25.

Submissions

Queensland Nurses' Union

PRELIMINARY SUBMISSION TO THE BUNDABERG HOSPITAL COMMISSION OF INQUIRY ON BEHALF OF THE QUEENSLAND NURSES' UNION

The Queensland Nurses' Union (QNU) has extended its co-operation and that of its members to this Commission of Inquiry by way of provision of information, including statements of its members, to the Commission. The QNU will continue to co-operate with and assist the Commission in this regard. So as to further assist the Commission in its task and represent the interests of members, some of whom will be witnesses before the Commission, the QNU seeks leave to appear at Commission hearings by Counsel, John Allen, instructed by Roberts & Kane, Solicitors.

These submissions are preliminary only. The QNU has not yet finalised its inquiries in relation to matters the subject of the Commission's Terms of Reference. Nor is the QNU in possession of all of the information gathered by other parties. The Commission is yet to hear any evidence. At a later point, the QNU intends, through Counsel, to make full submissions in relation to each of the Commission's Terms of Reference.

ABOUT THE QNU

The QNU is the principal health union operating and registered in Queensland. In addition, the QNU operates as the state branch of the federally registered Australian Nursing Federation. The objects of the union are both professional and industrial in nature. Pursuant to the Rules of the QNU, the objects of the QNU are to foster high standards of nursing practice, promote the professional and educational advancement of nurses, and promote the economic and general welfare of nurses. The Rules provide that the QNU may take all steps to participate with all other agencies in promoting measures to meet the health needs of the public.

The QNU covers all categories of workers that make up the nursing workforce in Queensland: registered nurses, enrolled nurses and assistants in nursing, employed in the public, private and not-for-profit health sectors including aged care. QNU members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management.

Membership of the QNU has grown steadily since its formation in 1982 and as at May 2005 was in excess of 33,500 and still growing. The QNU represents the largest number of organised women workers of any union in Queensland. Like the nursing profession as a whole, the overwhelming majority of QNU members are women (93%).

The QNU has a democratic structure based on workplace or geographical branches. Delegates are elected from the branches to attend the annual QNU conference, which is the principal policy making body of the union. It is rank and file membership that drives the agenda of the QNU. In addition to the annual conference the QNU has an elected council and an elected executive, which have decision-making responsibilities between conferences. Council is the governing body of the QNU.

QNU members working for Queensland Health are employed under federal industrial instruments. Members in the private sector are employed under state industrial instruments. In addition, since 1994 when there were no enterprise agreements covering nurses, the QNU has become party to over 200 enterprise agreements which cover a diverse range of health facilities and other non-health establishments where nursing services are provided (for example, schools, prisons and factories). The QNU therefore has a clear and comprehensive understanding of the complexity of contemporary health service delivery and the diversity of locations where health services are delivered.

BUNDABERG BASE HOSPITAL ISSUES

The QNU expects that evidence to be presented before the Commission will establish that:-

- Dr Jayant Patel was permitted to perform surgery beyond his own clinical competence and beyond the scope of practice of the Bundaberg Base Hospital;
- hospital management were aware of serious concerns held by other doctors and nursing staff as to Dr Patel's clinical practice;
- hospital management failed to take appropriate action to address those serious concerns;
- Queensland Health officials threatened staff with serious reprisals for communicating such concerns to any person outside the Department; and
- Queensland Health's inaction contributed directly to unnecessary loss of life, serious injury and suffering of patients. It also caused nursing staff great anxiety and distress.

Surgery beyond Dr Patel's competence and beyond the scope of practice of the Bundaberg Base Hospital

A number of factors determine whether a particular surgical procedure can properly be performed at a particular hospital, for example the Bundaberg Base Hospital, or whether a patient should be transferred to another hospital. These factors include:-

- whether surgical staff and necessary medical and nursing staff of sufficient skill and experience are available to undertake such a procedure; and
- whether the hospital's surgical and post-operative facilities are appropriate for such a procedure.

In relation to appropriate post-operative facilities, the nature of available intensive care facilities is of utmost importance. The Intensive Care Unit (the "ICU") at the Bundaberg Base Hospital is a Level 1 Combined Intensive Care/ Coronary Care Unit. Because of the limited number of available appropriately qualified and experienced nursing staff, there are restrictions upon the number of acutely ill patients who can have their needs met in the unit at any one time.

The Joint Faculty of Intensive Care Medicine has published a Policy Document which outlines the minimum standards relating to work practice/caseload, staffing and operational requirements, design, equipment and monitoring for Level 1, 2 and 3 Intensive Care Units[1]. Level 3 units are well resourced units located in tertiary referring hospitals such as the Royal Brisbane and Princess Alexandra Hospitals. Level 1 Intensive Care Units, such as that at the Bundaberg Base Hospital, should generally only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care.

The Bundaberg Base Hospital could only realistically deal with a maximum of 2 patients on ventilators at any one time because of nursing staffing levels. Also, the Bundaberg Base Hospital ICU does not have the services of a specialist Intensivist[2], unlike hospitals in Brisbane to which patients requiring high level of intensive care are appropriately referred.

Dr Patel was permitted to perform surgery which was beyond the scope of practice of the Bundaberg Base Hospital, namely, that which should have been performed at a hospital with a higher level of intensive care facilities. He was also permitted to perform surgery of a type beyond his own clinical competence.

Dr Patel ignored the concerns of other medical staff and nursing staff that patients should be transferred to Brisbane for a surgical procedure and/or after suffering post-operative complications. The farcical, but tragic, situation occurred whereby other medical staff and nursing staff would take steps to, in effect, hide patients from Dr Patel and organise the transfer of patients to Brisbane at times when Dr Patel was not present to intervene to prevent transfers.

Examples of adverse outcomes for patients and complaints by nursing staff and the QNU to management and other authorities

It is expected that the Commission will hear evidence as to a number of patients who have suffered unnecessary death or serious injury because of the circumstances at the Bundaberg Base Hospital. The QNU expects that such evidence will include evidence in relation to the following patients, who are referred to by way of examples of the tragic situation confronted by patients, medical staff and nursing staff. To protect the privacy of the living and the feelings of the loved ones of those deceased, these patients are referred to in this submission by way of a code used in preparation of statements from QNU members for submission to the Commission. The Commission has been supplied with a list of patients referred to by name, Queensland Health UR number where it is known, and the code.

[1] http://www.jficm.anzca.edu.au/publications/policy/ic1_2003.htm
[2] A medical director who is a Fellow of the Joint Faculty of Intensive Care Medicine

On 19 May 2003, **Patient P34** underwent the major surgical procedure of an oesophagectomy performed by Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff and the family of the patient that the patient was stable.

The ICU Nursing Unit Manager, Ms Toni Hoffman, spoke to the Director of Medical Services, Dr Darren Keating, on two occasions in late May or early June 2003 to voice her concerns about the treatment of this patient. At one of those meetings she was accompanied by the then Director of Nursing, Ms Glenys Goodman, and on another occasion by Dr Jon Joiner, a General Practitioner who would perform local anaesthesia for the hospital. Ms Hoffman expressed her concerns to Dr Keating as to surgery such as oesophagectomies being undertaken at the Bundaberg Base Hospital, which lacked appropriate intensive care facilities for post-operative care for patients undergoing such major surgery. She also expressed her concerns as to Dr Patel describing a patient as stable when they were obviously critically ill. Dr Keating's response was that Dr Patel was a very experienced surgeon with whom staff would have to cooperate. He told Ms Hoffman that there was an expectation that the Bundaberg Base Hospital would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced in performing this type of surgery.

On 6 June 2003 **Patient P18** underwent an oesophagectomy performed by Dr Patel. Despite post-operative complications that required returns on subsequent days for further surgery because of wound dehiscence (the wound coming apart), Dr Patel intervened to prevent the transfer of the patient to the Royal Brisbane Hospital and he was not ultimately transferred to the Royal Brisbane Hospital until 20 June 2003.

