Review of Health Policies in Queensland for the TJ Ryan Foundation and Together Union

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Kirril Shields PhD, MPhil, MA, BA
School of Communication and Arts
The University of Queensland

Linda Shields MD, PhD, FACN, FAAN
Professor of Nursing, Charles Sturt University, Bathurst NSW and
Honorary Professor, School of Medicine, The University of Queensland
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INTRODUCTION

This report, commissioned by the TJ Ryan Foundation and the Together Union, analyses Queensland Health governmental policy implemented by the Newman government over the duration of their term in office, from 2011 to 2014. The report focusses upon specific issues that arose due to the Newman government’s health policies. Some of these issues the LNP government inherited from the previous Labor government, under the leadership of Anna Bligh. However, the radical shifts the Newman government undertook across many aspects of Queensland governance, including the health sector, left a negative legacy that is still being rectified under the current Palaszczuk government. Many health reforms that occurred during the Newman government’s time in office were, in some measure, a mimicry of what had occurred, and is still occurring, in the United Kingdom (UK) and the UK’s revamping of the National Health Service (NHS). The Newman government employed a pool of people who had worked in the NHS, using this imported knowledge and expertise to reorganise and update Queensland Health. This resulted in sizable amounts of legislation in regards to health in Queensland being rewritten, redeveloped, or newly implemented. While some of this was a success, a good percentage of these policies has left Queensland Health damaged. Here the report assesses some of these policies, and examines specifically the Newman government’s want to privatise health in Queensland, issues of staffing and staff morale, a lack of transparency, and how this transparency related to what the Newman government saw as their great success, an end to patient waiting lists. Overall, the reported is intended as a means of documenting where health polices under the Newman government lacked substance, examining makeshift policies intended for short-term affect, or policies that had no solid substance behind their implementation. The report speculates on how such policies could have been delivered differently, and how these policies need be rectified. Similarly, considerations are given here as to how these policies were met in the public arena, and how the Newman government detrimentally failed to acknowledge the prevalence of social media where their health policies were concerned.

First, some background into those institutions that have commissioned this report. The TJ Ryan Foundation is a progressive think tank located in Brisbane, Australia, aimed at, as their website states, “stimulating debate on issues in Queensland public administration and to review policy directions of current and past State governments on economic, social and cultural issues” (TJ Ryan Foundation 2015). The Together Union is, according to their website, an organisation that aims to better lives in Queensland by creating “a community of empowered workers, engaged and active union members and supportive community members. Together they take responsibility and ownership for issues they care about and use their collective power to make change” (The Together Union 2015). The commissioning of this report by these two institutions aims to stimulate debate
within the health sector and in Queensland politics in general and to assess the damage the Newman government may have had on Queensland’s health sector. The report will add to community knowledge and act as a means of empowering further policy change, change that will be of benefit to the health sector in Queensland, and to Queenslanders in general. This report, therefore, is an investigation of the Newman government’s health policies, and questions the government’s legitimacy when compared with the UK’s NHS system that has in the past, implemented similar health policy to mixed review.

*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 private health system, means that the safety net of free health care for those who in need is protected (Shields 2014). The system is considered just and fair as 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 the free public system as required and 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 patient 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.*

*When the Newman government came to power in March 2013, its huge majority in the parliament meant that many changes were implemented across Queensland with little opposition or even discussion. Nowhere was this more visible than in the health care sector. The Newman government attacked the Queensland health system, 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 cited the pay roll debacle (Ludlow 2013) that saw the crash of a new electronic pay roll system, 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 (Remeikis 2013). While these problems certainly occurred under Labor’s governance, the new Liberal-National Party (LNP) government, when giving reasons for draconian cuts in public spending, including cuts to the health sector, ignored the effects of the disastrous natural disasters of Labor’s last year in office. These natural disasters saw 75 percent of Queensland under flood, with the remaining 25 percent 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.*
Queensland, therefore, experienced a raft of economy measures under the LNP party that saw the loss of over 12,000 jobs across the public service (Moore 2013), and the health sector was one of the hardest hit. In an attempt to create efficiencies, the LNP government brought senior managers from overseas, largely the UK, to implement changes across Queensland Health. During the three years of their leadership in the state of Queensland, former British NHS employees filled a large number of senior management and clinical positions. Similarly, and partially as a consequence of this staffing, over the three years of Newman governance, many NHS policies infiltrated Queensland Health. This included target-driven health care, National Emergency Access Targets (NEAT) and the so-called “four-hour-rule”, and National Elective Surgery Targets (NEST). Also mimicking the NHS, in Queensland Health, and accompanying the implementation of these polices, cuts to health funding were rigorous and many preventative (primary health care) services were drastically reduced in the hope that the Federal Government would pay for these services; an outcome that has yet to occur.

This report, then, compares and contrasts the Newman government’s policies against those implemented in the British NHS. In doing so, the report aims not only to consider the effects of implementing new health policy in the UK, but to highlight some of the mainstream media and social media backlash that has occurred there. This backlash is due to the implementation of government policies in the UK that have not been generally popular, and sentinel events have caused public concern, patient complaints, and debate within and about the NHS. The feedback from both public and mainstream media in the UK shows that certain policies have been met with affection, while others are considered failures. Though the media can show a particular bias towards government legislation depending on political leanings, public media campaigns on Facebook, for example, or in comments found attached to certain news articles, provide a more accurate depiction of public opinion in regards to the NHS in its current state. The report examines criticism of the NHS from both within the system and from outside. It focusses on central concerns including the industrialisation of the NHS, the lack of personal care for both staff and patient alike, the funding cuts that paradoxically demand higher patient care, and the fractures in the NHS that are also beginning to be noted in the Queensland health system because of similar implemented measures. A plethora of material examines these aspects of the NHS and this report draws on this material to engage in a discussion of how, for example, the privatisation of certain parts of the NHS has been received in UK public media. This backlash has also been evident in Queensland due to the Newman government’s implementation of like-minded health policy. The report, in comparing the NHS to Queensland Health, suggests means of readdressing health policy in Queensland with the
inadequacies of the Newman government’s policies in mind, while also hoping to stem serious public outcry due to these past governmental policies.

One section of this report will focus briefly upon the UK’s parliamentary debates, governmental discussions that led to health care policy decisions, but also debates that are a result of these policies not working as intended. The debates, located in Hansard (UK Parliamentary records), that led to the implementation of these policies are scrutinised against later examinations where such policies have led to deaths, patient dissatisfaction, or a large-scale lack of morale among the NHS workers. Issues are again those highlighted above, and include the privatisation of the NHS, staff morale, the attempt to cut costs on a significant scale, and hopes to make all aspects of the NHS system transparent to the public. The UK’s parliamentary records provide access to House of Commons debates, governmental board meetings, published policy, and various types of media releases.

Following this investigation, the report will then look to Queensland and the policies enacted under the Newman government in relation to health. First, the report looks at professional and social media that review governmental health policies, showing how the government was seen to lack good decision making in a number of areas according to these reviews. Specifically, the report explores specific issues examined in the discussion about the NHS, including privatisation, cost cutting and staffing, staff morale, and transparency, or a lack thereof. This section of the report will also home in on the Newman government’s so-called “success”, which they claimed as the reduction of patient waiting time. This is discussed in some depth as there is much here that highlights where the Newman government went wrong, as this was an issue that, to some measure, was responsible for the overwhelming political defeat the Newman government suffered in the 2015 elections. Here, social media and public knowledge as noted on public sites, shows the difference between political propaganda and policy, and public perceptions of this policy. In this case, there was discord between the two.

The report explores Queensland parliamentary debate during the Newman Government as a means of assessing the decisions behind the government’s implementation of policies that resemble NHS polices. In doing so, media statements are drawn on from current and pasts governments. In turn, this will suggest that criticism that has befallen the NHS, both within and outside of the system, due to policy flaws and short-fallings, may—if not already experienced—become a problem in Queensland’s health system. The report then aims to suggest alternate pathways and policies as a means of negating problems that may arise due to the implementation of said policies. These alternatives are to be seen in both policy itself, and in the ways policy could be interpreted by the
public given the topical nature of certain health services in Queensland of late. The report, while showing the inadequacies of the policies, draws attention to the importance of popular perception in regards to health issues and health services, and how this perception can help or hinder further political policymaking.

HEALTH CARE AND THE NHS

Sentinel Events, Patient Complaints, and Debate Within the NHS in Britain.

According to a corpus of mainstream and social media, Britain’s NHS is currently, and has been for half a decade, encountering backlash due to a number of political policies implemented over the past series of governments. Here the report looks at sentinel events in the NHS policy implementation and assesses the general criticism that has arisen as reported in mainstream and public media. These policies had been, in some measure, replicated by the Newman government, and in the later section of the report, criticism in the Queensland press and social media is studied. The media, in this case, is British media including *The Guardian*, *The Independent*, and *The Daily Express*, to name but three sources. Social media includes well-known outlets such as Facebook, but included also are blog sites and public forums. Along with these are readers’ comments in news media outlets, and while these may have been vetted depending on the media source, such comments provide interesting insight into public opinion.

