Hospital funding and services in Queensland

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Abstract

The Queensland health sector has been characterised as unique. The population has traditionally relied on the public sector to provide necessary hospital and other health services across the vast distances that make up the state, although there is a strong non-government sector also. More recently, and over the last 5-6 years stability and drive at the management level in the public sector has supported reform and progress, consistent with the national agenda. The Queensland reputation of cost efficiency and effectiveness in service delivery and outputs to meet national standards continues as this Chapter demonstrates.

Introduction

Geographic and demographic context

Queensland is unique in many respects. The State forms the great north-eastern triangle of the Australian continent and comprises 22.4 per cent of its landmass. Fifty–four percent of the state is north of the Tropic of Capricorn that poses a number of specific public health challenges for the population residing in the tropical environment. It has an international border with Papua New Guinea, which, in turn, has a free people movement treaty with the Australian Government. It is the fastest growing state in Australia due to a combination of economic and social factors over the last two decades. The overall population has increased, mainly through internal migration, so that it is now the third largest state in population numbers: three and a half million estimated as at June 1999 (ABS, Australian Demographic Statistics, Cat. no 3101.0).

Table 1: Queensland Population relative to other States and Territories

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Australia
As at 30.6.99	6,411.70	4,712.20	3,512.40	1493.10	1861.00	470.3	192.9	310.2	18,966.80

Source: Australian Demographic Statistics, ABS Cat No. 3101.0

The economy is strong. The State has prospered through agriculture, mining and more recently, tourism. A recent Government priority to make Queensland a 'smart state' is seeing an increasing emphasis in economic investment in the health and scientific areas.

The profile of the population is similar to that of other Australian states and territories with two exceptions: the relative 'youth' of the population and the fact that around 25 percent of Australia's Indigenous peoples reside in the state. This influences the priorities of the public sector health services. For it is the public sector that overwhelmingly provides health services for Indigenous peoples and for the elderly.

The Queensland public health sector has also been characterised as unique. Certainly, the development of the public sector health services was shaped by political history. A long period of Labor Governments in office during the early development of Queensland as a state resulted in increasing government intervention and control of the public hospitals. This culminated in the 'nationalization' of the public hospitals in 1944. From this time, Queenslanders were able to receive inpatient treatment free of charge. Consequently, the large majority of Queenlanders came to rely on the public hospital inpatient and outpatient services for their health services. This was a benefit not enjoyed by other Australians until the introduction of Medibank in February 1974.

Other significant features of the public system are the infrastructure of salaried medical practitioners working in the hospitals, and a high degree of centralised control (Butler, 1989). There was a brief flirtation with decentralisation of power and control of health services with regionalisation introduced by the new Goss Labor Government between 1991 and 1996. Although it did not survive, the reform that accompanied it brought Queensland's system more in line with other states and territories' over the latter part of the last decade. Changes included support for accreditation, clinical credentialing, and other quality processes, introduction of case- mix albeit as a management tool, an information management infrastructure, greater industrial democracy for health workers, wage parity with other systems, and attention to performance management and outcomes.

Along with the reform, an analysis of the Queensland public sector over the decade confirms the legacy of a strong investment in hospital services per se, continuation and growth of the salaried medical officers infrastructure, and a centrally managed direction and policy setting for the state. This has occurred along with a real per capita increase in the State Budget allocated to Health over the same period (see Figure 5 on Funding in the State Budget).

There has been a high degree of stability at Executive level in the Department since the 1996 restructure and the appointment of a new Director General. The structure is described in Figure 1. The Director General has directed his energies to promoting the concept of 'one organisation' and encouraging clinician leadership and a systems approach to management. The structure and effort, to some extent, follows the funder-purchaser-provider model. The funder is found in the first major division: the Policy and Outcomes Division, which is headed up by a Deputy Director General. Policy functions for Indigenous Health, Mental Health, children, aged and rural health are found in this division, along with the health outcomes effort (in the Health Systems Strategy Branch). The Health Funding and Systems Development Unit in the Branch has corporate responsibility to negotiate with the State, Commonwealth and other external funders for monies for the portfolio. The second major division: the Health Services Division has the role of purchaser, although other functions such as Public Health is in this division . A General Manager (Health Services), who is essentially an 'operations manager', heads the Division. An example of the purchasing aspect of the Department's operations can be illustrated by the role of the Statewide and Non-government Health Services Unit which has responsibility as the transaction centre for purchasing a broad range of health services from non-government organizations, private sector organizations and health service districts, consistent with policy and funding priorities. Queensland Health has adopted a predominantly public sector delivery system for hospital services. However there are contract arrangements that exist with some collocated private hospitals and two privatized hospitals. The privatized hospitals are Build Own Operate Transfer (BOOT) models. One of these is operated by the for-profit private sector at Noosa on the Sunshine Coast, and the other by a non-profit religious order at Robina on the Gold Coast.

In 1999, Queensland Health adopted a Zonal structure (Figure 2), which has a purchasing and co-coordinating role. The Northern Zone is the largest in area and extends from the east coast of the State south of Mackay to Cape York and west to the Queensland border. The Central Zone extends from south of Mackay down the east coast to the northern banks of the Brisbane River and west to the Queensland boarder. The Southern Zone extends from the southern banks of the Brisbane River down the east coast to the southern border of Queensland and out to the western border of the state.