Ms Hoffman communicated her concerns in writing to the then Director of Nursing, Ms Goodman, and to the Director of Medicine, Dr Keating, in the period of time that Patient P18 remained in the ICU.

During 2003, every patient at the Bundaberg Base Hospital who had a peritoneal dialysis catheter placed by Dr Patel had complications with acute and chronic infections, migration of catheters requiring further surgery and incorrect external positioning of the catheters. On 17 December 2003 **Patient P30** underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been positioned correctly in the first place.

As a result of concerns raised by nursing staff as to this death and the hundred percent complication rate regarding peritoneal dialysis catheters inserted by Dr Patel, hospital management eventually reached an agreement with a medical supply company and a local private hospital. Pursuant to this agreement, the medical supply company undertook to pay for insertion of such catheters into Bundaberg Base Hospital patients at the private hospital.

On 27 July 2004, Dr Patel intervened to prevent the transfer to Brisbane of **Patient P11**. He then took it upon himself to intervene in the care of the patient and insert a pericardial drain. Such a procedure involves the insertion of a tube with a needle on its end through the abdominal wall under the diaphragm and up into the pericardial sac which surrounds the heart. Such a procedure is one that can be accomplished by any reasonably competent surgeon on the first attempt. Dr Patel forcefully attempted to insert the pericardial drain. He was unable to do so on his first or many subsequent attempts, leaving the patient with multiple stab wounds in his upper stomach. Whilst doing so, Dr Patel made loud comments that the patient would die and did not need to go to Brisbane. These circumstances caused great distress to nursing staff attending to the patient and to the family of the patient, who were nearby. The patient died before he could be transferred to Brisbane.

Nursing staff prepared statements detailing their knowledge of the circumstances of this patient's treatment which were later communicated to hospital management. Ms Hoffman spoke to Bundaberg Base Hospital doctors, the local acting Coroner, an officer of the Queensland Police Service and the head doctor of the Royal Flying Doctor Service. It appears that no action was taken at this time to address these concerns.

Nursing staff communicated their concerns about Dr Patel to the QNU. Ms Kym Barry, a Professional Officer of the QNU, met with the Director of Nursing, Ms Linda Mulligan, on 6 October 2004 to discuss the concerns. Ms Mulligan expressed the view that there appeared to be a personality clash between Dr Patel and Ms Hoffman which might be resolved by mediation. Concerned that Ms Mulligan may be dismissing events as a mere personality clash, Ms Barry advised Ms Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and the Health Rights Commission.

Ms Hoffman forwarded a letter dated 22 October 2004 to the District Manager, Mr Peter Leck, concerning **Patient P11** and other matters. Attached to the letter were written statements from other nursing staff. A short time later, three Queensland Health officers travelled from Brisbane and lectured senior Bundaberg Base Hospital nursing staff as to the constraints upon Queensland Health employees disclosing confidential information to others. Staff were specifically told that they were not permitted to tell their union about what went on at the hospital and that breach of such prohibition would result in loss of employment and liability to imprisonment.

On 20 December 2004, nursing staff became aware of a planned surgical procedure by Dr Patel of a gastro-oesophagectomy. The ICU already had two patients on ventilators and could not accommodate a third. Medical staff agreed with nursing staff that Dr Patel's surgery should be postponed. Dr Patel insisted that the surgery should proceed and that one of the patients already being ventilated in ICU (**Patient P44**) should have her ventilator turned off as she was 'brain dead'. Ventilation of Patient P44 was ceased at the direction of Dr Patel without the requisite brain death testing being carried out.

Dr Patel then commenced surgery of a gastro-oesophagectomy upon **Patient P21**. During surgery, despite the repeated concerns voiced by medical and nursing staff, Dr Patel ignored obvious signs of internal haemorrhaging by this patient. At the conclusion of surgery Dr Patel ordered that the patient be transferred to the ICU. Patient P21 died the following day due to blood loss. Nursing staff expressed verbal and written concerns to hospital management within the following days. They were subsequently indirectly informed that hospital management had determined that Dr Patel was not to be permitted to perform surgery of this type in the future.

On 23 December 2005 **Patient P26**, a fifteen year old boy who had been involved in a motor vehicle accident and had a possible femoral artery injury, was transferred to the Bundaberg Base Hospital by helicopter. Patient P26 underwent surgery by Dr Patel. Later that day he was returned to theatre to receive fasciotomies for compartment syndrome of his left leg. Dr Patel declined to order on table x-rays or an angiogram, which were suggested by nursing staff to ascertain why the patient was suffering from compartment syndrome. Dr Patel insisted that such further investigations were not necessary. Nursing staff and medical staff continued to have concerns about the condition of the patient's leg, which was mottled, extremely stiff and had no discernable pulse. Other doctors expressed concerns as to the patient's condition and agreed with nursing staff that he needed to be transferred to Brisbane. The patient was not transferred to Brisbane and received further surgery later that day. The patient continued to suffer from compartment syndrome of his left leg. Nevertheless, the patient was not transferred to Brisbane until his condition had deteriorated to such an extent that his leg required amputation. Nursing staff were understandably concerned about the treatment of this patient and expressed concerns to doctors and hospital management.

Dr Patel is permitted to continue as Director of Surgery

Despite the matters outlined above and other indications of post-operative complications that threw into question Dr Patel's clinical competence, and complaints about his misbehaviour towards women members of staff, he continued to perform his duties as Director of Surgery. Dr Patel claimed to be valued by management because of the money he made for the hospital. Staff believed Dr Patel when he suggested that he was immune from criticism due to his contribution to the finances of the Health District.

In February 2005, the District Manager, Mr Leck, instructed Theatre nursing staff that the rate of elective surgery at the Bundaberg Base Hospital was to be increased through to the end of the budget year (30 June 2005) so as to meet budget targets. In an email dated 8 February 2005 Mr Leck stated that "[a]ll cancellations should be minimal with these cases pushed thru as much as possible". By this time, the elective surgery targets had become unmanageable. The Theatre was under staffed, nursing workloads were excessive and nursing staff were becoming physically exhausted. Dr Patel told nursing staff that Mr Leck had told him to meet the elective surgery targets at any cost. When nursing staff raised with Dr Patel concerns about the size of some of his surgical lists and the effects that would have on nursing overtime, he became verbally abusive, raised his voice and said that "if the staff have to work back they have to work back". This often meant working late into the night as

the surgical lists were fully booked with no capacity for emergencies. Emergencies would push out the list and staff would often work well into the night to finish the elective surgery list and the non-life threatening emergency cases that had built up during the day. Nursing staff felt that they could not do anything about this situation as it appeared to be driven by management giving Dr Patel full support in achieving surgery targets regardless of the quality of care provided and the impact upon hospital staff.

In February 2005, nursing staff were informed of a Queensland Health investigation against Dr Patel, however, he continued to perform his duties as Director of Surgery.

The QNU makes further representations on behalf of its members

From October 2004, the QNU continued to communicate with Ms Hoffman and other nursing staff as to their concerns.

On 2 February 2005, QNU officials met with Ms Mulligan in relation to ICU nursing concerns. Ms Mulligan indicated that there would be an investigation into matters.

On 4 February 2005, QNU officials met with Mr David Kerslake, Health Rights Commissioner, and raised concerns based on particulars from Ms Hoffman's letter dated 22 October 2004. They indicated that it would be in the public interest for Mr Kerslake to investigate and asked whether there was anything that the Health Rights Commission could do to investigate such matters. Mr Kerslake indicated that he would have to be directed by the Minister for Health to undertake such an investigation. He advised that complaints relating to individual medical practitioners would be referred to the Medical Board. Mr Kerslake also stated that the Health Rights Commission did not have any direct links to the Coroner's Office in terms of receiving recommendations made by the Coroner relating to health systems and processes.

On 11 February 2005, QNU officials met with Queensland Health's Chief Medical Officer, Dr FitzGerald. Dr FitzGerald and his colleague, Ms Jenkins, confirmed that they were undertaking a clinical audit of surgical procedures at Bundaberg Base Hospital and that nurses who had provided statements would be interviewed.