The major concerns this report focusses upon, as deemed important due to the large amount of criticism aimed at certain NHS polices, are first, the industrialisation, or privatisation, of the NHS; second, the affects privatisation is having on both staff and patient morale; third, the desire for a transparent NHS and why this transparency and accountability has, so far, been relatively benign; fourth, the desire to cut patient waiting times, and the reality of this as perceived in the public and in the media; and lastly, large-scale cost cutting on top of staffing measures, and the reaction to such cost cutting by the British public. This overview of such polices as noted in the press and in social media is discussed in relation to the perceptions the government has, and continues to have, about various NHS policies. The report investigates how the government came to the decision to implement such policies, and how these polices are being redressed and rewritten due to public criticism and outcry. This will show that the policies, while intended to be a positive influence on the NHS, have not always been met with success, and brings into question the Newman government’s decisions to implement the same policies in Queensland, showing that the criticism that befell the NHS is beginning to be apparent in Queensland social and mainstream media.
Health care costs have rendered the NHS unsustainable, and a raft of scandals have led to the much criticism of the NHS (Shields 2014). The most notable of the se scandals was the Mid Staffordshire Trust scandal that resulted in four major inquiries (Health Care Commission 2009, Alberti 2009, Colin-Thome 2009, Francis 2010, 2013), all of which concluded that the Trust (a “Trust” in the NHS equates to a health district in Australia) had failed; this was due to the emphasis on meeting targets rather than patient care. According to these reports, there was too much focus on finances to the detriment of clinical care; and there was little or no attention to clinical outcomes as well as inadequate supervision of services by the Trust Board, poor clinical engagement, and understaffing (Francis 2013, Shields 2014). These concerns, in some measure, sum up problems present in the current NHS systems and in Queensland’s health system. Costs are at the core of many of the policy decisions acted out in the UK and in Queensland, and cost cutting has been something of a catchcry for governments of both countries. These cost-cutting exercises are the reason for many of the issues discussed in this report, including staff reduction, the selling of public health services, recruitment from agencies. This cost cutting has also meant a reduction in patient services across many individual health outlets in the UK and in Queensland.

According to a report that was published in 2012 titled “Can NHS Hospitals Do More With Less?” , the NHS attempted to save £20 billion over four years in an attempt to “bridge the gap between a virtual freeze in real-terms funding, and rising demand” (Hurst and Williams 2012). In order for this cost cutting to work, the report states that hospitals needed to improve productivity and efficiency. What the report found was that, in fact, costs were difficult to reduce, but productivity was a viable means of improvement in and of itself, thereby producing cost cutting. Alongside the need to improve productivity, factors such as market competition, changes in technology, payment changes and performance management were also noted as having some impact on the quality of patient care (Hurst and Williams 2012). It was factors such as these that, sparking fears the quality of care in the NHS would drop, spurred fervent discussion in government sectors and, more influentially, in the media and the public. The Guardian in 2012 reported that one in ten patients in the UK was receiving poor care and as a result of such care there was the risk these patients would be in danger of receiving wrong medication (Campbell 2012). Large-scale concerns expressed through the media, such as that aforementioned, led to the Care Quality Commission, established to investigate concerns regarding patient care in various regions of the UK. This commission concluded that one aspect of this cost cutting, “a lack of staff, especially those with the right skills, is a key reason why one in ten patients are denied respect and dignity, 15% are not fed properly and 20% have their care and welfare neglected” (Campbell 2012). The commission further found that NHS services throughout the UK, and in many separate NHS departments, was
considerably strained due to these fiscal restrictions, and this was going to worsen as demand for services rose and resources became inadequate (Care Quality Commission 2011/2012). The investigation also concluded that 16 percent of hospitals of the 250 it inspected did not meet any adequate standard of care for patients in general, again linked to cost cutting and a reduction of staff. The report states that the NHS “have clearly struggled to make sure they had enough qualified and experienced staff on duty at all times, and then to make sure staff were properly trained and supervised – making it more difficult for staff to understand and focus on the needs of each and every patient” (Care Quality Commission 2011/2012). In summing up its findings, the Care Quality Commission stated that there was a fear that cost cutting would lead to “cultures in which unacceptable care becomes the norm” and “an attitude to care that is ‘task-based, not person-centred’” (Care Quality Commission 2011/2012). Similar fears were echoed in various media sources following the publication of the report leading to further publicity woes for the NHS in the press and in public media. The British Medical Association, upon reading the report stated that, “The government’s £20bn efficiency savings drive will lead to fewer staff being recruited. And when trusts struggle financially, it is frontline staff and patients who suffer. You can’t reduce services and say that patients won’t be affected” (Campbell 2012). While the issues as discussed here are broad in nature and do not examine the specificities of each case, the media and the public realised that sweeping accusations as located in the Care Quality Commission report signalled large-scale inefficiencies, and this was duly noted in both media mediums.

Privatisation.

One of the major concerns that has led to mass upheaval in the past years in the UK, and some unease from staff and patient alike in the NHS, has been governmental attempts to industrialise British health care; the “corporatisation of a health service” as it has sometimes been dubbed. This privatisation is a debate in and of itself that centres on profit, fragmentation and the destabilisation of the NHS. The result of privatisation has not, as was intended, altogether eased the burden on public health facilities, for private companies, as one doctor noted, “cherry-pick what they want to do. They naturally do the easy stuff, leaving the NHS with the more complicated elements that are more expensive. That can cause real problems” (Triggle 2015). However, privatisation of the health sector only accounts for 6.1 percent of the UK’s health system. Similarly, privatisation is not systemic across the entire NHS, for in some areas, such as mental health, and according to the King’s Fund, spending on private mental health providers rose by 12 percent in 2012/13, but dropped by 2.5 percent in the NHS (Gilburt et. al 2014). Therefore, there are anomalies present when discussing the privatisation of the NHS. Overall, however, the privatisation of the NHS has met with negative, rather than positive feedback, and has had wide sweeping effects that, in
some instances, have cost the British government money, rather than finding a reduction in spending.

To date, the bulk of patient cases in the UK still falls under the responsibility of the NHS, a burden that *Guardian* health columnist, Anthony Browne, considered in 2001 an archaic response to an ever-growing problem (Browne 2001). Browne suggests the only way to fix the state of the NHS is to privatise while also encouraging private health insurance, a policy that has recently taken effect in the United States under the Obama administration (Browne 2001). While a possible viable option, this optimistic and somewhat far-fetched approach to the NHS negates the very foundations of the NHS and the reasons for its establishment in 1948. Initially funded through taxation and national insurance, the NHS was, and continues to provide “comprehensive health and rehabilitation services for the prevention and cure of disease”. These core values remain the main drivers behind the NHS, and it is mottos such as this, or ones similar, that find themselves in many articles and parliamentary debates to do with the NHS. Therefore, the government faces a problem, whereby the ethos of the NHS needs to remain intact, and yet privatisation, as they see it, has to occur.

The problems associated with the privatisation of the NHS are, according to *The Week*, sixfold (2015). There is the erosion of NHS principles as discussed above, principles established in 1948, in particular the principle of free health services. There is a fear of fragmented services as outsourcing begins, meaning that private companies will not work with the NHS and two separate entities will form. There is a fear of less transparency due to private companies regulating their own practices, something that has already been experienced in the UK to date and which causes widespread anxiety in online debates. Further, there is a fear that standardised health care will disappear, and people in one region will experience compromised health care when compared to other regions. Speaking on this topic, British MP Debbie Abrahams stated that, “where there is competition, privatisation or marketization in a health system, health equity worsens” (The Week 2015). Last, there are concerns that private health companies will prioritize profit and neglect patient care. The King’s Fund, an independent charity working to “improve health and health care in the United Kingdom”, believes that privatisation does not come with as many risks as outlined above, but does state that benefits can be outweighed “by costs and difficulties of competitive process” (King’s Fund 2015). Since the 2012 Health and Social Care Act, an act that removes the Secretary of State’s obligation to secure and offer comprehensive health care, however, 70 percent of new NHS contracts have been outsourced to the private sector, suggesting, as Kieran Doherty from Reuters states, “patient care is no longer a priority, instead brand names are more important” (Doherty 2014).
Somewhat ironically, the first private healthcare operator in the UK to run a hospital called Hinchingbrooke Hospital declared in January of 2015 that it was to going pull out of the hospital due to the lack of return it was getting on its investment. This meant, then, that the UK government had to buy the hospital back from the company, as it feared the closing of this health provider would cause too much political backlash. More pragmatically, the government was left with the problem of a population in one region not having access to adequate health care. The buying back of health resources from private companies is one of a series of noted paradoxes in the UK where budget cuts and privatisation have led to more spending rather than savings. According to Reuters “Circle Holdings Plc said it would walk away from running Hinchingbrooke Hospital in eastern England, adding to the pressure on Prime Minister David Cameron over the running of the National Health Service (NHS), which is expected to be a central issue in campaigning for this May’s national election” (Sandle 2015). The rebuying of this hospital cost the UK government something between £7 million and £12 million and this cost is ongoing as services are updated and the hospital restaffed with NHS employees. This was not a standalone affair, for since 2014 there have been a number of regional councils in England buying back hospitals recently built by private investors, but these have generally been smaller clinics in outlying regions when compared to Hinchingbrooke.