Figure1: Queensland Health Organisational Chart

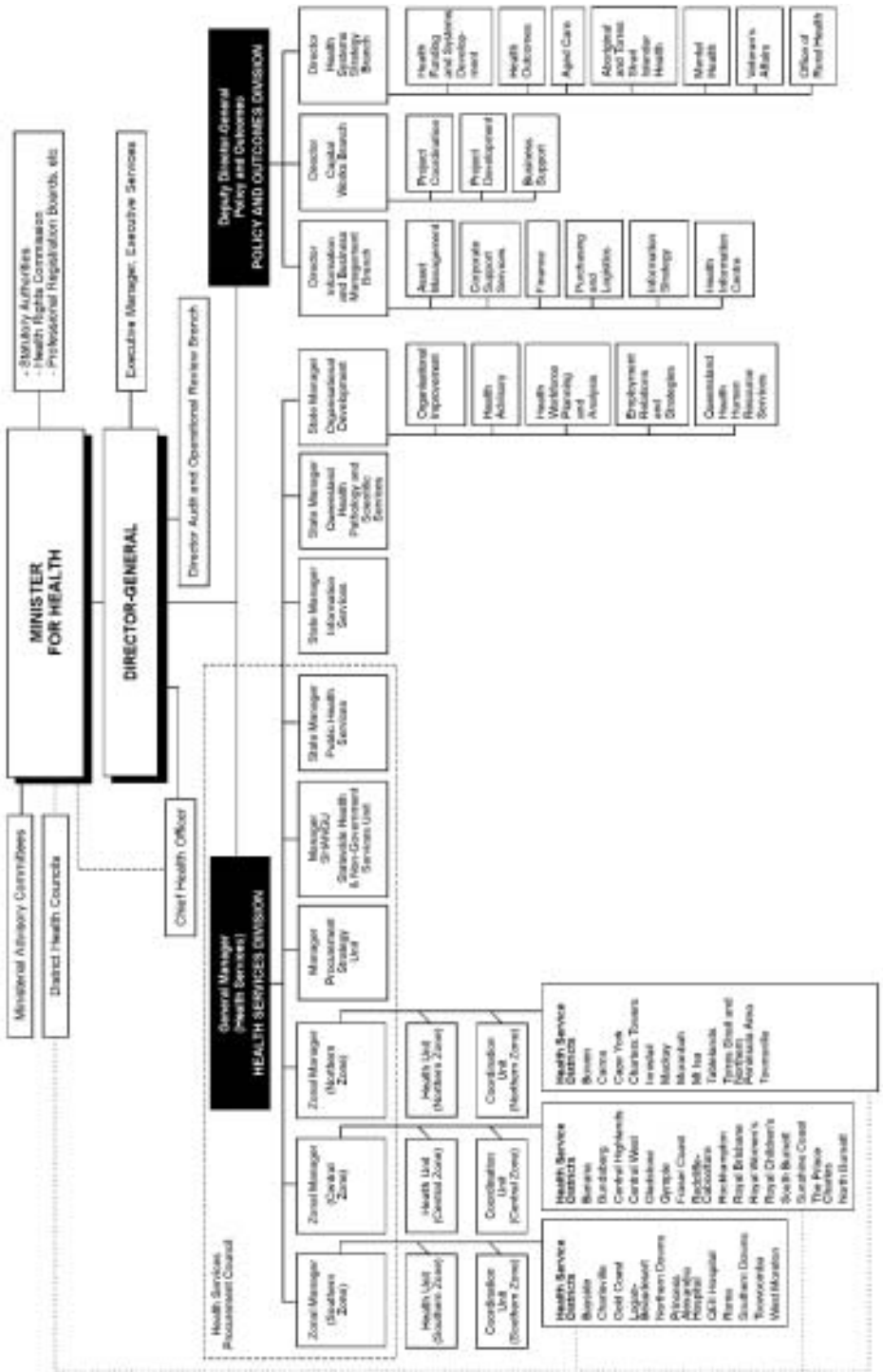
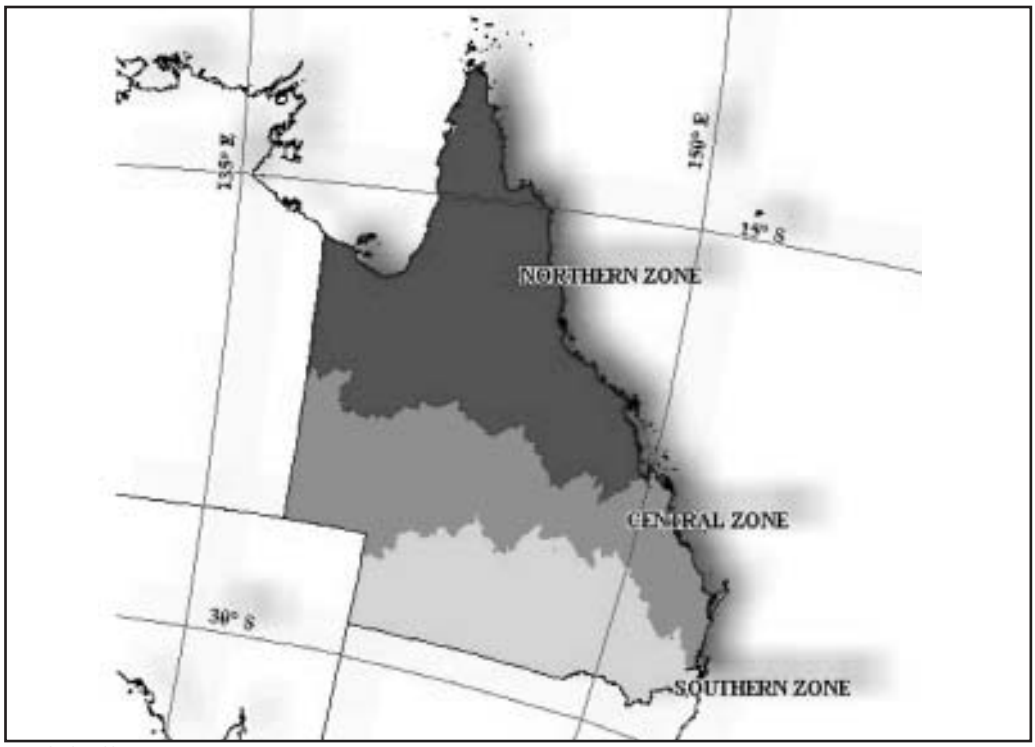


Figure 2: Zonal structure



Queensland Health 2000

Thirty eight (38) health service districts underpin the zonal structure. In addition, the state provides funds to the Mater Misericordiae Hospitals' Brisbane complex (often regarded as the 39th District) for services provided to public patients and to support their Capital Works Program.