On 15 February 2005, QNU officials met with Mr Jim O'Dempsey, Executive Officer of the Medical Board. They inquired of Mr O'Dempsey if Dr Patel in fact held surgical qualifications as his practice would seem to suggest otherwise. Mr O'Dempsey confirmed that the Health Rights Commission could refer a complaint to the Medical Board for investigation. He confirmed that providers and users of medical care could make a complaint to the Medical Board in relation to an individual doctor.

A nurse blows the whistle

By March 2005, no action had been taken to restrict the surgical practice of Dr Patel. He informed staff that his contract as Director of Surgery had been extended.

Also by March 2005, Ms Hoffman had, either personally or through the QNU, communicated concerns regarding Dr Patel's practice to:

- other doctors in the hospital including Dr Carter, Dr Miach, Dr Strahan and Dr Berens;
- the Director of Medical Services, Dr Darren Keating;
- the Director of Nursing, Ms Linda Mulligan;
- the District Manager, Mr Peter Leck;
- Dr Gerald Costello, the head doctor for the Royal Flying Doctor Service;
- senior nurses from the Royal Flying Doctor Service;
- the Chief Health Officer for the State of Queensland, Dr Gerald FitzGerald;
- the Queensland Police Service;
- the local acting Coroner;
- the Health Rights Commission; and
- the Medical Board of Queensland.

Yet Dr Patel continued to operate on patients.

By this time, Ms Hoffman had reached a point of desperation as to what could be done to prevent unnecessary death and suffering of patients under the hands of Dr Patel. She was aware that the Member for Parliament for the electorate of Burnett, Mr Rob Messenger, had expressed an interest in an industrial matter involving nursing staff at the Bundaberg Base Hospital. She spoke with Mr Messenger and provided him with a copy of her written complaint to Mr Leck dated 22 October 2004, asking that he de-identify the document by deleting patient names and nurses' names before doing anything further with it. She accepted an offer by Mr Messenger for her to anonymously claim "whistleblower status" before being interviewed by him.

Reprisals by Queensland Health

After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing called a meeting of ICU staff. This meeting was attended by the District Manager, Mr Leck, who expressed anger about nurses breaching the confidentiality provisions of Queensland Health's Code of Conduct. Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice. Nursing staff felt extremely intimidated by the comments by Mr Leck who failed to give any of them an opportunity to respond to his comments or to discuss their concerns about Dr Patel.

On 28 March 2005, the Bundaberg *News Mail* published a letter to the editor from Mr Leck. Mr Leck stated that:

- the fact that allegations had been made public was "reprehensible"
- he had received no advice that the allegations were substantiated
- "A range of systems are in place to monitor patient safety and the community can be assured that we constantly work to improve our service delivery."
- "Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

On 7 April 2005, nursing staff attended a staff forum attended by the District Manager, Mr Leck, the Director-General of Queensland Health, Dr Steve Buckland, and Minister for Health, the Honourable Gordon Nuttall MP. Mr Nuttall and Dr Buckland told staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health investigation that had been underway would not be released. Mr Nuttall stated that the only way staff could stop such rubbish was to vote Mr Messenger out at the next election. Dr Buckland said that no decent doctor would want to come to Bundaberg to work in these circumstances. Staff felt that they were being criticised as being disloyal and believed that the Department would not be further investigating matters regarding Dr Patel.

Queensland Health maintains QNU members cannot give information to the QNU without the express written authority of the Director-General

Even after this Commission of Inquiry was announced and the Crime and Misconduct Commission announced its own inquiries into a complaint by the QNU of official misconduct on the part of Queensland Health officials, Queensland Health continued to adopt an approach, relying upon the provisions of the *Health Services Act 1991*, which would have had the effect of inhibiting Queensland Health employees in communicating matters of concern to the Commission and the CMC through the QNU. It was not until 17 May 2005, after correspondence with the QNU's solicitors, that Queensland Health communicated its general authority for QNU members to communicate to the QNU and its legal representatives matters of relevance to official inquiries into the Bundaberg Base Hospital.

It would appear Queensland Health maintains that, in the absence of such written authority, members of the QNU who voice concerns as to hospital practices and administration to the QNU, could be in breach of confidentiality provisions and subject to disciplinary or criminal action. The QNU will, at an appropriate time, address submissions to the Commission as to legislative changes that may be required to leave it beyond doubt that QNU members will be able to raise such matters with the QNU, and other appropriate bodies, without the fear of disciplinary action or criminal prosecution. It is expected that such submissions may be addressed to necessary amendments of the *Health Services Act 1991* and the *Whistleblowers Protection Act 1994*.

QUEENSLAND HEALTH - CULTURAL ISSUES

A significant concern to the QNU is the dominant culture that pervades Queensland Health. This culture is one of an obsession with secrecy, a failure to embrace differences of opinion and critical analysis, intimidation of those who dare to question and entrenched power imbalances. This dysfunctional culture has contributed significantly to the circumstances giving rise to this Inquiry.

Queensland Health has a "shoot the messenger" culture: an obsession with secrecy and ensuring that the appearance that "all is well" is maintained at any cost; a failure to address medical dominance and arrogance; a failure to embrace different views and critical analysis; and perhaps most importantly an overemphasis on efficiency gains rather than effectiveness within the system. Coming in on budget and meeting elective surgery targets receive higher priority than the important objectives of ensuring optimal, appropriate and timely care. At Queensland Health what is valued most highly is the dollar bottom line.

The almost paranoid obsession with secrecy and failure to share meaningful data with "partner" organisations such as health unions (not to mention the community as a whole) are fundamental barriers to accountability. In the last ten years or so every effort has been made to get Queensland Health off the front page of *The Courier Mail* and this has resulted in those with a genuine interest in information that is required to enable proper scrutiny of the system being denied access to necessary information. The winding back of the Freedom of Information regime in this State has greatly facilitated this culture of secrecy and lack of accountability.

Queensland Health's dysfunctional culture is further entrenched by a "can't do" attitude and lack of appropriately functioning structures. In the last decade or so, the QNU has had to fight every step of the way to even achieve the lawful entitlements of its members. There is a fundamental lack of consistency of approach across the Department, with no one consistent view on human resource and industrial relations matters. Every Health Service District appears to be a "power unto themselves" in this regard – there is no one organisational position that is consistently applied.

Queensland Health employees, including nurses, experience the disparity between the publicly stated values espoused by the Department in documents such as the Vision Statement and strategic plans and those exhibited in their workplaces on a daily basis. Their real life experiences do not match their employer's rhetoric.

Team relationships suffer from a widespread culture of bullying and intimidation. Staff members are informed publicly that "you are either with us or against us – if you are against us you can leave". Reasonable critical analysis and debate is stifled. The level of bullying and intimidation that occurs in the Department is unparalleled in any other Queensland government agency, as confirmed by the findings of the *Queensland Government Bullying Taskforce* (2002).

There are great inconsistencies with regard to the way in which staff are treated within Queensland Health that arise from fundamental and longstanding power imbalances. The QNU notes that Dr Patel was able to continue to practice while the Department was investigating extremely serious allegations against him. The QNU's experience has always been that when a nurse is under investigation for practice concerns of a serious nature they are immediately suspended or moved to alternate, non-patient contact, duties. There is apparently one rule for doctors and another for all other health workers.

COMMENTS IN RELATION TO THE QUEENSLAND HEALTH INITIAL SUBMISSION TO THE BUNDABERG HOSPITAL COMMISSION OF INQUIRY DATED 16 MAY 2005

Generally speaking, the submission by Queensland Health demonstrates a remarkable lack of insight into the magnitude of the Department's failures. There is no doubt that these failures contributed to the tragic events at Bundaberg Base Hospital. The picture of systems and processes in place to safeguard patient outcomes, as described by Queensland Health, is in sharp contrast to the reality of what has occurred and continues to occur in public hospitals, including the Bundaberg Base Hospital. The tale of "The Emperor's New Clothes" is brought to mind in connection with Queensland Health's proud depiction of its current processes for maintaining and improving clinical standards, receiving, processing, investigating and resolving complaints and its systems of accountability. The contents of the submission are consistent with the experience of the QNU in that there is a wide gulf between Queensland Health's stated objectives and procedures and the reality of practices within the public health system.