According to one NHS blogger called “A Better NHS”, a further problem to do with privatisation is that those who are least educated, less well-off, are “more likely to describe themselves as struggling financially, less likely to own their own home, less likely to have internet access, more likely to be disabled or a single parent” (2015), and hence, cannot take advantage of health competition. Private health care is selective and privileges those on better incomes, or with medical insurance, and accessing private health is limited. With privatisation buying out much that was public these lower economic patients suffer. Similarly, there exists a concern that people over the age of 65 and have cognitive-impairment, learning difficulties or mental illnesses are more likely to rely upon the NHS and less likely to be able to navigate private health firms. This again limits the access such individuals have to health care options. The blogger also writes that “according to the CMA report, energy consumers who valued long-term relationships based on trust and familiarity were also not served well by competition and choice” (A Better NHS 2015). Another commentator who writes on the same bog site believes that many patients do not know how to measure good health care, especially if one does not work in the field. The commentator writes, “How would you know if you were getting fobbed off or if your provider is only offering a cut-price service/treatments because the provider is budgeting so tightly? As an allied health professional, I often see people who have had care elsewhere, assuming it to be ok, perhaps as good as it gets. They are often surprised how much better things can be. Sadly, I often see people who have not had the best care and for
whom too many wrongs cannot be undone. How can the consumer know they are getting the right care?” (A Better NHS 2015). One of the problems associated with the privatisation of the NHS as noted on this blog site—and on other social media sites that comment on the NHS—is the knowledge that patients, if forced into a situation where they attend an under-staffed public hospital or a private hospital that appears to privilege profit before care, are not aware of alternatives. If the industrialisation of the NHS is to work for the patient, there needs be installed measures to ensure that the patient receives the same amount of care at either institution, or that if the patient receives care that they may regard second-rate, then this needs to be clearly understood, and the patient can then make alternate arrangements.

Social media and blog sites offer criticism that creates binary dichotomies outlining, mostly, the problems with institutions such as the NHS. While this is a valid form of critique, as noted in discussions to do with patient care and privatisation, rational conversation soon snowballs, and where one person questions the system, another becomes adamant that the system is broken. In debates centred on NHS privatisation, a bulk of the commentary is well thought through but there exists a great deal that is emotive in content and therefore lacks rationality. Where rational thought is found is in the reports and in commissioned studies, though these often contain a bias, depending on the source of funding. However, their observations lack the emotional drive that sullies commentary on social media sites.

One such report by the King’s Fund suggests that one of the future organisational models for the NHS is the idea of hospital franchises. This entails a former NHS site taken over by a management body for a certain period. The franchisee is responsible for the operation and the finances of the franchise for that set period of time. An example of this is the franchise for Good Hope Hospital, run by the private company Tribal Secta. While this appeared a good idea, the contract was terminated after two years due to fiscal downturns, the hospital running at a loss rather than a profit. What a franchise allows is for another company, or another trust to take over the contracting, as occurred in this instance. The Heart of England NHS Foundation Trust took up the management franchise and eventually the hospital, not just the managerial sector, was run by this trust. What the King’s Fund report also examines as a means of rectifying some of the problems the NHS is experiencing are the building of hospital chains; the consolidation of hospitals into larger health care facilities that stretch the length of the UK, similar to any company organisation that wishes to expand nationally. However, this has its drawbacks. The report states that in general, large multi-hospital chains in the United States have not had “a positive outcome for the consumer” (Cuellar and Gertler 2005). Strong evidence has shown in the United States that hospital consolidation does not drive costs down, but in fact increase the cost of health care, especially when
these large corporate entities become the main health supplier of a region (Berenson et al. 2012; Melnick and Keeler 2007). The report adds that, “consolidation has not released significant cost savings unless providers have consolidated their services onto a smaller number of hospital sites” (Vogt et al. 2006). Therefore, consolidation does work when low occupancy numbers (less that 55 percent) are recorded, and smaller hospitals are built with that in mind. Contrastingly, big hospitals with low occupancy numbers add to costs (Connor et al. 1997) due to the added expense of real estate and the need for more infrastructure (Cuellar and Gertler 2005; Dranove et al. 1996). Similarly, the King’s Fund suggests that hospital mergers are not a way forward, stating that these mergers frequently fail to achieve their stated objectives, stating that “Some estimate that up to 70 percent of mergers have failed to add value” (KPMG 2011). In the UK between 1997 and 2006, a study conducted by Gaynor et al. (2012) saw minimal productivity increase in the 102 of the 112 hospitals merged, and no financial improvement. While in theory a merger looks good, in actuality health care mergers appear mostly to increase costs to health care (Vogt et al. 2006; Kjekshus and Hagen 2007).

**Staffing.**

While privatisation has both benefits and pitfalls, industrialisation of the public health sector has caused widespread difficulties to the staff who work within the system, and to patients looking for a certain amount of respite and care. For the staff, this apparent industrialisation has lessened their personal involvement, as their workplace is one that comes to lack stability, with short-term contracts, especially for doctors, replacing permanence and the knowledge of long-term employment. As British nurse practitioner, Brian Kellett, writes, nurses under the current NHS system are required to “work harder, do more paperwork, get less pay, get less of a pension, get taken over by a private health company, do your job with less equipment and fewer staff, be constantly scrutinised and roll over and take it because even if you complain no one will listen to you” (2012). In the nursing sector, according to the Guardian in 2012, 44 percent of nurses in the UK were looking to leave their jobs as they lacked job satisfaction and work stability (Kellett 2012). This had to do not only with restructuring and privatisation, but also with an increase in paperwork that meant less time caring for patients. As a result, the Guardian article goes on to say that many nurses were leaving, or had left the NHS and the nursing profession to become poorer-paid healthcare assistants (Kellett 2012). These health-care assistants could work on contract in the private or public sector, not be held accountable to the NHS system, did not have to fill out what was considered excessive paperwork, and could return to what they wished to be doing, caring for patients. Along with a lack of job security, another key concern of NHS staff, nurses and doctors alike, was and is the mounting pressures placed on patient ratios. Once these figures saw one nurse to six or eight
patients, whereas under the current NHS system there is a minimum of one nurse to ten patients, and this patient to nurse figure is higher in some hospitals. 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)). On a social media forum, The Student Room, a number of contributors made mention of this problem, and discuss not just the nursing to patient ratios, but also the stress placed on doctors throughout the UK; “GPs have about 5-10 minutes per patient, nowhere near enough [time] to do a thorough history or examination on most patients” (2014).

In some staffing areas there has seen an outsourcing of staff, especially in sectors such as nursing, where health practitioners have left due to dissatisfaction. This has led to huge fiscal blowouts; something the UK government had not realised would eventuate when first suggesting cuts to nursing and medical staff. This has created another of the paradoxes noted under the current NHS system, whereby budget cuts have only increased spending. According to The Telegraph in 2015, “ballooning levels of spending on agency nurses and doctors mean NHS trusts are paying the equivalent of £750,000 a year just to fill one post. Hospitals have spent £3,200 for one doctor to cover a single shift, with payments of up to £2,200 for a nurse to work 12 hours. A new report by NHS regulators reveals an £822 million deficit across the NHS, which can be blamed entirely on spiralling spending on temporary workers” (Donnelly 2015). Simultaneously, in another of the paradoxes to plague the NHS, The Telegraph reports that management are being forced to spend exorbitant amounts on agency doctors and nurses to prevent closing wards down. The closing of wards or hospitals is not an option for those in government, hence the spending on outsourcing (Donnelly 2015). The Telegraph writes that, “this winter, United Lincolnshire Hospitals NHS Trust paid £3,257 for one doctor to work a shift of 12 hours, and remain on call to work for 12 hours. The sum is equivalent to an annual salary of £765,395 or £16,285 a week. Meanwhile, Shrewsbury and Telford Hospital NHS Trust paid the record sum of £2,200 to hire one nurse to work 12 hours – equal to a weekly wage of £11,000 or an annual salary of £517,000. A large chunk of the payments are taken by the agencies who hire them” (Donnelly 2015). On the same topic, the Guardian reported in mid-2015 that rising demands for care, a soaring bill for agency staff, and the need to make billions of pounds of efficiency savings contributed to the serious financial downturn and led to warnings that this could soon damage patient care (Grierson 2015). Here another of the paradoxes concerning the NHS appears, for the government wished for, and continues to wish for, fiscal savings that do not inhibit or detract from patient care. This, as stated above, put pressure on staff who feel they
are being underpaid while being overworked, and has led to the mass exodus of many health care professionals from the NHS over a four to five year span.

From 2010 to 2013, and according to a Royal College of Nursing report, 61,276 jobs had been lost in the NHS. This was across the board, in hospitals and in clinics, but also in aged care and NHS-run retirement homes. As a result of such a mass downsizing, patient care again was seen to be compromised, and in 2012, Michelle Mitchell, Charity Director of Age UK, stated that, “it is appalling that 15% of hospitals and 20% of nursing homes failed to ensure people were given the food and drink they needed and that a significant proportion were equally unable to protect the dignity and respect of their patients and residents” (Campbell 2012). Mitchell went on to say that the NHS was negating its “professional and moral duty to make sure the dignity of their patients and residents is enshrined in every action” (Campbell 2012).

Staff Morale.