The thirty-eight health service districts are responsible for the management and delivery of health services to their communities. These include hospital and community based clinical services such as oral health, child and youth health, community health, Aboriginal and Torres Strait Islander health, women's health, mental health, home and community care services, sexual health and alcohol and drug services. A District Health Council, consisting of 8-10 members of the local area, appointed by Government provides community input, informs the strategic directions and guides the way health services are delivered in each district. Other community input is received via advisory committees managed through the different areas of the corporate office: aged care consumer reference group and mental health consumer reference group are two examples.

Queensland Health is responsible for the delivery of health services with other portfolios taking responsibility for community services, disability (including psychiatric disability) and like 'human' services. Coordination of government effort is achieved through both budgetary arrangements, the *'managing for outcomes'* requirements and *'whole of government'* output investment initiatives. The Queensland Government's *Charter for Fiscal and Social Responsibility* guides these approaches that, in turn, conform to the Government's budgetary and strategic priorities.

The majority of the population relies on the public sector for services but there is a substantial private hospital sector, both for profit and not for profit. This is described later in this documentation.

Challenges

In 2001 –2002, Queensland faces a range of challenges that are common to other states and territories. These revolve around

- competing pressures linked to managing budgets,
- rapid diffusion of new health services technology and clinical services approaches,
- fragmented and uncoordinated health care funding and program boundaries,
- high professional expectations by those working in the public health care system,
- mal-distribution of some specialist medical and nursing practitioners,
- expectations by consumers for access to culturally appropriate, timely and evidence based services,
- a government that is conservative about many aspects of health services reform, and
- limited ability to derive more productivity from the system.

A variety of approaches are in place to meet these challenges, most notably via the Strategic Directions 2001-2010 document that spells out the three major directions for Queensland Health over the next decade. These are:

1. Addressing the Burden of Disease
2. Improving Indigenous Health
3. Balancing the Investment in Health.

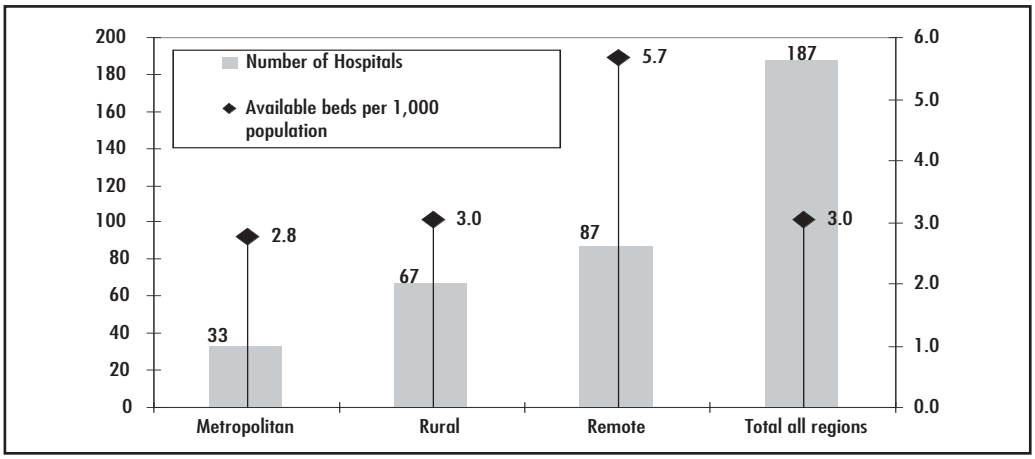
Hospital provision

Profile of Queensland hospitals

Queensland's health system comprises a relatively large number of hospitals that are highly accessible and of significant capacity. The hospitals are organised on a zonal self-sufficiency model, by role delineation, and by networks. In 1999-2000, there were 187 public hospitals in Queensland, including 179 acute hospitals, 7 psychiatric hospitals, and 1 alcohol and drug facility. Over the last six years, there has been a concentration on reducing the reliance on large psychiatric institutions for the provision of beds for those with a mental health condition requiring hospitalization; and the establishment of acute mental health beds in general hospitals.

Queensland Health has historically ensured that hospital services are available throughout the State. As a result, over eighty per cent of public hospitals are located outside the Queensland metropolitan, with 67 and 87 hospitals in rural and remote areas, respectively (Figure 3). There are more available beds per 1,000 population in rural (3.0) and remote (5.7) areas than in the metropolitan area (2.8). The latter is higher than the national average for remote areas (4.9).

Figure 3: Number of Queensland public acute and psychiatric hospitals and beds per 1,000 population by location, 1999-2000.



Source: AIHW, Australian Hospital Statistics, 1999-2000

Additionally, there were 89 private hospitals in 1999-2000, including 56 acute and psychiatric hospitals accounting for almost 20 per cent of Australian private acute and psychiatric hospitals. Of the total private acute and psychiatric hospitals in Queensland, 27 (48 per cent) are religious or charitable hospitals. Nationally, the ownership pattern is 25.4 per cent religious or charitable. Queensland's private acute and psychiatric hospitals also include 23 'for profit' hospitals and 6 other types of private hospitals such as bush nursing, community and memorial hospitals.

A significant trend in the private hospital sector establishments is the strong growth in freestanding day hospital facilities. Queensland now has 33 of these facilities compared with 4 in 1991-92. These are comprised of 3 general surgery, 7 specialist endoscopy, 9 ophthalmic, and 14 other centres including fertility, plastic surgery and sleep disorders clinics.

In addition to psychiatric and drug and alcohol hospitals, Queensland provides 29 types of specialised services through its public acute hospitals (Table 2).