Paragraph 1.4 of the submission purports to be a discussion of the "health workforce" but addresses only the medical workforce and makes no mention of the nursing workforce. This appears to be consistent with the position taken by Queensland Health in previous industrial negotiations and proceedings with the QNU, in that Queensland Health has maintained, despite all the evidence to the contrary, that there is no nursing shortage. The submission provides statistics as to the decrease in the medical practitioner rate. The Commission may wish to note that in 1995 the number of fulltime employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).

In relation to paragraph 1.6 of the submission, evidence that will be presented before the Commission by QNU members and others which will demonstrate a stark difference between the reality of the administration of the public hospital system by Queensland Health and the admirable stated mission, vision and values of the Department.

In relation to paragraph 3.3 of the submission, the stated mechanisms for receiving, processing, investigating and resolving complaints about clinical practice and procedures at Queensland Health hospitals, particularly where such services result in adverse outcomes, do not provide for any process whereby medical or nursing staff concerned about the clinical practices of a doctor can do so in a reliable formal manner. Evidence that will be

put before the Commission will show that attempts by nursing staff to address to management concerns regarding the clinical practice of Dr Patel were met with inaction, discouragement and at times open hostility and threats of retribution. Once again, the systems and processes, as described by Queensland Health, stand in stark contrast to the reality of the situation.

In relation to paragraph 3.4 of the submission, the same comment can be made. The systems of accountability failed miserably to protect patients at the Bundaberg Base Hospital and will continue to do so without fundamental change to the administration and culture of Queensland Health.

In relation to paragraph 3.5 of the submission, Queensland Health fails to identify some obvious factors that currently impact upon the availability of medical practitioners across the State, such as:

- the restrictive practices of medical colleges in relation to entry into training programs, designed to heighten the demand for specialist practitioners and thus their earning capacity;
- the form of remuneration arrangements for medical practitioners; and
- the failure of governments at State and Federal level to address health matters in a comprehensive and concerted manner.

WIDENING OF THE TERMS OF REFERENCE OF THE COMMISSION OF INQUIRY

Since the establishment of this Commission of Inquiry, the QNU has been encouraged by public comments by the Premier and Minister for Trade, the Honourable Peter Beattie MP, indicating that issues extending beyond the Bundaberg Base Hospital will be investigated by the Commission. We also note recent media reports of the Commissioner to the same effect. The QNU supports any requisite widening of the Terms of Reference so as to allow the Commission to effectively investigate the wider issues of the malaise of the Queensland health system that have contributed to the tragic situation at the Bundaberg Base Hospital. The QNU hopes that the Commission is not inappropriately constrained in investigating and reporting upon any inadequacies of the Queensland public health system.

OTHER INQUIRIES OF RELEVANCE

Prior to the establishment of this Commission of Inquiry, the QNU lodged a complaint with the Crime and Misconduct Commission regarding the failure of Queensland Health officials to act upon complaints by nursing staff about Dr Patel. The QNU has co-operated with the subsequent CMC investigation by providing the CMC with relevant information and facilitating interviews by the CMC of nurses in Bundaberg. Such assistance to the CMC is ongoing.

The QNU intends to provide a detailed submission to the Systems Review of Queensland Health that is currently being conducted by Mr Peter Forster. The QNU has met with Mr Forster and outlined broad concerns relating to the terms of reference for his inquiry and also provided him with background materials that may be of assistance. The documents provided to Mr Forster are listed below. The QNU would be happy to provide all or any of these documents to the Commission of Inquiry upon request. As can be seen from the list below, the QNU has for many years been expressing concern about the structure and culture of Queensland Health. Unfortunately, there has been a distinct lack of action by governments of both political persuasions to address these issues. The QNU welcomes the opportunity to provide constructive input into the Bundaberg Hospital Commission of Inquiry, the CMC Inquiry and the Queensland Health Systems Review as these inquiries present a long overdue opportunity to design meaningful systemic change.

The following documents were provided to Mr Forster:

- QNU Submission to then Health Minister Hon Peter Beattie *Planning for the Future of Queensland Health* (February 1996);
- QNU *Issues of Concern to Nurses* Submission to Political Parties in the lead up to 1998 Queensland election (November 1997);
- QNU Submission to the Ministerial Taskforce on Recruitment and Retention (June 1999);
- Letter to then Health Minister Hon Wendy Edmond re Proposal for Second Phase of Nursing Recruitment and Retention Taskforce (29 October 2001);
- Letter to then Health Minister Hon Wendy Edmond re Disruption to health service delivery arising from shortage of health professionals (15 February 2002);
- QNU submission to the Senate Inquiry into Nursing (Feb 2002) – this is a detailed submission covering a wide range of concerns about the nursing workforce and although it is now a few years old many if not all of the issues raised still require attention;
- QNU Submission to the National Review of Nursing Education (Feb 2002) – this inquiry was held at the same time as the Senate Inquiry into Nursing so similar concerns were raised in this submission;
- QNU submission to Queensland Health – *Smart State 2020* (June 2002);
- University of Southern Queensland (USQ) summary of findings of research conducted on behalf of QNU – *Your Work, Your Time, Your Life* survey (July 2002) – please note this research was repeated at the end of 2004 and USQ is in the process of analysing this data at present and undertaking comparative analysis between 2001 and 2004 research. The QNU will be able to provide the Commission with findings of this new research on a confidential basis when a report is made available to the QNU;
- Affidavit of Elizabeth Mohle for Queensland Health EB 5 arbitration (November 2002) – information on staffing numbers, throughput and other issue of relevance contained in this document;
- QNU submission to Australian Council on Safety and Quality in Health Care on Safe Staffing (October 2003) – no further progress apparent from the Council on this taskforce;
- QNU publication explaining *The Business Planning Framework: Nursing Resources* (2003);

- QNU Briefing Document prepared for incoming Queensland Minister for Health - *Nurses: Worth looking after* (March 2004);
- QNU submission to Queensland Health on Qualifications Allowance for Nurses (June 2004);
- QNU submission to Queensland government prior to 2005-2006 Queensland Budget (December 2004); and
- Letter to Director General of Queensland Health on nursing strategy (April 2005).

The QNU also intends to provide a submission to the current Productivity Commission's *Health Workforce Study* and has already provided some relevant background materials to this inquiry to assist the preparation of a discussion paper. The QNU submission will concentrate on issues such as:

- Current inadequacies and inconsistencies in relation to the way in which work is valued in the health sector and the failings of our current systems (industrial and professional) to appropriately deal with this issue. This is linked with the manner in which productivity is assessed in the health sector and the undue emphasis placed on meeting efficiency indicators, and insufficient attention to issues of effectiveness and quality of care. The failures of enterprise bargaining in the health sector will also be addressed in the submission;
- Workload management in the health sector and the nexus between workloads and patient outcomes and how to ensure safe staffing levels;
- Current significant skills shortages in health (especially in nursing) and the failure of governments at the state and federal levels to adequately address these shortages;
- Issues of skill mix and substitution in the health and aged care sectors and concerns with current inadequacies in quality assurance systems and processes;
- Inconsistencies in health worker education in Australia and who bears the cost of this at present, especially with regard to post graduate studies and how this contributes to skills shortages. (For example, the differences in costs and arrangements for nurses undertaking post graduate studies compared to doctors);
- The need to significantly change the culture and power relationships in health in order to aid recruitment and retention of personnel and encourage genuine "consumer" involvement in health planning and decision making;
- Significant issues with respect to health and safety (and the impact on workers compensation) and other issues related to providing a safe and supportive workplace environment for health workers;
- The potential impact of demographic challenges on the health workforce and demand for health services;
- The need to review current remuneration arrangements for health practitioners (such as the fee for service funding arrangements for medical practitioners);
- The differential treatment of health workers with respect to government assistance for professional indemnity insurance;
- The need to promote innovation in models of health care such as multi-disciplinary primary health care teams and the role of nurse practitioners in these and other settings; and

- The lack of a coordinated, adequately resourced and nationally consistent framework for health workforce planning. The lack of political will to address this issue is of grave concern.