Similarly, the amount of change seen in the NHS has meant instability for many other staff members, from management to cleaners and gardeners. This has had as much to do with privatisation as it has to do with funding cuts. While individual changes due to the selling-off of public health assets might be viewed as a benefit to the NHS collectively, suggested Don Berwick in 2008, then President of the Institute for Healthcare Improvement in Cambridge, Massachusetts, change “drains energy and confidence from the workforce and middle managers” (Gerada 2014). The industrialisation of the NHS in Britain has meant that there is no longer a singular regulatory body, but one fractured due to the outsourcing of management, the competing providers, and the increase in mixed funding from the NHS and the private sector that does not compliment the ethos of the NHS staff. This, in turn, has led to a lack of communication among the NHS, with various regional departments suggesting that they are being given less information and less funding. This has further meant that outsourcing to private companies has not been regulated, and as a result there have been calls for greater transparency. The public and aspects of the government wish to see why certain private companies have been privileged with contracts, or other forms of work, over other just as competent providers.

Therefore, what was once considered a “tacit agreement” between the NHS and its staff “whereby the NHS provides sustenance, refuge, and support,” has been replaced over the span of four to five years with pragmatic (rather than patent care) decisions based on fiscal reward and the outsourcing of governance and decision-making (Gerada 2014). This, in turn, is having detrimental effects on staff and causing widespread anxiety not only due to staffing pressures and patient to nurse ratios, but due to a lack of confidence in managerial staff. According to Clare Gerada, the NHS
is now a place where staff feel “attacked, unloved, and abandoned by their political and managerial leaders” (2014). Somewhat ironically, patients experience a similar feeling of abandonment as policy emphasises cost efficiency over care. Patients are now involved in a system that, according to Professor of Primary Care at University College London, Steve Illif, was “changing from a craft concerned with the uniqueness of each encounter with an ill person, to a mass manufacturing industry preoccupied with the throughput of the sick” (Gerada 2014). In 2010, a British Parliamentary report conceded that productivity in the health sector was “a rather crude measure for money in the NHS, calculated by comparing inputs and outputs”. Therefore, the personal is being replaced by productivity, and there has been widespread outcry among the community as a result, as noted on numerous social media outlets. In a further twist to this ever increasing number of paradoxes, when staff are at an all-time low in morale, so is customer care, and yet, the outsourcing to private companies that is meant to alleviate stress on NHS staff has this body of health care professionals feeling undervalued. The NHS staff see the outsourcing of patient care as an indication that their work is of little value when compared to that of those private sector staff contracted to help. This is seen not only in the nursing and medicine sectors, but by managerial staff who feel that their skills are undervalued.

The constant change that negates stability, causing staff in turn to regard the NHS as unstable, creates a further paradox whereby those who need to care for patients feel they themselves are not being cared for. The emphasis placed on patient care is not being replicated among the staff themselves, causing further problems with staff morale (Gerada 2014). Part of this feeling of instability and lack of worth is due to the implementation of a policy of naming and shaming, a means of exposing those who may not be doing their job correctly. While to some in the NHS and the government this policy may seem a good idea (it allows the public a voice, for example), it has meant that staff members are constantly concerned about feeling shamed or humiliated by fellow work colleagues. Deliberate policies, such as that found in the NHS Choices, and the Friends and Family Test, provide sites to post anonymous comments about practices, clinicians, or hospitals online. As Clare Gerada notes, “these policies of naming, blaming, and shaming mean that doctors can face humiliation for any alleged transgression, even if what is seen as a transgression is merely being an understandable outlier in performance, or refusing to participate in a process” (Gerarda 2014). It changes the power dynamic to some degree, whereby those in the medical profession are being made accountable to a public that are no be medically informed, and then these medical staff are being reprimanded by managerial staff, sometimes managerial staff contracted to a health clinic. This has led to a decrease in younger doctors and nurses choosing these professions, and older health professionals retiring earlier, one doctor stating that these shortages could mean family GPs
are lacking in the not-too-distant future. There has also been noted a large scale migration in nursing in the NHS, and British nurses are now finding work in places such as Australia, the United Arab Emirates, and Canada where work conditions and pay rates are said to be better. With the current trend of earlier retirement of doctors there comes an absence in professional knowledge and mentorship, again discouraging new nurses and doctors.

In place of registered nurses, however, there has been a turn to healthcare assistants who are unqualified and are taking on nursing roles in wards and in aged care homes. According to Nick Collins in the Telegraph in 2012 “basic tasks which were once the job of trained nurses are being carried out by more than 50,000 low-paid and unregulated assistants due to budget cuts and growing demands on nurses’ time” (2012). Some of the healthcare assistants called on to make medical and nursing decisions had not completed year twelve high school. The Royal College of Medicine commissioned a report following stories within the NHS and in private care centres that talked of appalling care and much mismanagement due to the employment of these healthcare assistants. According to Collins, “figures released last month revealed that 43 hospital patients had starved to death and 11 died of thirst due to failures in the most basic levels of care on hospital wards, while 78 died from bedsores” (2012). This led to the Willis Commission stating that an all-graduate nursing staff is “not simply desirable but essential” (Collins 2012). In 2013 there were an estimated 300,000 health care assistants in the UK in the NHS, and an estimated 350,000 nurses. According to the Cavendish review of July 2013, “There are over 1.3 million unregistered healthcare assistants and support workers working on the frontline of care: although a profusion of job titles and lack of role clarity means that an exact count is not possible, even within the NHS” (2013). The Francis Inquiry, commissioned in 2010 and published in 2013, was ordered be undertaken by the UK government as 1,200 patients in the Mid-Staffordshire Trust were considered to have died due to staff shortages and unhygienic Accident and Emergency wards. The Inquiry was extremely critical of the lack of training these healthcare assistants received that in some measure exacerbated the death toll. The review concluded that the current system of employing healthcare assistants did not guarantee the safety of the public. The reports states that:

There are no minimum educational requirements to begin working as a healthcare assistant or support worker in the NHS or social care. Even literacy and numeracy are not always tested. Around two thirds of acute trusts are now using numeracy and literacy tests to screen candidates across most of their organisations. But a third do not. The review has also heard from home care workers whose ‘induction’ consisted of being handed a DVD to watch at home, before going out to a client. (Francis 2013)
In 2013, the then Royal College of Nursing general secretary, Peter Carter, said that some healthcare assistants were working with patients after no more than one hour’s training (BBC 2011).

Transparency.

In regards to the patient, enacted polices have, over the last four to five years, attempted to make the NHS accountable, allowing, even requesting, patients make complaints whenever they feel this is needed. As mentioned above, accountability is one factor among the many that is the cause of low staff morale within the NHS. The Mail Online in October 2014 reported, however, that patients were too scared to complain due to the adverse reaction from staff (Adams 2014). With staff already feeling let down by the government and by managerial staff, the ability to complain about their conduct caused morale to drop further (Adams 2014). The paper reports that for the public, six in ten people do not complain due to the patient thinking there will be an adverse reaction, and a third of those who do complain believe their treatment is affected as a result of this. Adams (2014) wrote that complaints were centred on staff who were not as qualified as surgeons or psychiatrists as these professions are deemed to be at too distant from the public in knowledge and education for them to be able to make complaints. Therefore, it was only the nursing staff and doctors who did not specialise who bore the brunt of the complaints and caused a segregation between these healthcare staff, and those such as surgeons.

This policy of openness and transparency, then, has its own pitfalls, and while the intention is good, for there needs be some means of accountability, the resulting after-effects, such as a lack of confidence by staff and patients alike and a work environment that encourages reporting other’s faults, create disharmony. Implemented by the government through their NHS Friends and Family test, the Guardian reports that, “a customer satisfaction test . . . seems to be rapidly losing credibility as a metric of care quality, while simultaneously becoming a way to collect industrial quantities of unstructured patient comments” (Munro 2014). What is also occurring is that these comments are being processed, and those making the comments are not further informed as to what changes have taken place as a result, leaving patients feeling both dissatisfied and irrelevant (Munro 2014). There have been some questions as to where exactly this feedback is being used, and a good percentage of government debate about the NHS system has been dedicated to this complaints process. For the government hoping to rectify some of the problems experienced in the NHS, both before and after reform, the ability to gather information that may alleviate problems is important; however, the means by which this information is gathered is problematic and has caused widespread dissent throughout the NHS.
**Cost Cutting.**

Further cost cutting, on top of staffing, has added to concerns, both in the mainstream media and on social media, in relation to the way the NHS is being changed. A contributor to The Student Room blog also makes mention of the divide between clinical staff and management, suggesting that management “typically know very little about the clinical issues of their own departments . . . far too much effort has been put into improving very crude and easily manipulated estimates of activity, with far too little attention to care quality or what patients think” (2014). Managerial decision-making based on fiscal and pragmatic output is a core concern in an article by the Guardian in October 2014, suggesting the British government expects to cut funding to the NHS while demanding the NHS improve upon patient care (Munro 2014). This has, in recent months, meant that “cracks” have begun to appear due to the implementation of policy that seems unable to balance patient care and cost cutting. For example, in the first half of 2014 “nearly 10,000 patients in England had to wait for more than two months for specialist treatment after being told by their GP that they had a suspected cancer” (Cooper 2014). Similarly, when private companies find that there is little to no profit in their business, the government acts to keep services in place, causing a great deal of cost and unnecessary expense, especially if these health services were part of the NHS before being privatised.