Table 2: Number of public acute hospitals with specialised services, Queensland, 1999-2000

Type of Specialised Service			
Obstetric/maternity service	61	Acute renal dialysis unit	5
Specialist paediatric service	29	AIDS unit	4
Psychiatric unit/ward	17	Intensive care unit (level III)	4
Coronary care unit	16	Major plastic/reconstructive surgery unit	4
Rehabilitation unit	16	Sleep centre	4
Domiciliary care service	15	Burns unit (level III)	3
Maintenance renal dialysis centre	15	Cardiac surgery unit	3
Oncology unit	15	Neonatal intensive care unit (level III)	3
Geriatric assessment unit	12	Clinical genetics unit	2
Hospice care unit	10	Transplantation unit—bone marrow	2
Nursing home care unit	10	Transplantation unit—liver	2
r Alcohol and drug unit	9	Acute spinal cord injury unit	1
Diabetes unit	8	Transplantation unit—heart (including heart/lung)	1
Infectious diseases unit	7	Transplantation unit—renal	1

Source: AIHW, Australian Hospital Statistics, 1999-2000

At the end of the 2000-2001 financial year, there were 81 public acute and psychiatric hospitals and 284 non-inpatient services with some form of external accreditation. Queensland Health's 52 pathology laboratories and all State government nursing homes are also accredited. The growing number of facilities with recognised external accreditation reflects government policy commitment to quality improvement in the hospital sector .

In 1999-2000, there were 15,573 available beds in acute and psychiatric hospitals, 366 (2.3 per cent) less than the average number of beds available in the previous year. Two-thirds (10,320) of these beds were in public hospitals and the remaining one-third (5,253) were in private hospitals. As highlighted in Table 3, eligible public patients accounted for the majority (61.6 per cent) of patient days in Queensland hospitals. Almost 83 per cent of eligible Department of Veterans' Affairs patient days occurred in Queensland private hospitals, which is the highest proportion in Australia.

Table 3: Patient days by accommodation status and hospital sector, Queensland, 1999-2000

Accommodation status	Public Hospitals	Private Hospitals	All Hospitals
Eligible public patient	2,765,902	38,486	2,804,388
Eligible private patient	184,273	1,144,072	1,328,345
Eligible Department of Veterans' Affairs patient	63,058	303,299	366,357
Eligible other patient	19,195	19,481	38,676
Ineligible patient	8,213	5,103	13,316
Total patient days	**3,040,641**	**1,510,441**	**4,551,082**

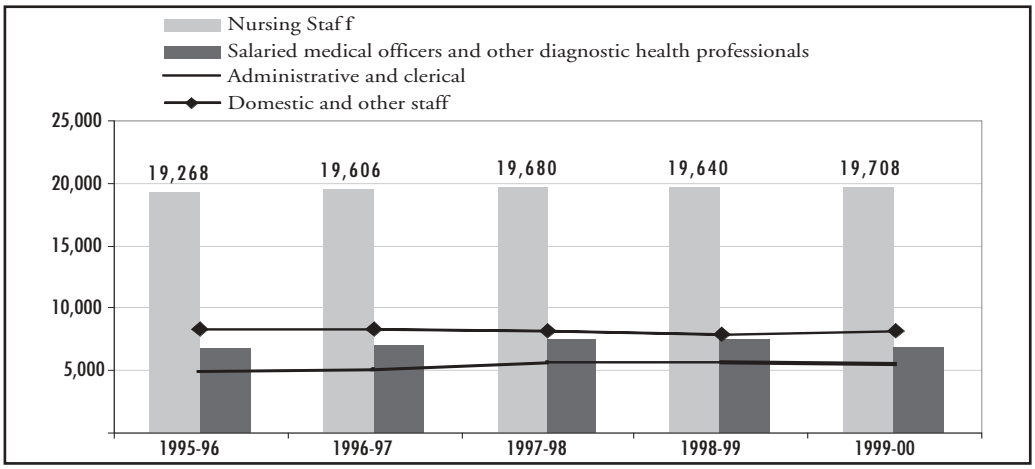
Source: AIHW, *Australian Hospital Statistics, 1999-2000*

In the past five years, Queensland hospitals have maintained a steady level of employment, with the number of full-time employees remaining between 39,000 and 41,000 (Figure 4). Similar to other jurisdictions, Queensland experiences a mal-distribution of health professionals. This is addressed by an annual Scholarship scheme directed, in part, to overcoming shortages in the rural areas and profession specific Ministerial task forces (Nursing and Allied Health).

Staffing

In 1999-2000, Queensland hospitals employed a total 40,323 full-time staff, with employment in public acute and psychiatric hospitals (30,943) over three times as much as the employment in private acute and psychiatric hospitals (9,380). Nursing staff was the largest group in Queensland's hospital labour force. They accounted for 45 per cent of total public hospital staff and over 60 per cent of total staff in private acute and psychiatric hospitals.

Figure 4: Full-time equivalent staff, Queensland acute and psychiatric hospitals



Source: AIHW, *Australian Hospital Statistics, 1999-2000*, ABS *Private Hospitals, Australia,* Cat No. 4390.0

There were also 6,864 salaried medical officers and other diagnostic health professionals employed in hospitals throughout Queensland in 1999-2000, representing 17 per cent of the hospital labour force. These figures would be substantially higher if the number of visiting medical officers (VMOs) were included. In 1999-2000, payments made to VMOs by Queensland public acute and psychiatric hospitals were $54,547M, representing 13 percent of the total recurrent expenditure on salaried medical officers and other diagnostic health professionals.

Access and efficiency

Queensland Health continues to strengthen its health service delivery by building facilities that increase equal access to high quality acute service, and by providing more flexible models of care and accommodation for patients. To facilitate equal access to hospital services, Queensland Health provides a Patient Transit Scheme (PTS). The PTS subsidises accommodation and transport for patients and in some cases their carers, who must travel to access specialist medical services that are not accessible within 50 kilometers of their nearest public hospital. Additionally, Queensland's public hospitals are supported by Pre-Admission Clinics. These Clinics are an intrinsic part of Queensland's hospital provision with 70-80 percent of elective surgical patients attending the clinic for assessment, education and discharge planning by medical, anaesthetic and nursing staff approximately one week prior to admission. A recent addition to the Pre-Admission Clinic model is a Surgical Preparation Area in which same-day surgical patients are prepared for the operating room. This service enhances bed management and facilitates the timely arrival of same-day admissions at the operating room.