GENERAL ISSUES OF CONCERN

Nursing and its regulation

Many attempts have and continue to be made to define the practice of nursing. In October 1998 the Queensland Nursing Council published a document titled *Scope of Nursing Practice Decision Making Framework.* This document defines nursing practice as follows:

> *"Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick and disabled so that people with identified nursing needs may maintain optimal well being or achieve a peaceful death. Nursing practice is largely determined by the context in which it takes place."*

The role of the nurse is broad and at times difficult to specify. This is in large part due not only to the intensely personal nature of the work performed but also because historically the so-called "soft skills" innate to predominantly female occupations such as nursing, have not been adequately identified, or ascribed appropriate value. Such skills are often difficult to articulate and indeed at times, are not formally seen as skills but rather personal attributes. Recent pay equity inquiries in both New South Wales and Queensland have acknowledged this difficulty.

Certainly there is an appreciation at a certain level within the community that a nurse's job is a difficult one – emotionally, physically and intellectually challenging. Nurses are generally highly regarded because of this, consistently topping public opinion polls of the "most respected" occupation. However, most members of the general community do not receive an insight into the breadth and depth of a nurse's role and the skill that nurses require to perform their role competently until such time as they (or a loved one) require nursing care. It is at such times that the value placed on caring, safe and competent nursing practice is in sharp focus.

The Queensland Nursing Council (QNC) regulates nursing practice in Queensland. The QNC is a statutory body established under the *Nursing Act 1992* and is accountable directly to Parliament through the Minister for Health. It maintains registers of registered and enrolled nurses and, in consultation with the profession, consumers and others, develops implements and monitors standards for the regulation, education, practice and conduct of nurses. As such the QNC performs a vitally important role as such standards are essential for the protection of nurses and patients of health services in this State.

The active and strict regulation of nurses by the QNC may be contrasted with the degree of regulation of doctors by the Medical Board. The QNU will at an appropriate time address further submissions regarding this issue with respect to the first of the Terms of Reference of the Commission of Inquiry.

There are three categories that make up the nursing workforce in Queensland – registered nurses, enrolled nurses and assistants in nursing. Registered and enrolled nurses are licensed employees who are answerable individually to their professional registration body (the QNC) as well as being subject to industrial instruments and legislation as are all other employees. Registered and enrolled nurses are employed across a wide variety of health care settings. Assistants in nursing are unlicensed employees and are employed in the non-acute care setting, predominantly in the aged care sector in this State.

In 2004 there 47,375 nurses registered or enrolled with the QNC (40,102 Registered Nurses and 7,232 Enrolled Nurses and 41 Midwives only). However, this figure should not be confused with the number of employed nurses as some nurses continue to maintain their license when not in paid employment. In Queensland in 2001 (latest available data) there were 32,805 employed Registered Nurses and 6491 employed Enrolled Nurses (total 39,297). In 2001 it is estimated that there were 9,900 employed Assistants in Nursing/Personal Care Workers in Queensland.[3] (Further data on employment status of nurses can be found below.)

Recent trends in nursing

The following information is obtained from the Australian Institute of Health and Welfare's (AIHW) Nursing Labour Force publications. Some of this information relates to national data as breakdown by state is not available.

Nurses are a significant occupational group. Nurses are the largest occupational group in the Australian health workforce, representing 54% of the total employed health occupations in 2001[4] and just over 40% of the total Queensland Health workforce[5] in that same year. The QNU is well aware that because of the size of the nursing workforce there is often a reluctance by government to address nursing concerns, particularly because of budgetary implications. Nursing, after teaching and administrative personnel, is the third largest single occupational group employed by the Queensland government.

[3] Shah C and Burke G (2002), *Job Growth and Replacement Needs in Nursing Occupations,* DEST (National Review of Nursing Education) Canberra, page 40.
[4] AIHW (2003), *Health and community services labour force, 2001*, Canberra page xiv.
[5] Queensland Health (2001), *Annual Report 2000/2001*, page 35.

Nursing remains a highly feminised occupation. Over 90% of nurses are women, although the proportion of male nurses in the profession increased by 1% between 1995 and 2001.[6] However the distribution of male nurses in job classifications and salary ranges is interesting to note with male nurses slightly under-represented in the lower levels (and salary ranges) and over-represented in the higher levels.[7]

The nursing workforce (like the health workforce and the community generally) is ageing. The average age of employed nurses was 42.2 years in 2001, having increased from 39.3 years in 1995.[8] The health and community services sector workforce is older and ageing more rapidly than the rest of the workforce. The number of employed registered and enrolled nurses under the age of 35 years decreased from 29.5% to 24.7% between 1995 and 2001 while the percentage aged over 45 years increased from 29.5% to 41.7% over the same period.

Over 50% of nurses are working part time. The number of nurses employed in a part-time capacity has steadily increased in recent years. In 1995 less than half (48.8%) of nurses worked part time and by 2001 this had increased to 53.7%.[9] At the same time the average number of hours worked per week has decreased from 32.4 hours in 1995 to 30.5 hours in 2001.[10]

Nursing numbers in Queensland are lower than the national average. Queensland continues to fall well below the national averages in terms of both the total number of employed nurses and total full time equivalent (FTE) employed nurses. The number of employed nurses (RNs and ENs) per 100,000 of population in Queensland was 1074 in 1995 and 1083 in 2001 compared to the Australian average of 1221 in 1995 and 1176 in 2001.[11] A more meaningful indicator of nursing supply is the number of FTE nurses per 100,000 population. In 1995 the number of FTE employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).[12]Although there was a 12% growth in total RN and EN numbers in Queensland between 1995 and 2001, there was a 2.3% decrease in the number of FTE employed nurses per 100,000 population during this period. Significantly the growth in third level unlicensed personnel has been greater in Queensland than any other part of Australia, growing by 47.5% (3.9% per annum) between 1987 and 2001. (Total employment of this category of worker in Queensland in 2001 was 9900.)[13]

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[6] AIHW (2003), *Nursing labour force 2002*, Canberra, page 1. Note: AIHW nursing labour force reports only deal with numbers of regulated nurses – RNs and ENs, so this data does not capture unregulated workers performing nursing work.
[7] AIHW (2003), *Nursing labour force 2001*, Canberra, page 23.
[8] AIHW (2003), *Nursing labour force 2002*, Canberra, page 1.
[9] AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
[10] AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
[11] AIHW (2003), *Nursing labour force 2002*, Canberra, page 8.
[12] AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.
[13] Shah C and Burke G, *Job Growth and Replacement Needs in Nursing Occupations,* DEST (National Review of Nursing Education) Canberra, page 40.

Pronounced skills shortages exist in all areas of nursing: According to the Department of Employment and Workplace Relations (DEWR) *National Skill Shortage Survey*, the depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. Workforce modelling commissioned by the recent National Review of Nursing Education predicts that there will be 31,000 nursing vacancies in Australia by 2006. Queensland Health continues to maintain that there is no nursing shortage in Queensland.

At the same time changes have also been occurring in the wider community and health sector that have impacted on nurses and nursing. Queensland's population growth is the highest of all states and territories in recent years - between 1995 and 2001 there was a population growth of 11%.[14] . This growth, which is predicted to continue, has put significant pressure on demand for health services. The Australian community as a whole is ageing, thereby increasing demand for health and aged care services. Technological advances and reform in the health sector in recent years has been significant and this has meant changes to care and work patterns. For example, length of stay in hospitals has declined and this has resulted in significant work intensification for nurses, as those they are caring for are more acutely ill while in hospital. There has been an increased level of acuity of patients across hospital, community and residential care settings. Community expectations of care and treatment have also increased significantly in recent years.
In a nutshell, the nursing workforce is ageing and although there are greater numbers of nurses the actual hours they worked has decreased. This means that there are fewer nurses caring for sicker and more demanding patients. This situation will only intensify given predicted population growth in Queensland, the ageing of the general population and the nursing workforce.