**United Kingdom Hansard Reports.**

Here the report collates UK parliamentary debate and parliamentary committee meetings, and focuses on issues to do with staff morale, budgeting, and patient care under the current NHS system. This section of the report highlights the ongoing struggle the government faces due to the implementation of government policy within the NHS. The reports that are drawn on mostly date from 2010 through to 2015, and include parliamentary debate in the House of Commons, but also committee review processes and outcomes. Here media and public opinion have shaped some of the debate and discussion, but mostly the Hansard reports reflect governmental questioning, examining the success of implemented budgetary or other policy measures.

At the core of these debates is efficiency savings. As mentioned before, cost cutting was the key driver when NHS policies began to be re-written. These, as outlined in a 2010 parliamentary paper (www.parliament.uk 2014 ), included cutting “back office” management, limiting staff pay and pensions, selling assets, rationalising procurement and drugs purchasing, and re-aligning the NHS IT programme. A means of budgeting within the NHS was “reducing the length of stays in hospital and using lower cost drugs”. This report, and the after-effects of this report once implemented, were collated as part of the NHS’s requirements to meet a 4 percent year-on-year efficiency gain that in
2010-2011 was successfully met, but was all too often represented by “short-term fixes rather than the long term transformation which the services needs” (www.parliament.uk 2014). Therefore, while savings were being met in line with government budgetary requirements, the sustainability of these budgets cuts came into question. At the start of Parliament sessions in 2010 the NHS was under debate, some parliamentarians suggesting that austerity measures that had already been undertaken such as the freezing of salaries, “squeezing the prices paid to hospitals for the treatment they provide, and cutting back on management costs” were unsustainable. While there were further recommendations that compromised patient care, such as reducing a patient’s length of stay in a hospital, such traditional cost cutting ventures were seen to be no longer viable. Similarly, as a result of such monetary measures, and due to the outcry of patients who felt neglected, budgeting focus was placed upon improving patient care, but neglected improving staff morale through a rise in wages. In 2014, the NHS Confederation told a British parliamentary committee that, “In the long term, we need to engage with our staff and unions to explore how we can come out of a period of pay restraint in a sustainable way, recognising the significant contribution of staff to delivering high quality patient care and generating solutions to the financial and demand challenge that we face” (www.parliament.uk 2014). Both the parliament and a number of associated committees have come to recognise, in recent years, the effects of monetary cuts on staff morale throughout all sectors of the NHS, but have yet to properly rectify the problem. Lord Patel, in his address to British Parliament on 9 July 2015, in a debate concerning the sustainability of the NHS, stated that, “Further reducing staff salaries and holding pay to 1% for the next four years, as announced yesterday, and reducing the price paid for treatment, is an option likely to lead to a further decrease in morale and less commitment from staff, leading to poorer-quality care, poorer outcomes and, dare I say, less likelihood of getting the productivity gains proposed” (www.parliament.uk 2015). As stated above, this reduction of staff salaries led to one of the paradoxes noted within the NHS system. Staff morale was to have a detrimental effect on finances as staff resignations meant that temporary staff were contracted to take their place. The result was that the NHS in 2014 spent £2.6 billion on consultants and temporary staff: these figures showed these contractors to be considerably more expensive than employees on a permanent contact.

Ironically, in 2015, while staff salaries were not being increased (though wage rises did occur due to natural monetary inflation), primary care concerns were not being met either. The length of wait times in some areas of the UK, late diagnosis that led to an increase in deaths, and a dwindling workforce due to a lack of morale, meant that not only were the NHS fiscal measures not good, but neither were performance measures. Such problems were amply discussed in the UK’s parliament; for example, Lord Patel’s address to the House of Commons mentioned above. What was once
considered an achievable goal by those who wrote NHS policy, and a policy replicated under the Newman government in Queensland, was a target to see 95 percent of patients within four hours of their arrival at Accident and Emergency (A&E) (Queensland Health 2013). In 2015, however, according to the member for the UK electorate of Copeland, Jamie Reed, there had been over the span of two years nearly 2.4 million patients waiting for more than four hours in hospital accident and emergency units in England. Reed goes on to say in her address to parliament that “almost half a million people have spent more than four hours on a trolley waiting to be admitted; and more than 1,500 have waited more than 12 hours to be admitted” (www.parliament.uk 2015). This was not a new problem for the NHS. In 2013 the government published “A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture” (Clwyd & Hart 2013). The findings of this report showed that in 2013 there were 3,000 complaints submitted a week, resulting in 162,000 complaints for the 2012/2013 period. The majority of these complaints fell into five categories. First, patients felt uninformed about their care and treatment. Second, patients felt that they were not treated with the compassion they deserved. Third, there was a lack of dignity and care and patients felt that they were neglected and not being listened to. Fourth, there were complaints about the staff and the patients felt there was no one in charge in the ward and staff were too busy to listen. Five, there was thought to be a lack of resources by patients and their families, such as extra blankets and pillows. This is in spite of the many official reports that span almost a decade that recommended changes to the system, but were rarely implemented.
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 (Shields 2014). 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 the 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 that the first point of call for people accessing a health service 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 gave the Queensland government the opportunity for substantial cost shifting.

Page 17 of the Newman government’s “Blueprint for Health” 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.

These two pronouncements are contradictory, and the second received 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.

Health promotion services in Queensland have been decimated, with clinics closed across the state (Shields 2014). 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 unforgivable. 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 (Shields 2014).

As per the COAG agreement (Australian Government 2012), Medicare Locals were to be the bodies that provide primary health care, but they were 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 Queenslanders waited for the Medicare Locals to take up the services that Queensland Health off-loaded, the health of Queenslanders was 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 (Shields 2014).

According to Yonek et. al (2013) there are a number of key features that a health system should maintain should it wish to remain performing well. These are: 1. A shared commitment throughout the country/state to achieving the system’s quality and patient safety goals. 2. A board that monitors patient safety and quality, and sets strategic goals that enables this. 3. The ability for health services to collaborate and share best practices for improving safety and quality. 4. Ensuring that performance, both internally and externally, is openly and transparent reported. 5. To emphasise teamwork to improve quality and safety. 6. To have “a mindset of perfect care and dramatic increases or stretch goals as compared to incremental improvement” (2013).
Debate in private and public spheres.

Many of the issues that have arisen in the UK to do with the NHS have also been seen in Queensland’s health system. While there has not been a literal replication of policy, many similarities exist and this has led to outcry in both the media and in the public due to the implementing of the Newman government’s policies. Many of the issues focused upon here are the same as those discussed above: the “selling off” of public health infrastructure, the morale of staff in Queensland hospitals and health clinics, the need for transparency, the desire to cut waiting times, and the large scale cost cutting. These are all pertinent topics that have come under debate in recent Queensland and Australian media, and similarly have found commentary on various social media sites. The Newman government also came under criticism for its handling of mental health services, and for its downsizing of nursing and midwifery staff.

Alongside such criticism, much of the backlash to do with the Newman government’s response to health issues was the lack of respect with which it credited the public, and Premier Newman and his Health Minister Springborg appeared oblivious to the escalating furore surrounding fudged figures and personal experiences that undercut what the government was attempting to sell the public. Where the Newman government seemed to lack an understanding included the power and perseverance of public opinion when physical and mental health issues were at stake. Unlike, for example, a policy aimed at roads or other infrastructure, health issues are emotive and the public and the media alike responded accordingly. As detailed below, many of the problems that befell the Newman government that resulted in their lack of popularity was already evident in public forums or in the media in general. This government also appeared to under estimate the strength and political sway of the Queensland Nurses’ Union of Employees (QNU) for there were many media statements issued by the QNU during the Newman government’s time in office that refuted government figures or media statements. What is apparent is that the figures presented by the QNU became more a public source of information about health services than those figures and statistics espoused by the government at the time.

Similarly, statements made by the government were to become a second best to emotive messages that were personal in content, as the public knew that friends and family could be affected by governmental policy. What is obvious through the reading of media material is that health issues are deemed a personal issue rather than something viewed from a distance, and opinions to do with health services in Queensland are often accompanied by a personal anecdote. What this then means is that government figures, even if these figures were correct, may not be as influential in swaying public opinion as expressed personal angst or worrying anecdotes. This is evident throughout many of the blogs and in the comments on news sites. What this then does is act as a personal refutation
to the government’s statistics. It is here, with an inability to understand the personal side of their policies, that the Newman government seemed also to lose favour with its constituents.