Nursing home-type patients and multipurpose health services

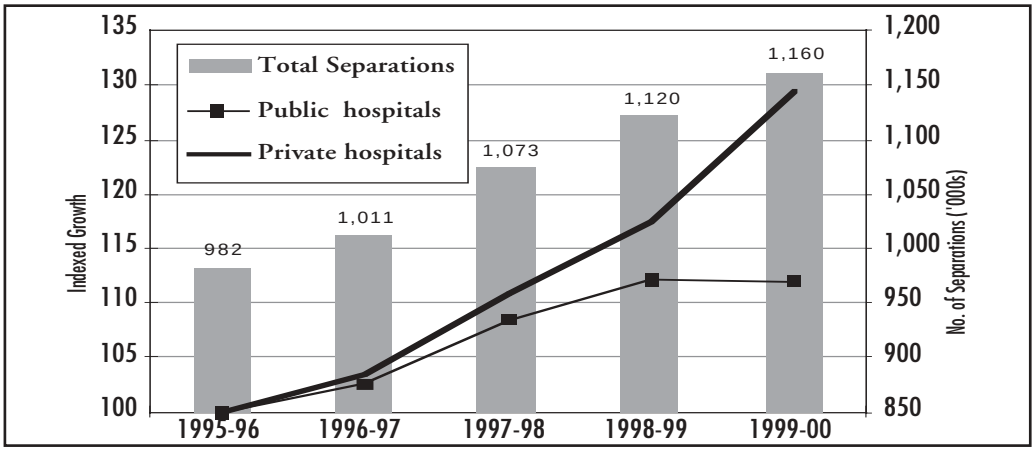
There were 1,791 beds as at 30th June 2000, comprising of 109 beds provided by Queensland Health for young disabled persons and 1,682 beds provided in residential care facilities for aged care. Nursing Home-Type Patients (NHTPs) account for less than 1 percent of the total separations in public acute hospitals and this reflects Queensland Health's commitment to ensuring there is timely and appropriate placement of NHTPs from the public hospital system into residential care, and effective management of acute hospital beds. This policy applies to State Government hospitals in the metropolitan area and to provincial towns where aged care beds are more numerous and the hospitals are not the appropriate care setting.

In rural and remote areas where there may be only one or no residential aged care facility it is more common for NHTPs to be managed in the local public hospital or Multipurpose Health Service. The Multipurpose Health Service program allows health services to be delivered in a flexible and sustainable way in rural and remote communities. The Multipurpose Health Service model is one based on primary health care principles, and incorporates the elements of active community involvement, needs based planning and local influence over the means of addressing needs. It is Queensland Health's preferred model for the delivery of health and aged care services in areas where the hospital's annual budget is below $2 million. Multipurpose health services can encompass the hospital, community health, and Home and Community Care services, and may entail new service developments, redevelopment or refurbishment of existing services, or rearranging existing services. There are a variety of arrangements for the multipurpose health service, with the majority of them under Queensland's Health's overall management and funding.

Hospital activity

The number of separations in Queensland hospitals continues to grow steadily, with private hospitals accounting for an increasing share of total separations (Figure 5).

Figure 5: Summary of separations, Queensland 1995-96 to 1999-00



Source: *AIHW, Australian Hospital Statistics, 1999-2000.*

Between 1995-1996 and 1999-2000, total separations provided by Queensland hospitals increased by over 18 percent (178,430). Private hospital separations increased by almost 30 percent (102,504), significantly higher than the 12 percent (75,926) increase in public hospital separations over the same period. Despite strong growth in private hospital separations, the majority of separations are still provided by public hospitals. In 1999-2000, there were over one million (1,160,324) separations in Queensland hospitals and 61 percent (707,914) of these were provided by public hospitals. The number of same day separations (588,2027) accounted for over half of the total separations in Queensland in 1999-2000, and represented a 42 percent increase from the number of same day separations (414,360) in 1995-1996. Private sector facilities have a higher percentage of same day separations than the public sector.

Table 4: Summary of Queensland hospital separations, 1999-2000

		Same day separations per 1,000	
	Total separations	Same day separations	Population
Public hospitals	707,914	326,432	198.9
Public acute hospitals	706,511	326,415	198.5
Public psychiatric hospitals	1,403	17	0.4
Private hospitals	452,410	261,595	123.6
Private free-standing day hospital facilities	85,594	85,588	23.4
Other private hospitals	366,816	176,007	100.2
Total	**1,160,324**	**588,027**	**322.5**

Source: *AIHW, Australian Hospital Statistics, 1999-2000.*

Eligible public patients accounted for 56 percent of total separations in 1999-2000 with the majority of these provided in Queensland public hospitals at an average cost weight of 0.97. (This, to some extent reflects the number of beds available throughout the State, particularly those in the smaller rural communities.) Private patients accounted for 36 percent of total separations and the average cost weight of private patient separations in public hospitals (0.98) was significantly below the average cost weight for Australia as a whole (1.07). However, private hospitals provided separations at a lower average cost weight (0.94) than Queensland public hospitals, consistent with the trend nationally.

Table 5: Separations by accommodation status, Queensland 1999-2000

Accommodation status	Separations	Separations per 1,000 population	Average Cost Weight
Public Hospitals			
Eligible public patient	644,086	181.3	0.97
Eligible private patient	46,909	13.0	0.98
Eligible Department of Veterans' Affairs patient	10,610	2.8	1.15
Eligible other patient	4,064	1.2	1.69
Ineligible patient	2,245	0.6	1.19
Total	**707,914**	**198.9**	**0.98**
Private Hospitals			
Eligible public patient	4,329	1.2	0.78
Eligible private patient	375,916	103.4	0.94
Eligible Department of Veterans' Affairs patient	57,304	14.8	1.21
Eligible other patient	12,798	3.6	0.91
Ineligible patient	2,063	0.6	0.89
Total	**452,410**	**123.6**	**0.97**

Source: *AIHW, Australian Hospital Statistics, 1999-2000.*

Between the ages of 15 and 54, females have a higher separation rate than males. However, males have higher separation rates for all other age groups. The higher female separation rate may be associated with childbearing, especially for the 25-34 year age group that also has a high bed day rate. For most age groups, the difference in the separation rate between males and females is reflected by a corresponding difference in the bed day rate. However, in the 35-44 year age group, males have fewer separations yet account for a higher patient bed day rate. Also, in the 85 years and over group, the female separation rate is lower yet the bed day rate is notably higher than for males in that age group.