The nature of this crisis in nursing and its causes has been identified—all that is missing is the political will to address the issues in a comprehensive manner. Some work has been done within Queensland Health through the Nursing Recruitment and Retention Taskforce and subsequent bodies. However, some issues, especially establishing appropriate nursing workloads, require further urgent attention. There is also an urgent need to establish and support mechanisms to promote appropriate nursing workforce planning across all sectors in Queensland and at the national level.

Broader Context

Queensland's current strong economic position, and in particular the State's continued strong economic growth and higher than expected government sector operating surplus, places the Government in an enviable position compared to most other state and territory governments. In November 2004 the independent international ratings agency Standard and Poor (S and P) released its analysis of the Queensland Government's financial status, continuing its AAA credit rating. S and P concluded that Queensland's balance sheet is the strongest of all Australian states, with very low net financial liabilities. On releasing the rating S and P credit analyst Rick Shepard stated:

[14] AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.

The finances of the general government sector are exceedingly strong, with financial assets exceeding gross debt and superannuation liabilities combined; the only state where this is the case. The sector also regularly produces cash (after capital expenditure) surpluses. A large capital expenditure program will see the extent of the financial surplus decline a little in the next two years, but overall general government will remain extremely strong financially.[15]

In light of the demographic challenges of continued population growth, the ageing of the population, the decentralised nature of Queensland and changes in community expectations and demand for services, the QNU believes that Queensland's comparatively strong financial position means that the Government should place particular emphasis on making sustainable improvements in service delivery and infrastructure. The QNU welcomes the Premier's commitment following release of the S and P AAA credit rating that it "affirms our commitment to a large infrastructure program".[16]

Infrastructure and service needs have already been highlighted in documents such as the *Draft South East Queensland Regional Plan* and the *Queensland Health Strategic Plan 2004-2010*. What is needed are ongoing processes that involve community consultation and will coordinate and prioritise the funding of competing areas.

In light of the challenges confronting the Queensland community, the QNU considers that it is essential that the issues of community needs and expectations be examined in a coordinated and comprehensive way. This is especially important in the areas of health and aged care services because of the anticipated increase in demand for services as a result of the population aging, cost blow outs related to technological advances, increasing consumer demands, lack of integration of services and expectations and structural inefficiencies and duplication related to dual federal/state government responsibilities in this area.

The role that state and territory governments can play in facilitating a coordinated and evidence based approach assumes particular importance as momentum for the significant health reform agenda being pushed during negotiations for the last Australian Health Care Agreement (AHCA) has effectively been lost. Much needed health reform can only be delivered through proper community debate and engagement. QNU's preference is for this to be achieved on a national level through the establishment of a broadly representative National Health Reform Council. In light of the present attitude of the Commonwealth Government the QNU believes that state and territory governments must take up this challenge and fund the establishment of state based Health Reform Bodies. A properly constituted and representative Queensland Health Reform Council would inform the implementation of the Queensland Health Strategic Plan and other processes such as regional plans, in addition to future AHCA negotiations with the Commonwealth. For the QNU, such a body is a prerequisite to holistic health sector reform. It is essential that patient representatives and organisations such as the QNU be represented on any such body.

[15] Standards and Poor Media Release, 17 November 2004.
[16] Media Release from Premier Beattie, 17 November 2004.

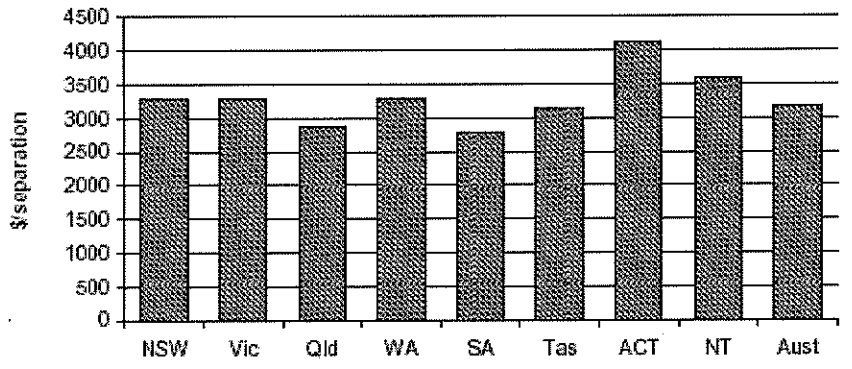
An undue emphasis placed on achieving efficiency related outcomes

Queensland public hospitals are the most economically efficient hospitals in the country. The annual *Report on Government Service* prepared by the Steering Committee for the Review of Government Service Provision has repeatedly highlighted the comparative efficiency of Queensland's public hospitals and its 2004 report is no exception. For example:

> *The recurrent cost per casemix-adjusted separation nationally in 2001-02 was $3017. Across jurisdictions it was highest in the ACT ($3769) and lowest in Queensland ($2741)*[17]

The specific dollar recurrent cost per casemix separation in 2002-2003 was not stated in the Report on Government Services 2005, but is represented graphically below[18]:

Figure 9.14 **Recurrent cost per casemix-adjusted separation, 2002-03**[a, b, c, d, e, f, g]



[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights, from the National Hospital Morbidity Database, are based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.2 cost weights (DHA 2003). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multipurpose services. [e] Data for NSW are preliminary. [f] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. [g] All hospitals in the NT, one very small hospital in Victoria and two very small hospitals in SA have had their inpatient fraction estimated using the HASAC ratio (see AIHW 2004a).

Source: AIHW (2004a); table 9A.4.

The 2003-2004 Queensland Health Annual Report quotes the average cost per weighted episode of care at $2631 whereas in 2002-2003 this figure was $2713[19].

In the previous ten to fifteen years there has been significant reform in the Queensland public health sector that has lead to efficiency gains. Significantly, these gains have been achieved in the context of either tight constraints on or actual decreases in (depending on

[17] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004,* page 9.47, Canberra.

[18] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.49, Canberra.

[19] Queensland Health Annual Reports – 2002-2003 p 47 and 2003-2004 p21.

data relied upon) nurses employed by Queensland Health. (See section below on Queensland Health data difficulties).

These reforms have included but are not limited to:

- significant technological advances and broadening of the knowledge base of nurses and other health workers (this has coincided with the transfer of nurse education to the tertiary sector);
- decreased hospital length of stay – from 5.38 days in 1990/91 to 3.0 days in 2003/2004 (target for this year was 3.08 days)[20];
- increased throughput and patient acuity –

	1990-91	2002-03	2003-04
Total admitted episodes of care	514,635	734,107	749,949
Total day only patients	No data	348,038	352,385
Total non Inpatient Occasions of service	6,120,632	8,867,807	8,813,831[21];

- a significant capital works programme in the public sector that has also resulted in a decrease in available beds per 1,000 population from 3.3 in 1993-94 to 2.7 in 200-2001[22];
- significant changes to models of care;
- restructuring of health service delivery; and
- implementation of new career structures and roles for health workers and significant public sector

Hospital activity and patient acuity rates have increased over the last ten years. Associated with this increase is a decreasing length of stay. This means that a patient treated ten years ago who required a hospital bed for a number of days may now be treated as a day patient. A patient who may have been cared for in an intensive care unit ten years ago may be in a ward today.

Increased throughput and decreasing length of stay in public hospitals combined with significant health and information technology development over the last decade have resulted in work intensification for nurses. As patients are admitted for shorter periods of time, the level of patient dependency for the period of hospitalisation is higher. That is, patients are sicker—as they improve they are discharged for their recovery phase. Patients

[20] Queensland Health Annual Reports.
[21] Queensland Health Annual Reports – note data for 2002-2003 and 2003-2004 come from the 2003-2004 Annual Report data pages 22-26.
[22] AIHW *Australia's Health* 1996 Table 5.6 and *Australian Hospital Statistics 2002-2003* Table 3.2, Canberra.