**Privatisation.**

According to Stephen Duckett in the *Conversation*, the selling of public health assets was, in 2013, somewhat in governmental vogue throughout Australia (2013). Duckett cites Sydney’s Northern Beaches hospital and the Sunshine Coast University Hospital. The article states that “private-public partnerships or private contracting in Australia have a chequered history and many such arrangements have collapsed. The Queensland government’s announcement that it would outsource the Sunshine Coast University Hospital, for instance, was made in the same week that the Victorian government decided to buy back the buildings of the privatised Mildura Hospital to facilitate a much-needed expansion” (Duckett 2014). Duckett states that one of the problems with this arrangement is due to its democratic risks, that being that governments come and go and their policies are short-term rather than long-term. The South Australian Auditor General pointed out, (stated by Duckett), because the contracts “can extend for periods in excess of the life of a particular Parliament and, on the basis of historical experience” the Government of the day makes superficial decisions or decisions that have no long-term foresight. Furthermore, according to a former Commonwealth Auditor General, Pat Barrett, “commercialisation and privatisation can strain the thread of accountability between executive government and the elected representatives of the people in parliament” (Duckett 2014). These factors, Duckett notes, are never considered when entering into the privatisation of what was once a public piece of infrastructure. This, coupled with the fact that hospital public-private partnerships “have a very high failure rate (probably in excess of 50%)” means that the selling of public health assets is a dubious decision. Hospitals mentioned as examples of this public/private dilemma are the Gold Coast’s Robina hospital, Queensland’s first attempt at a public-private partnership, and the Sunshine Coast University Hospital. As a result of these decisions that are less than economically fruitful, government should show caution when negotiating public-private partnerships as past mistakes could be made again. As Duckett states, “given that risks are never fully transferred to the private sector in these partnership arrangements, governments need to be very clear about what benefits accrue to offset the costs of the arrangements” (2014). The private sector, therefore, needs to make it clear that they will show innovation, ensure costs are manageable and quality is not to be compromised, and that they will be held accountable should problems arise. Overall, writes Duckett, the efficiency difference between public and private hospitals “is, on average, the same” (2014).

One of the debates that erupted in 2010 in the media and in the government was a result of the Newman government’s attempt to “sell off” public hospitals, including the Sunshine Coast
University Hospital. According to the QNU, privatisation of Queensland hospitals would divert funding from essential services with the aim of making a profit (Queensland Nurses’ Union 2015a). As a result of such privatisation, fewer services would become available to the public, and therefore there remains an onus on the government to ensure services remain. As occurred in the UK, if privatised hospitals do not make a profit and the private sector wishes to let them go, then the government is obliged to buy them back, for the closing down of health services is deemed an unwise social/political decision. QNU cite as an example the New South Wales Port Macquarie Hospital, stating that the government paid twice for it when the State government took it back in the early 2000s after the company who ran it no longer saw it a viable business. Similarly, in conjunction with the need for profit, QNU believes there will be a loss in the affordability of health care due to privatisation, imposing unwanted costs on individuals and families (Queensland Nurses’ Union 2013b).

The QNU held rallies throughout Queensland to stop the privatisation of Queensland’s health services and spokesperson, Des Edler, stated that, “Privatisation leads to uncertainty and instability in service provision, it sees governments often having to take facilities back to clean up private sector failures and will eventually lead to the imposition of costly fees for most patients” (Queensland Nurses’ Union 2013b). While the selling of these public assets never went ahead, there were many more health polices enacted by the Newman government that mimicked NHS policy and some of the UK government’s decisions discussed above. These were a result of similar privatisation, or were threatened due to the privatisation of the hospitals. Jo-Ann Miller, Shadow Minister for Health in 2013, stated that the selling of hospitals “inevitably means more job cuts and more frontline service cuts and the potential wind-back of hours within which outpatient services are offered” (Miller 2013). This was reflected when the Newman government sacked swathes of health care workers.

**Staffing and Morale.**

What was evident in Queensland Health under the Newman government was a lack of morale within the health sector in Queensland. This was due to many of the same experiences noted in the NHS, including a significant swathe of job cuts from many departments, not just health. Various nurses, as reported in a QNU press release, made statements highlighting the growing mistrust of the Newman government. One nurse wrote that, “Staff morale is at an all-time low. I’ve been with Queensland Health for over 20 years and I have never experienced such miserable times. Staff have lost hope that things will improve, we are lied to and mislead. We are working harder, with less staff, less equipment. Programs that we slaved to get established have been cast aside” (Queensland Nurses’ Union 2015b). Similarly, other nurses reported a lack of morale across Queensland within the
hospital systems, and in turn worried about the quality of care patients could experience under such rampant employment cuts as were carried out by the Newman government.

Such job cuts, as reported by the QNU in 2011, pushed hospitals to “breaking point” causing further disharmony amongst the health professionals. What resulted was not only tension and unease, but questions of misconduct began to be noted in various hospitals and patient lives came under risk due to a lack of staffing. Beth Mohle, Secretary of the QNU, wrote “We are very concerned patients and staff are at risk as a result of these massive health cuts. In addition to cutting jobs, the authority of senior nurses to ensure patient safety has been greatly diminished through significant organisational restructuring at a Hospital and Health Service (HHS) level. This means that in many instances, non-nurses are over riding the decisions of nursing management on staffing and therefore patient safety and quality” (Queensland Nurses Union 2014). Similarly, where there were holes left in the health sector, private health professionals were contracted to fill gaps akin to the processes found in the NHS, which increased costs rather than provided savings, replicating another of the anomalies that became apparent in the NHS once staff numbers dwindled due to discontent.

The Queensland health cuts included the closing of 126 hearing clinics and the axing of school nurses. They included the closure of the Barrett Centre, a mental health facility for youths, even after, reports the Facebook site, The Shame Files, the Newman LNP government received documents warning of potential deaths if the centre was closed. The Facebook site suggested, as was the case, that there were no alternate care options for those in the centre, which had a seriously detrimental effect on patients (2014). As a result of the closing of the Barrett centre, three teen deaths were investigated in late 2014. The Newman government shut this mental health facility in January of 2014, promising other services, and yet, shortly after, three teenagers who were high-risk in the centre had already committed suicide. As a result, the current Labor government is in the process of conducting a $9.5 million inquiry as there is enough evidence to suggest these deaths were preventable had the facility not been closed. A report by Queensland Health had warned the Newman government that the “Interim service provision of [Barrett Adolescent Centre] closes and the tier 3 is not available, is associated with risk” (McLeish 2015). One of those teenagers who committed suicide was taken from the adolescent centre and placed in an adult facility where she was given independent accommodation, resulting in a lack of specialist and age-appropriate care resources the patient needed.

Boards and Committees.

While health practitioner numbers were being cut by the Newman government, they paradoxically strengthened numerous health boards that were not, writes Dr Mark Bahnisch, “accountable to communities, or to the best in clinical and health management” (2013). These
boards were criticised on social media as leaning too much towards the policies of the Newman government with positions filled by those who supported the Newman government and the government’s proposals. 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 (Queensland Health 2013). According to the Queensland Health Blueprint of 2013, boards were established to “compete on key performance indicators. Savings redirected to boost local service” (Queensland Health 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) was appointed with the power to choose 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 2014). Another service removed as a result of these governmental decisions was the director of nursing (Calcino 2013). While the nursing, midwifery and medical professions campaigned against this, the trend developed further across the state. Solid evidence demonstrates the value of having professions answerable to their own profession, a fact that would seem obvious (Wong, Cummins & Ducharme 2013).

Then Opposition Leader Annastacia Palaszczuk stated of the boards that, “Given the Health Minister has said nothing more than the issue relates to employment . . . procurement contracts, is this just another example of jobs for the boys and contracts for mates?” (ABC News 2014). These boards, to some degree, were responsible for the large-scale implementation of NHS systems, the Together Union stating that bureaucrats from overseas had been recruited to these boards as a means of cutting costs in the Queensland health system. As noted by a Cairns blogger, Hillbillywatch, the Cairns boards did not comply with the Health Boards Act 2011 in which members selected are supposed to include specific persons with specific skills. They write that, “‘persons with knowledge of health consumer and community issues relevant to operations of the Service’, ‘where relevant, persons from universities, clinical schools, or research centres with expertise relevant to the operations of the Service’” (2103). Newly formed boards, the blogger states, did not include those relevant people despite, the blogger continues, the fact that “James Cook University uses the Cairns Base as a teaching hospital and part of their program. This leaves the board short of the Guiding Principles under the Act” (2013). There was, as result of replacing two board members in the Cairns district, no specialist doctor or nurse representative, resulting in a board that included two accountants, the local LNP member, a general practitioner, and a pharmacist (Hillbillywatch 2013).
Waiting Lists.

One of the policies that came under vehement attack in Queensland’s social and mainstream media was the patient waiting lists. Lawrence Springborg, the Newman government Health Minister at the time, praised Queensland as being an exemplar of health performance across Australia. Conversely, as reported in the *Guardian* in 2015, Dr Chris Davis reported that the government had cut waiting time by “contracting out an enormous amount to private groups, many of whom are LNP donors” (Robertson 2015). In years past, and as noted in other countries including the UK and America, 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); this has been characteristic of Queensland Health under several different governments. The Newman government came to government with a will to improve things in health, and in particular, cut waiting times. However, their solutions to this intractable problem have generated unforeseen consequences (Shields 2014).

As a way to decrease waiting times and improve throughput in the health system, Queensland Health, similarly to other health departments in Australia, borrowed from the NHS. The NHS has devised targets that need to be met, and tied these to funding, with bonuses to trusts for reaching targets in a prescribed time, and penalties for not doing so (Shields 2014). Queensland Health has transported targets from the NHS. One such is the National Emergency Access Target, or NEAT, which is defined in the Blueprint 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” (2013). This has been colloquially dubbed the “four-hour rule”. Patients who present to an emergency department (ED) in any hospital in Queensland must be discharged from that ED either to 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 beds/trolleys in ED were full (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; a good thing in theory. Australian, and Queensland, public health services have embraced the NEAT with gusto, though with little critical assessment (Shields 20XX).