Table 6: Rate of separations and bed day utilisation per thousand persons, grouped by age and gender, all Queensland hospitals, 1999-2000

Age group	Separation rate/1,000		Patient bed day rate/1,000	
	Females	Males	Females	Males
< 1	431.3	571.3	2618.4	3143.9
1–4	157.2	211.6	268.1	357.2
5–14	78.4	102.4	157.5	190.7
15–24	230.1	144.6	586.6	511.3
25–34	369.9	168.7	1109.7	608.8
35–44	292.9	214.0	744.9	759.3
45–54	332.4	309.8	991.6	906.9
55–64	473.5	506.0	1421.4	1867.2
65–74	724.4	868.4	2980.9	3603.9
75–84	854.3	1228.6	5808.1	7125.7
85 +	865.9	1139.2	12048.2	10147.9
Total	**343.8**	**306.9**	**1342.2**	**1210.1**

Source: *AIHW, Australian Hospital Statistics, 1999-2000, and ABS, Queensland Population Data.*

The highest number of separations in 1999-2000 was for diseases and disorders of the digestive system, with 55 percent of these provided by private hospitals. However, public hospitals provided more separations for most diagnostic categories with the exception of diseases and disorders of the eye, the male reproductive system, and the error DRGs, where private hospitals provide more separations. Of interest is the significantly higher number of separations provided by public hospitals for diseases and disorders of the kidney and urinary tract (61,440 more than private hospitals) and for pregnancy, childbirth and puerperium (42,425 more than private hospitals).

Table 7: Separations and Patient Days by Major Diagnostic Category, Queensland 1999-2000

Major Diagnostic Category*		Separations		Patient Days	
		Public	Private	Public	Private
01	Diseases and disorders of the nervous system	30,876	13,449	159,222	83,997
02	Diseases and disorders of the eye	11,243	27,021	16,979	29,892
03	Diseases and disorders of the ear, nose, mouth and throat	33,635	27,247	51,637	37,101
04	Diseases and disorders of the respiratory system	41,099	16,481	188,843	103,208
05	Diseases and disorders of the circulatory system	57,983	27,972	238,123	144,753
06	Diseases and disorders of the digestive system	71,547	87,409	174,689	176,135
07	Diseases and disorders of the hepatobiliary system and pancreas	12,920	6,403	49,745	27,177
08	Diseases and disorders of the musculoskeletal system and connective tissue	54,519	41,616	199,958	189,808
09	Diseases and disorders of the skin, subcutaneous tissue and breast	33,309	27,643	82,210	65,288
10	Endocrine, nutritional and metabolic diseases and disorders	8,075	3,456	35,815	16,022
11	Diseases and disorders of the kidney and urinary tract	91,921	30,481	140,616	55,318
12	Diseases and disorders of the male reproductive system	6,028	6,298	14,529	18,414
13	Diseases and disorders of the female reproductive system	24,055	22,658	46,202	45,639
14	Pregnancy, childbirth and puerperium	60,687	18,262	163,703	77,154
15	Newborns and other neonates	8,732	2,046	79,918	17,285
16	Diseases & disorders of the blood & blood-forming organs, & immunological disorders	8,605	4,987	19,576	11,243
17	Neoplastic disorders (haematological and solid neoplasms)	35,553	32,248	56,517	45,520
18	Infectious and parasitic diseases	8,814	2,839	38,672	17,415
19	Mental diseases and disorders	22,428	12,626	220,446	88,102
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	5,839	2,424	23,423	9,537
21	Injuries, poisoning and toxic effects of drugs	25,928	4,173	62,730	15,718
22	Burns	1,407	114	6,972	514
23	Factors influencing health status and other contacts with health services	19,672	14,480	41,922	22,754
ED	Error DRGs	988	1,316	8,135	10,926
PR	Pre-MDC (tracheostomies, transplants, ECMO)	1,570	384	42,516	9,564
Total		**677,433**	**434,033**	**2,163,098**	**1,318,484**

* Separations for which the type of episode of care was reported as acute, or newborn with qualified patient days, or was not reported.
Abbreviations: MDC—Major Diagnostic Category, DRG—Diagnosis Related Group, ECMO—extracorporeal membrane oxygenation.

Source: *AIHW, Australian Hospital Statistics, 1999-2000.*

In 1999-2000, the average length of stay in Queensland hospitals was 3.9 days per separation, with the average length of stay in public hospitals (4.3 days) higher than in private hospitals (3.3 days). When same-day

separations are excluded, the average length of stay in Queensland hospitals is 6.9 days per separation, with the average for public and private hospitals, 7.1 days and 6.5 days respectively.

In 1999-2000, the average length of stay for each diagnostic category varied between public and private hospitals (Table 8). Of interest is the relatively high average length of stay for mental diseases and disorders that was higher in public hospitals (9.83) than in private hospitals (6.98). Similarly, the average length of stay for newborns and other neonates was higher in public hospitals (9.16) than in private hospitals (8.44). The average length of stays were lower in public hospitals for most diagnostic categories where public hospitals provide considerably more separations like diseases and disorders of the kidney and urinary trace and pregnancy, childbirth and puerperium (Table 7 & 8).