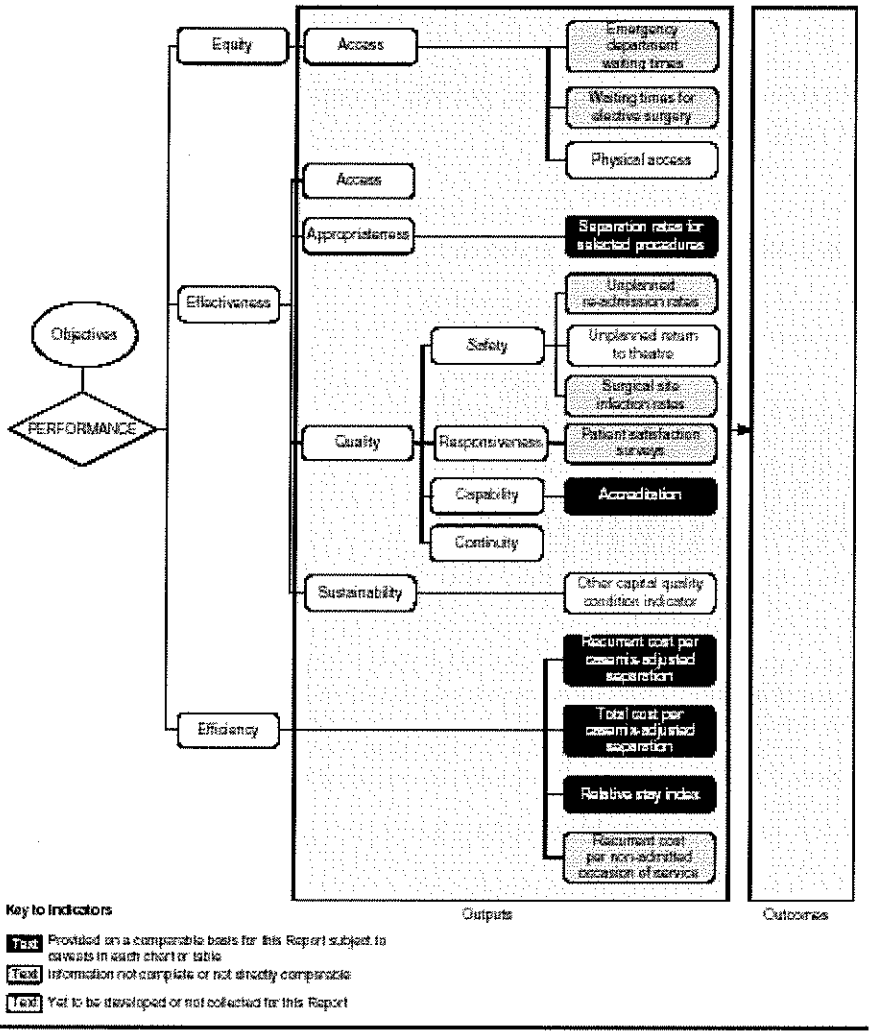
are discharged sicker and quicker. The implications for nurses and nursing are that nursing work has intensified and is much more complex.

Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes. In contrast, insufficient emphasis is placed upon the quality of care provided and whether health outcomes are satisfactory. The QNU's members are increasingly experiencing that this emphasis on efficiency gains is having a negative impact on quality of care as nurses are placed situations where they are unable to deliver an optimal standard of nursing care. This results in nursing wastage as nurses leave the health system or decrease their hours of work because they can no longer cope with the unrealistic work intensification and the consequences this has for their ethical obligations as health professionals. The common complaint of nurses in the current climate is that that they love nursing but hate their job. Nursing is incredibly personally rewarding – nurses love nursing, and it is the context in which they work, one of budgetary constraints and insufficient resources and their often unsafe and conflict ridden work environment that is the source of angst for many nurses. This has, in part, resulted from the unsustainable drive for efficiency that must urgently be re-examined. The quality and effectiveness of services provided should be the primary focus of Queensland Health and form the background to any measures of efficiency.

Governments report progress towards the achievement of agreed performance indicators to the Steering Committee for the Review of Government Service Provision and this is reported in the annual *Report on Government Services.* The current performance indicator framework for public hospitals that is contained in *Report on Government Services 2005* is reproduced below.[23]

[23] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.20, Canberra.

Figure 9.11 **Performance indicators for public hospitals**



Historically Queensland has spent less on health services compared to other states and territories

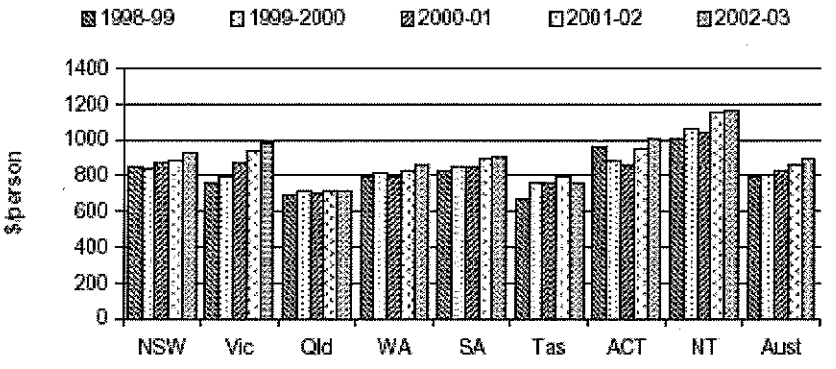
Queensland also continues to have the lowest per capita health expenditure in Australia. This lower level of expenditure is particularly striking considering the additional costs associated with delivering health services in Australia's most decentralised state. The 2005 *Report on Government Services* prepared by the Steering Committee for the Review of Government Service Provision repeatedly highlights this continuing trend:

> *In 2002-03, government real recurrent expenditure on public hospitals (in 2001-02 dollars) was $895 per person for Australia, up from $791 in 1998-99. It ranged from $1165 per person in the NT to $712 per person in Queensland in 2002-03.*[24]

[24] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.4, Canberra.

Government expenditure trends in public hospitals from 1997/98 to 2001/02 are represented graphically as follows[25]:

Figure 9.2 Real recurrent expenditure per person, public hospitals (including psychiatric) (2001-02 dollars)a, b, c



a Expenditure excludes depreciation and interest payments. **b** Data for 2002-03 for NSW are preliminary. NSW hospital expenditure recorded against special purposes and trust funds is excluded. NSW expenditure against primary and community care programs is included from 2000-01. **c** For 2001-02, Tasmanian data for two small hospitals are not supplied and data for one small hospital are incomplete. For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2002-03, Tasmanian data for one small hospital were not supplied and data for five other small hospitals were incomplete.
Source: AIHW (2004a and various years); ABS (unpublished); tables 9A.2 and A.2.

A report released by the Federal Health Minister in June 2004 titled *The state of our public hospitals* claims that (based on AIHW and 1998-2003 Australian Health Care Agreement data) the Queensland government's recurrent expenditure per person on public hospitals in 2000-2001 was the lowest in Australia at $322. (Queensland and Tasmania tied for equal seventh place. The national average expenditure was $371)[26].

Increases in Queensland budget expenditure in the health area have failed to keep pace with significant population growth and increased demand for health services in recent years. The recent Queensland Health Capital Works program process for determining hospital bed numbers required significantly under-estimated future demand for services in many areas. This is clearly demonstrated through recent hospital activity data, for example hospital waiting list information. The response of the Government to the blow out in public hospital waiting lists appears in part to be to transfer demand to the private sector, be this through individual consumers taking out private health insurance, self funding health services in the private sector or Queensland Health contracting services out to private hospitals.