The NEAT has had consequences unforeseen by those who hoped to improve patient care with efficient throughput and decreased waiting times both in Queensland and in the UK (Shields
The British Medical Association, in a UK 2005 reviewed target-driven health care, found that 82% of EDs surveyed thought 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 of NEAT found that staff felt under pressure to avoid ‘breaches’ of the target; and staff described, again, bullying if they did not meet targets and poor staff morale as a result of this bullying. Patients were being inappropriately and hurriedly re-designated or re-labelled so that they could be discharged from the ED early. The authors of the British Medical Association report concluded that the four-hour rule led to target-led rather than needs-led care (Mason et. al 2010, Letham et. al 2012).

“Access block” is seen as the main inhibitor to the effective implementation of NEAT (Fitzgerald et al. 2014, Green 2014; Keijzers 2014, Khanna, et al. 2013, Lawton et al. 2015). This occurs when a patient has been in ED for the maximum four hours, but there is no bed available in the hospital wards to which they could be sent, or possibly, no bed available in the required specialist area. New models of care within hospitals are needed to break down access block (Fitzgerald et al. 2014). However, some hospitals have been innovative in attempting this, creating alternatives to keeping patients in ED just to meet the “four hour rule”, variously given names like “Medical Admission Units”, “Clinical Decision Units”, “Rapid Admission and Planning Units”, “Short stay Units” and so forth (Green 2014). These really mean that yes, the patient is out of ED, but bring questions about the appropriate staffing of units. If the cost (both in patient and economic outcomes) exceed the benefits of staying in ED a bit longer then are these units really doing any good, or are they just there so the administrative target of NEAT can be met?

Some question the measurements of NEAT, which are endpoint measures only. Surely what happens clinically in the four hours spent in ED should be taken into consideration as well? Time to treat the ED patient is shortening because of NEAT. Green states “Diagnostic workups have changed from ‘fine dining’ to ‘fast food’. We see more patients faster and spend less time with them. We have even set up ‘drive through’ service in some centres with ‘see and treat’ models.” (Green 2014, p 1). However, the main concerns about NEAT are based on the fact that the aim of 90% of patients being seen within four hours was set by a panel and is not evidence-based. Some evidence exists that if
access block is addressed then inpatient mortality is reduced (Geelhoed & De Klerk 2012), but more appropriate and clinically focussed parameters need to be measured to determine quality of care are needed to really assess the appropriateness of such targets (Keijzers 2014, Khanna et al. 2013). There is a real danger that the “four hour rule” has become an end in itself, seen as a good thing by administrators and accountants, but not necessarily the best for clinical outcomes and patients (Lawton et al. 2015).

In Queensland, on social and in mainstream media, one reason for the Newman government’s demise was due, it appears, to the fabrication of health figures that did not seem realistic to people who themselves had experienced Queensland health first-hand. According to Steve Bishop in the Independent, whenever the Newman government boasted of its achievements, such as fixing waiting lists and waiting times, tens of thousands of people reacted negatively via social media such as Facebook or Twitter (2014). In the Brisbane Times, for example, after reporting that the Newman government had reduced waiting times in EDs by a considerable amount, three comments among many suggest patients were experiencing something other: “I only have 2.5 years to go on a 3 year wait for a basic hernia operation. Springborg is as incompetent as the rest of this woeful government” (Remeikis 2014), and “My daughter has waited for over twelve months to get ONTO a waiting list of people needing to see an ENT specialist” (Remeikis 2014), and “I am one of these ‘people’ waiting to get on the list. After consulting my GP, who forwarded my health issue and details to Qld Health, I was pleasantly surprised to receive a reply within 7days. This letter stated that status would be assessed and I would be notified accordingly. I have not to date had any further communication from Q Health and that was in excess of 2 years ago” (Remeikis 2014). The government at the time were claiming the “best ever” surgical wait times, but the Opposition suggested the figures had been fudged “by ignoring the waiting list to go on the wait list”. MP for Stafford, Dr Anthony Lynham was quoted by Remeikis (2014) as saying that there were 400,000 people, nearly three times the population of Townsville, just waiting to get onto a waiting list. “If you want to make a waiting list go away, the first thing you do is stop anyone from getting on to the waiting list and that's the first thing they did,” Dr Lynham said. “The second thing you do and the most foolish thing you do is reduce the waiting list by the most expensive method possible. So you take people off the waiting list by hiring them through the private hospitals, private surgeons and you reduce the waiting list by the most expensive way possible” (Remeikis 2014).

A positive article written by Andrew Wilson, who was Director of the Menzies Centre for Health Policy at the University of Sydney, about the Newman government’s success in the health sector is an interesting example of how one article that is vague in content, is rebutted by a multitude of comments (2015). Included in these comments is one by Joy Ringrose that reads, “This
article glosses over some atrocious decisions made by the Newman government. Springborg proudly claims to have ‘reduced hospital waiting lists by 80%’. He did this by dropping the sick OFF those lists. They are now on a ‘health list’, that is, a list to see a specialist” (Wilson 2015). Her comment and others go on to accuse the Newman government of Americanising Queensland’s health system, and suggesting that the government’s decisions benefitted a major donor of the LNP, Ramsay Health. Ringrose’s commentary does not stand alone and many more that speak ill of the Newman government’s health policy, and the fabrication of waiting list information are at the core of these concerns. According to some of this feedback, the effects of needing to reduce surgical times, and ED time, can be noted in the Dr Jayant Patel scandal. The managers of the health district in which Dr Patel worked, it is suggested, were pleased as 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 money and enhancing reputations (Thomas 2007). 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 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). Such poor judgement could easily have emerged from the well-intentioned, target driven health care that characterised Queensland Health during the Newman government. While the Patel incident occurred under a Labor government, the debacle should have been a lesson learnt for the LNP government.

Transparency.

Transparency, according to the Queensland Health website (2015) means that the department collects and collates data, “including but not limited to clinical conditions, health care provision and activity, hospital and service performance, public health and population health initiatives, program administration, human resources, financial performance, capital delivery and workplace incidents”. In the UK, a recent website called “Dr Foster” (http://www.drfoster.com/), an independent body removed from the government, has been set up to act as something of a NHS watchdog. Dr Foster is an interactive website allowing patients to compare and contrast hospitals across the UK. It means patients and prospective patients can research the quality and safety of the hospitals they are looking to use. The site itself collects information that may be of relevance to the patient, including information to do with patient safety, the clinic or hospitals performance, and also shows patient feedback. As a result, hospitals across the UK are ranked. The idea behind Dr Foster is
to use data to improve hospital performance, and this is something that private Australian hospitals run by companies like Healthscope, Australia’s second biggest hospital company, has recently launched. But in comparing this website to those found in Australia, the ABC suggested that there was a general lack of transparency in Australian health services, including Queensland (Scott 2011). As outlined in the many comments posted by the public following the publication of an ABC article that compares the UK’s Dr Foster to an Australian equivalent, there are problems with this model, some suggesting this type of feedback could be the demise of the public sector (Scott 2011). Too much transparency could lead to unease, or to unwarranted and bias critiques of the public sector. “If I listened to the experiences of acquaintances, there wouldn’t be a single hospital in Greater Melbourne or Greater Sydney I could visit. Yet somehow, I’ve never had a problem during any of my hospital visits, anywhere, ever” writes one commentator called dkril (Scott 2011). As noted in 2012 in a report by the Togetherness Union, such transparency needs to be applied to both the public and private sector, for there was, in 2012, a concern that the private sector was under-reporting earned income. A lack of accountability was what concerned a swathe of media, including Madonna King from ABC radio and the Courier Mail, who made an issue of accountability when investigating patients with letters from their GPs who were being turned away from Queensland hospitals. As King states “The latest issue and how the Government is dealing with it mirrors the ineptitude and lack of transparency that we saw with the Queensland Health payroll problems. At no point does the Government openly admit a problem. It must hope that you never find out, or subscribe to the view that ignorance is bliss - or that by sticking its head in the sand, the problem will just disappear” (King 2011). This lack of transparency was, and continues to be openly criticised by the public on many blog sites and on public news forums. Similarly, writes the Environmental Defenders Office, on 8 January, in the lead up to the Queensland State Election, The Australia Institute wrote an open letter to the leaders of Queensland’s political parties asking each to commit to the principles of accountability and good governance put forward by The Honourable Tony Fitzgerald AC QC. The letter stated that, “The erosion of accountability and transparency has damaged democracy in Queensland. Successive governments have become too close to industry lobbyists and representatives, particularly from the resources industry, undermining public trust in the political process” (Jabour 2015).

**Readdressing Policy in Queensland.**

The crux of changes made to the NHS are sometimes the result of privatisation. This has led, as outlined above, to many problems, including staff dissatisfaction, a lack of morale, and, somewhat paradoxically, where money is meant to have been saved, in fact spending has increased. As a result, governments in general need be wary of selling off health assets. While this is a general blanket
statement, it is acknowledged that some privatisation is beneficial and there are upsides to the selling of health assets when done in a measured informed way. Australia’s two-tiered health system means that privatisation is necessary and that those who can afford it will pay the medical insurance for this private health service. The government, therefore, need be wary of placing either too much emphasis on one form of health service, whether private or public. For while private health insurance is fine for all those who can afford it, many cannot. It could be that instead of approaching the health facilities and questioning their possibility of becoming private, the government addresses the client, encouraging all those who earn over a certain amount to pay for private medical insurance. This then frees up the public waiting rooms and allows any staff who work in the health services to spread themselves across the private and public arenas as they so choose. The result is a balance and one form of health cover does not privilege another.