Table 8: Average length of stay by Major Diagnostic Category, by hospital sector, Queensland 1999-2000

Major Diagnostic Category		Average length of stay		
		Public hospitals	Private hospitals	All hospitals
01	Diseases and disorders of the nervous system	5.16	6.25	5.49
02	Diseases and disorders of the eye	1.51	1.11	1.22
03	Diseases and disorders of the ear, nose, mouth and throat	1.54	1.36	1.46
04	Diseases and disorders of the respiratory system	4.59	6.26	5.07
05	Diseases and disorders of the circulatory system	4.11	5.18	4.46
06	Diseases and disorders of the digestive system	2.44	2.02	2.21
07	Diseases and disorders of the hepatobiliary system and pancreas	3.85	4.25	3.98
08	Diseases and disorders of the musculoskeletal system and connective tissue	3.67	4.56	4.05
09	Diseases and disorders of the skin, subcutaneous tissue and breast	2.47	2.36	2.42
10	Endocrine, nutritional and metabolic diseases and disorders	4.43	4.64	4.49
11	Diseases and disorders of the kidney and urinary tract	1.53	1.82	1.60
12	Diseases and disorders of the male reproductive system	2.41	2.92	2.67
13	Diseases and disorders of the female reproductive system	1.92	2.02	1.97
14	Pregnancy, childbirth and puerperium	2.70	4.22	3.05
15	Newborns and other neonates	9.16	8.44	9.02
16	Diseases & disorders of the blood &blood-forming organs, & immunological disorders	2.27	2.25	2.27
17	Neoplastic disorders (haematological and solid neoplasms)	1.59	1.42	1.51
18	Infectious and parasitic diseases	4.38	6.14	4.81
19	Mental diseases and disorders	9.83	6.98	8.80
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	4.01	3.94	3.99
21	Injuries, poisoning and toxic effects of drugs	2.42	3.77	2.61
22	Burns	4.96	4.51	4.92
23	Factors influencing health status and other contacts with health services	2.13	1.57	1.89
ED	Error DRGs	8.24	8.30	8.28
PR	Pre-MDC (tracheostomies, transplants, ECMO)	27.06	26.39	26.94
Total		**3.19**	**3.04**	**3.13**

* Data pertain to acute episode types only (includes qualified newborns).

** The underlying data from which the MDC's are derived are based on ANDRG Version 3.1 Diagnostic Related Groups.

Source: *Queensland Hospital Admitted Patient Data Collection*

Private patients in Queensland using private hospitals

Private patient status demonstrates the availability of choice between public and private providers and is a significant and important dimension of the delivery of health care in Queensland.

Eligible private patients accounted for 36 percent of total separations provided by Queensland hospitals in 1999-2000. Of the total 422,825 separations for eligible private patients, 89 percent (375,916) was provided by private hospitals, suggesting high utilisation of private hospitals by private patients.

In 1999-2000, Queensland private hospitals provided more separations to private patients on a per 1,000 population basis (103.4) than any other State or Territory, and the average cost weight of these separations was slightly below the Australian average cost weight for eligible private patients.

Table 9: Private patients in Queensland private hospitals

	1996-97	1997-98	1998-99	1999-00
Number of Separations	312466	329534	347998	375916
Percentage of Total Separations	86.2	84.9	84.6	83
Patient Bed Days	1045154	1063981	1092326	1144072
Percentage of Total Bed Days	78.4	77.4	77.6	75.7

Source: *ABS Private Hospitals,* Cat No. 4390.0

Despite the high utilisation of private hospitals, there is strong demand on Queensland's public health system because private patients can still elect to be public patients for many of the complex and high cost treatments. As a result, promoting greater community understanding of the treatment options available in both the public and private sectors will become increasingly important to improving health outcomes and reduce the heavy reliance on the public health system in Queensland.

Cross border issues

The utilization of Queensland hospital services by non state residents relate to two main issues: the attractiveness of the State as a domestic tourist destination, and the flow from mainly Northern New South Wales to the teaching and specialist referral hospitals in Brisbane.

In 1999-2000, almost 3 percent of separations provided by Queensland hospitals were for patients whose usual residence was not Queensland. However, this proportion is not a true reflection of the costs associated with cross border services provided by Queensland hospitals. In particular, the average cost weight of separations is high for patients from the Northern Territory (1.55) and New South Wales (1.35).

Table 10: Separations in Queensland 1999-2000, by State or Territory or usual residence

State or Territory of usual residence	Number of Separations		Average cost weight of separations	
	Public	Private	Public	Private
New South Wales	10,087	14,856	1.35	1.11
Victoria	1,656	948	0.99	1.03
Queensland	691,426	434,222	0.97	0.97
Western Australia	324	114	1.22	1.17
South Australia	421	235	1.20	1.02
Tasmania	143	126	1.32	1.35
Australian Capital Territory	173	82	0.83	1.43
Northern Territory	288	241	1.55	1.05
Other Australian territories(a)	30	28	1.33	1.50
Not elsewhere classified(b)	2,775	1,158	1.27	0.93
Not reported	591	400	. .	. .
Total	**707,914**	**452,410**	**0.98**	**0.97**

(a) Includes Cocos (Keeling) Islands, Christmas Island, Jervis Bay Territory. (b) Includes resident overseas, at sea, no fixed address.

Source: *AIHW, Australian Hospital Statistics, 1999-2000*

Funding arrangements

Commonwealth-state funding

Queensland's public health system is funded primarily from State and Commonwealth resources, with small contributions from Health Insurance funds, individuals and other parties (Table 11). A Revenue Retention arrangement is in place with the Queensland Treasury that includes direct transfer of Commonwealth funds to the Department.

