare Locals if, indeed, the Federal government is going to be responsible for that).

B. Why do we look only to the UK? Other countries have extremely good health systems, which, unlike the NHS, are not broken. Sweden has an excellent health care system (Shields 2000, 2002, Sweden 2014) which is paid for by taxation, and is based on primary health care and prevention of illness, at the same time providing the highest standards of secondary and tertiary health care. France, for many years, had its health care system rated as the best in the world (About-France.com 2014). Queensland Health could look to those countries for expertise and ideas.

C. Finally, there are many health experts across Australia who could be recruited to work in Queensland.

CONCLUSION

Queensland's health system has provided wonderful care to its citizens for a century. It is now in danger of being so compromised it will break, as the NHS is doing. In the long run, if primary health care is not supported and people are not supported to prevent themselves getting sick in the first place; if unforeseen circumstances are not seen and acted upon; if Queensland Health continues to develop rudderless ships with no leadership for its professions, and if it continues to be a subject of the cultural cringe, then Queensland patients and users of the health system will suffer.

Donald Horne in 1964 said "if we are to remain a prosperous, liberal, humane society, we must be prepared to understand the distinctiveness of our own society'. This could be translated to relate to the health services of Queensland:

'If we [Queensland health services] are to remain a prosperous, liberal, humane [service], we must be prepared to understand [and celebrate] the distinctiveness of our own [healthcare] society'. Adapted from Donald Horne, “The Lucky Country” 1964

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