The closure of the Barrett Centre has left a scarring legacy, and any restructuring of mental health services needs particular care, thought and planning. Privatisation also needs to be very carefully examined when dealing with mental health service providers. These mental health facilities may be best investigated outside of generalised attempts at privatisation. If privatisation of these facilities did occur, then there needs to be a very considered implementation and justification. Mental health has only recently been seen to be accepted in the mainstream of public opinion, and this is apparent in news reports that highlight, for example, youth suicide, depression, or the suicides of public figures. As a result, this topic remains emotive in public media spheres and any governmental hiccup is likely to be met with a far greater public outcry than issues to do with less topical health related issues. Therefore, the privatisation of mental health facilities is sensitive in the public and media sphere.

There needs be greater transparency when dealing with the public as much backlash in public and private media forums has come not only from the problems with waiting lists, but with the cover-up of figures. The public needs to be openly informed of what exactly is meant by a waiting list for there is much criticism of a government when figures and words are cloaked and have double meaning behind them. As evidenced on social media such as the Facebook site, The Shame File, the public are generally aware of the inconsistencies and cover-ups a government makes. As noted by the current government in May 2015, that “the top-level advice ... was that there were a significant number of faults with the previous LNP Government’s Wait Time Guarantee program. The advice was that the WTG was focussed only on waiting times for elective surgery, which is only one part of the patient journey which includes specialist appointments and diagnostic testing” (Dick 2015). While a government press release was needed to tell Queenslanders the truth of the waiting list situation, unfortunately for the LNP government this information was already known widely.
among the greater Queensland community. It seems that any dishonesty, whether intended or not in the government sectors, is openly noted on social media, and when health issues are discussed, a more vehement opposition arises. Therefore, all figures of all lists should be available for the public to see and scrutinise. Even if the figures are not what the government expects or promises to its constituents, transparency and honesty are rated higher in the public sphere than fabricated figures.

The current government has, to date, promised a revamping of Queensland health services. In July of 2015, in a press release, Health Minister Cameron Dick said the Government would invest a record $14.2 billion in health in 2015-16 to support growth for health services and deliver its election commitments. “Real action on waiting lists – not the former LNP Government’s gimmicks – employing more nurses, and upgrading regional hospitals are Labor’s priorities in health,” Mr Dick said. “We are investing record amounts in health and ambulance services to address key areas of demand and reverse cuts to frontline services made by the former LNP Government. We will refocus the health system on patient safety, employ more nurses and midwives, and rebuild preventive health and mental health services that have suffered from a lack of investment” (2015). Similarly, the current government is attempting to rectify staff morale by employing a further 400 nurses across the state, and this, the Premier stated, “would lead to shorter stays in hospital, improved clinical outcomes, reduced waiting times and better access to care” (Palaszczuk & Dick 2015). Here is where policy needs to inform governments, for the Premier appears to be simply repeating catch phrases of the Newman government. More evidence needs to be provided to support these assumptions, and if there is no substance to such claims, then alternate ways of dealing with the health system have to be implemented. For example, it may not be ideal to suggest shorter stays in hospital, and that longer stays prevent further costs. If a patient has not adequately recovered, then readmission may be needed, thus greatly increasing cost. What has been of benefit to the government’s policies are the recovery of nursing to patient ratios, and the current government have recalibrated figures so as not to have Queensland health resemble the NHS. “The government will legislate for phased implementation of minimum nurse–to–patient ratios that will ensure safe, quality care in our hospitals and the best possible outcomes for patients,” Mr Dick said. “These ratios of 1:4, 1:4 and 1:7 respectively for morning, afternoon and night shifts will ensure that when a patient presses the bedside buzzer, they will promptly get the caring attention they need” (2015).

Education needs to be an issue of focus as this will led to a lessening of those aforementioned NHS deficiencies. At the present moment, 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 percent of British nurses held degrees (Sastry 2005), though the number with degrees steadily grows now registration requirements have been lifted (NHSCareers, no date). Entry requirements to the diploma programmes in the UK 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 education standards in the UK will have beneficial effects there. Here the current government’s pledge to dedicate $110.7 million over four years to support nursing and midwifery graduates will help this NHS deficiency being replicated in Queensland. This is in contrast to one of the policies instigated by the Newman government that saw the sacking of 1,800 nurses and the removal of a nursing graduate scheme.

With this is the emphasis on localism and the need for smaller regions to be autonomous, knowing that these smaller regions understand their patient demographics best. In this, the NHS has made some headway, and Sweden is held as the exemplar, this localism being effective as a local governance model. Six “essential actions” are purportedly required to bring about a transition to localisation: “lifting the burden of bureaucracy, empowering communities to do things their way, increasing local control of public finance, diversifying the supply of public services, opening the government to public scrutiny, and strengthening accountability to local people” (Briggs 2014). Localisation might provide the opportunity to build on the initial enthusiasm engendered by the health reform for the local health districts or hospital authorities and the Medicare entities to work together to do things better at the local community level. It will require government(s) to provide generative space that allows this and gives permission for local governance structures and managers to respond to opportunity (Briggs 2014). “This generative space is currently cluttered with the language of performance management, targets and indicators, a preoccupation that has limited value and diverts attention from achievement of more effective care; an approach that should be replaced with discussion and debate about how to do things better, being effective ahead of efficient and how might we add value. While this is still being debated in the NHS, how to effectively become ‘localised’, in Queensland this becomes a lot easier given that there is less population” (Briggs 2014). Geographically, however, there are far greater distances to contain than in the UK, so localisation needs some further development. For example, when dealing with the increase of local control of public finance, how does geographic distance affect this? What this does mean, essentially, is greater autonomy for regions while the government is not wholly responsible for each and every region. “Guidelines need be met, but each separate locality can be examined individually in regards to the privatisation of certain health services. For example, this could provide private mental health companies the opportunity to establish themselves in regions if a region has not got a
facility in place. In essence, Queensland Health needs to move away from the emphasis of governance on rules around form and structure (institutional power) to governance by rules around practice. At the local service delivery level Queensland Health needs flexible opportunities to garner localism through strategic use of quasi markets, contestability, community and relational governance and the governance use of fit for purpose networks” (Briggs 2014).

CONCLUSION.

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 imported 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 that 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 (Queensland Health 2013). Other “goods” from the NHS include the highly developed way children are cared for in hospitals. Since the revolution in paediatric care that 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.

However, Queensland Health 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 within the NHS does not mean it is appropriate for, or will work, in Queensland Health. Queensland Health needs to target specific people for the good things that could be gained as a result of their employment; for example, health visitors could help re-start primary health care services.

Why look only to the UK? Other countries have extremely good health systems, which, unlike the NHS, are considered exemplars in many ways. 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. Such European modelling was behind the Newman government’s announcement in late 2014 of a “Queensland Health guarantee”. Modelled on the Scandinavian health systems, this meant that “the Wait Time Guarantee means if your local Hospital and Health Service can’t provide treatment within the medically recommended time, you’ll be offered the next available appointment in a public or private hospital elsewhere in the state at no cost,” Mr Springborg, Health Minister at the time said. He further stated that, “these patients won’t have to pay for any travel or accommodation costs, if they are treated more than 50 kilometres from their original hospital. This can only be achieved in a well-managed, well-resourced world-class health care system” (Queensland Government 2014). Similarly, France, for many years, had its health care system rated as the best in the world (About-France.com 2014). Queensland Health could look further to those countries for expertise and ideas. Then there are the Nordic countries, as mentioned before, such as Norway, Sweden, Finland and Denmark who have the best health care systems in the world. Why look to the NHS solely? It would be better to take what is best from many differing countries. It appears that the Newman government sought quick fix solutions roughly modelled on the NHS, and failed to explore alternate options, or to forecast the pitfalls of adopting certain NHS models when there are other models that work a little better. As mentioned above in discussing localisation, Sweden could provide the best practice model upon which a Queensland model could be based.

Overall, the current government has done much to rectify both the ills of the past government in regards to health policy, and they have also done much to improve the government’s image in regards to health services. By taking what is best of the NHS and looking at those aspects that did not work, by adopting some practices and avoiding others, Queensland Health will strengthen. An entire whitewash of health services, including mental health, is reactive and short sighted. As proven by the many mishaps and a few deaths, short-term policy may work in some legislative areas, but not health. The current government needs to work outside of the parameters of office and realise that long-term benefit does not come from wanting to prove themselves in three years, and have evidence of this. It requires a strategy that forecasts decades ahead, not short term. This is noted by a nurse, Sarah Beaman, who wrote about the Newman government’s health system on Nurse Uncut in 2013 that, “this money-saving strategy by the Board is false economy and is going to have significant long term consequences to nursing and our ability to provide a high standard of safe nursing care. The government is not interested in the future of the health of our communities or the future of nursing. This government is not planning for the future” (2013). With this in mind, and as stated above, further countries offer health policies that can add to what has already been adopted from the NHS, and what is already working in Queensland Health at present.
These policies are both at a fiscal level, and also in regards to the ongoing maintenance of patient care. So the future of Queensland Health should be far reaching, and should encompass the best of health services from around the globe. It is now, in a time of growth and wealth, that these measures can be implemented to ensure that this is then cemented for generations to come.
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