This approach is fraught with problems. The QNU expressed its many concerns about the waiting list strategy to the Minister for Health earlier this year. From an economic perspective the QNU believe that such an approach is inflationary and demonstrates the Queensland Government's tacit endorsement of a greater shift to a "user pays" system in health. The QNU questions the private sector's ability to perform services for public

[25] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.5, Canberra.
[26] Australian Government (June 2004), *The state of our public hospitals*, page 17, Canberra.

patients at a cheaper cost than public hospitals and is extremely concerned about the lack of publicly available cost benefit analysis data on this strategy.

This strategy (along with vague references in the recently released Queensland Health strategic plan to increasing "partnering" with the private sector) are of concern to the QNU because of the apparent lack of accountability frameworks for such activities. It must be clearly and publicly demonstrated to the Queensland community that such activities are both cost effective and are of an appropriate standard. Although the QNU holds significant concerns about the availability of adequate data in the public sector, some data is nonetheless available. The community is not provided with sufficient information on private health sector activity given that the Freedom of Information regime is not applicable to the private sector and there is also no comprehensive performance indicator information available for this sector.

The current approach by Queensland Health also does nothing to address a significant cause of waiting list "blow outs" - namely control of waiting lists by medical specialists. Indeed, such a strategy could result in additional reward for specialists who manipulate waiting lists if they are paid more to undertake the procedure in the private system. It has been reported in the media that Queensland Health is taking action against the Royal College of Pathologists for the restrictions they place on entry to their training courses and other state governments are hinting at taking similar action against the Royal College of Surgeons. This long overdue examination of restrictions on medical specialist numbers will hopefully facilitate better public scrutiny of and debate on health service demand and supply issues.

The lack of access to meaningful data upon which to make informed decisions, encourage community debate, measure outcomes and ensure accountability

The lack of reliable publicly available data from Queensland Health in a range of areas should be the source of significant embarrassment to the Queensland Government. This is not only a source of frustration for the QNU. The QNU understands that other government agencies are also concerned about the lack of meaningful data, especially of a financial and human resource nature. Lack of openness and transparency is an issue for the whole of the Queensland Government (exemplified by the recent winding back of the FOI regime in this state) but is particularly a problem in relation to Queensland Health. Urgent action is required across the public sector and especially within Queensland Health to improve access to meaningful information so as to enhance transparency, planning and accountability.

By way of example, despite being one of the largest Queensland public sector agencies (with the second largest budget allocation), Queensland Health cannot state with any degree of accuracy its actual number of employees at any given time. Until very recently, Queensland Health was the only government department required to report MOHRI (Minimum Obligatory Human Resource Information) data that could not do so. Even though Queensland Health is reporting MOHRI data in the 2003-2004 Annual Report (as is prescribed by the Ministerial Portfolio Statements), the QNU has grave doubts that the data recorded is accurate as Queensland Health can not provide the QNU with data on actual numbers of nurses employed and current vacancy levels. It is not uncommon for a number of different figures to be given to the QNU by Queensland Health Districts in response to

requests for nursing numbers. The QNU therefore has no confidence in the data Queensland Health provides in respect to nursing employees.

Accurate workforce planning and reporting (for example, legislated Equal Employment Opportunity reporting against set government objectives) or proper budgeting can not take place in an information vacuum. Immediately addressing Queensland Health's information deficiencies, especially in relation to human resources, should be a top priority for the Queensland Government. The current situation represents a critical and ongoing risk for the Government and until such time that it is addressed a fundamental accountability flaw will continue. The community of Queensland is entitled to expect that such a significant Department has accurate and efficient systems for gathering data. Given the information systems that are now available it is difficult to comprehend why this issue has not been addressed.

Associated with the lack of human resources information is the lack of organisational will to implement standardised human resources and industrial relations practices and policies across Queensland Health. For some years now Queensland Health has been informing the QNU that a standardised HR/IR policy and procedure framework is proposed. However, the QNU has seen little progress towards achievement of this objective. Until such time as this issue is addressed, the QNU and other unions will continue to experience extreme difficulty in obtaining compliance with industrial instrument provisions. This is not only a source of frustration for health unions but also their members- the employees of Queensland Health - who are tired of the continual buck shifting between facility/district/zone and corporate office levels. The QNU's members simply want to cut through the bureaucracy and achieve their rightful entitlements. The current situation destroys relationships and good faith between Queensland Health and unions and Queensland Health and its employees.

The Government should exercise extreme caution in claiming it has created "extra" nursing positions in recent years. Not only is Queensland Health HR data notoriously unreliable, it should also be noted that it has been estimated by Queensland Health that demand for nursing services will increase by 30% between 2000 and 2010.[27] The number of nurses per 100,000 population in Queensland has decreased in recent years and Queensland Health has also significantly expanded services in some areas of particular population growth or demand growth due to other factors. Given these factors, and based on available information, the QNU believes it is safe to assume that the number of nurses employed by Queensland Health has been decreasing (or in a best case scenario has remained static), be this in numbers of full time equivalents (FTE) employed or actual head count of nursing employees.

There is broad nursing workforce data highlighting the increasing shift to part time work by nurses (over 50% of nurses are now working part time). The QNU has access to significant Queensland anecdotal evidence on the causes of this major shift through QNU membership research undertaken by the University of Southern Queensland in 2001, which is currently being repeated. National and Queensland evidence highlights that a significant contributing factor to this change in working patterns is work intensification. Nurses are decreasing the hours they work per week so they can better

[27] Queensland Health Workforce Planning Discussion Paper (2002), *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010, page 12.*

cope with excessive workloads. When nursing vacancies are not filled those left in the system are expected to cope as management refuses to cut services provided in order to match supply of nursing services with demand. Addressing the causes of decreasing nursing workforce attachment will be central to finding sustainable solutions to the growing demand for services evidenced by indicators such as lengthening waiting lists for elective surgery.

As stated above, extreme care needs to be taken when interpreting nursing workforce data. For example, the Government has stated that it has exceeded a 2001 election promise to employ an additional 1500 new nursing graduates over three years. (A similar promise was again made in the lead up to the 2004 state election.) Just over 1500 new graduates were employed in the three year period since 2001 and another 500 are expected to be employed in early 2005. (As of December 2004, 520 new graduates have been employed by Queensland Health during 2004.) However, these new graduates have only been employed into existing nursing vacancies and should not be interpreted as meaning that the Government has employed additional nurses. As has been acknowledged by Queensland Health officials, this simply has not occurred. An examination of the available data demonstrates that these "additional" nurses have not been employed. Queensland Health has admitted for example, that it is routine for nursing vacancies in the second half of the year not to be filled so that positions will be available for new graduates in the new year.

The QNU and its members continue to be extremely concerned and frustrated by the way in which they are forced to "do business" with Queensland Health. Lack of access to meaningful and timely information that would enable them to participate in a genuine partnership with Queensland Health to improve the health of Queenslanders is a major source of this frustration. The overly bureaucratised "can't do" ethos that pervades Queensland Health is also a problem. A new approach is required in order to properly address critically important issues such as nursing skills shortages and to improve access to high quality, appropriate and sustainable health services.

CONCLUSION

The issues confronting the Queensland public health system are many and serious.

However, it is essential that recognition be given to the overwhelming majority of employees of Queensland Health who are competent, dedicated, hardworking and steadfastly committed to delivering high quality public health services to the people of Queensland. Day in, day out, these employees do their utmost to provide the best care they can within the budgets allocated, often contributing additional unpaid hours so that public patients receive adequate care. Most Queensland Health employees provide the highest quality of care against the odds.

Every step must be taken to ensure that the morale of the Queensland Health workforce does not suffer as a result of the adverse publicity being generated as a result of the current inquiries. The health workforce is critical to the rebuilding of a positive culture in Queensland Health and to the community's faith in our public health system.

CONFIDENTIAL ATTACHMENTS

1. List of witnesses as per para 34.2 of the Practice Direction dated 18 May 2005
2. List of Bundaberg Base Hospital patients