Table 11: Sources of funding for Queensland public and private hospitals, 1997-1998

Funding Source	Expenditure ($ million)			
	Private hospitals		Public hospitals	
Government sector Commonwealth Government	992	(49.2%)	23	(3.1%)
Department of Veterans Affairs	8	(0.4%)	144	(19.2%)
State government	928	(46.0%)	-	-
Government sector total	**1,928**	**(95.6%)**	**167**	**(22.3%)**
Non-government sector Health Insurance funds	34	(1.7%)	459	(61.2%)
Individual out-of-pocket expenses	8	(0.4%)	57	(7.6%)
Other parties	46	(2.3%)	66	(8.8%)
Non-government sector total	**89**	**(4.4%)**	**583**	**(77.7%)**
Total hospital funding	**2,017**	**(100%)**	**750**	**(100%)**

Note: this excludes funding for public psychiatric hospitals, nursing homes and ambulance

Source: AIHW, Health Expenditure Bulletin no. 16: Australia's health services expenditure to 1998-99. (Table A6 page 25),

The Australian Health Care Agreement (AHCA), which commenced on 1 July 1998 and will continue until 30 June 2003, constitutes the major agreement between the Commonwealth and Queensland in the provision of health services. The AHCA is an agreement to provide and jointly fund health care for eligible persons who choose to use State funded health services. Queensland Health has an estimated total funding of $5.8 billion over the five years of the AHCA. Funding from the Commonwealth comprises of both general and specific purpose grants. General grants account for approximately 50 percent of the funding provided to Queensland's public hospital system. Specific purpose grants relate to initiatives such as mental health, palliative care, quality health care projects and the National Health Development Fund (NHDF). These payments are subject to a variety of conditions, performance criteria and other constraints on their use.

The AHCA makes an explicit provision to adjust funding to reflect movements in private health insurance. This has important implications since the Commonwealth's reforms in private health insurance policy have substantially increased the level of private health insurance coverage in Queensland. The percentage of Queensland residents covered by private hospital insurance was 42.4 percent in the March quarter of the 2000-2001 financial year. This was a significant increase on the March quarter of the previous year, with an additional 454,000 persons in Queensland acquiring hospital insurance.

Table 12: Coverage of hospital insurance offered by registered health benefits organisations, persons and percentage of Queensland population

Quarter ending	31-Mar-00	30-Jun-00	30-Sep-00	31-Dec-00	31-Mar-01
Coverage '000	1,077	1,436	1,521	1,517	1,531
% Population	30.30%	40.30%	42.50%	42.2%	42.4%

Source: Private Health Insurance Administration Council (PHIAC) URL: http://www.phiac.org.au

Despite these strong increases, Queensland continues to have a lower level of private health insurance coverage compared to the national average of 45 percent. Moreover, private patients can still elect to be public patients for many of the complex and high cost treatments, and the excesses and exclusionary measures in private health insurance policies provide consumers with little incentive to elect to be treated privately. Therefore, promoting greater community understanding of the treatment options available in both the public and private sectors will become increasingly important to improving health outcomes and reduce the heavy reliance on the public health system in Queensland.

Broad overview of funding arrangements in Queensland

The public sector in Queensland has undertaken significant reform in recent years. A key element of this reform has been the implementation of Managing For Outcomes (MFO), a fully integrated planning, budgeting and performance management framework, since 1 July 1999.

Fundamental to the MFO framework was the shift from cash-based budgeting to an accrual basis that reflects the changing emphasis of the budget from looking at inputs (the resources used to produce something) to outputs (services and products) and outcomes (the impact of those services and products on the community). As a result, Queensland agencies now receive funding through the State Budget based on specified costed outputs. Linking into the Whole-of-Government Priorities and Outcomes, Queensland Health has five Departmental Outputs as tabled below.

Table 13: Queensland Health Output Groups for MFO Reporting

Output group	Description
Treatment and Management (Acute Inpatient Services)	Includes a broad range of medical, surgical and obstetric treatment services provided through the network of public hospitals across the State.
Treatment and Management (Non Inpatient Services)	Covers the provision of hospital-based emergency medical and surgical treatment on an outpatient basis and community-based treatment such as oral health services.
Integrated Mental Health Services	Covers the full continuum of care through the integrated provision of inpatient, outpatient and community-based mental health treatment, as well as mental health promotion and illness prevention activities such as suicide prevention.
Health Maintenance Services	Services provided in residential aged care facilities and hospital and community-based rehabilitation, respite and palliative care services and Home and Community Care services for frail older people and people with intellectual and physical disabilities.
Public Health Services	Covers the provision of integrated, specialised community and population wide activities that foster the protection of health, prevention of disease, illness and injury and the promotion of health and well being. Includes services and initiatives such as immunisation, breast and cervical screening, health education, and school based oral health services.

Source: State Budget 2001-02 – Ministerial Portfolio Statement – Queensland Health

Supporting the MFO framework is the *Queensland Health Strategic Plan 2000 – 2010* which helps guide the development of a health system, and associated outcomes and outputs, that is responsive to the needs of the community. The three strategic directions given priority for the 2000-2010 period are:

- Addressing the Burden of Disease;
- Improving Indigenous Health; and
- Balancing the Investment in Health.

Queensland Health has also effectively incorporated into the MFO framework important considerations relating to capital works planning, delivery and maintenance of assets and other infrastructure required for the provision of health services. These considerations are reflected in the *Information Management Strategic Plan 2001-2006* and the *Capital Investment Strategic Plan 2000-2005*.

As a key element of the MFO process, agencies are required to report on their performance, reflecting whether they delivered the agreed levels of service at the budgeted cost. Every financial year, Queensland Health provides an operating statement for each of its output groups together with key strategies and financial statements, and this is reflected in the Ministerial Portfolio Statements (MPS). The MPS incorporate financial information as well as non-financial information in the form of performance measures and targets.

To support the strategies and financial statements within the MPS, Queensland Health prepares an annual Business Plan that details service delivery and development targets, and budget commitments relating to capital works and information management. Individual business areas across Queensland Health also utilise local business planning to operationalise strategic priorities and policy directions.

Once the budget has been finalised and the Appropriation Bills passed by the State Parliament, Queensland Health systematically informs the various procurement advisory areas of the Department to ensure that funds are directed towards the required priority areas.

State budget structure

The 2001-2002 budget for Queensland Health is almost $4.06 billion, with almost 50 percent ($2.02 billion) allocated to acute services (Table 14).

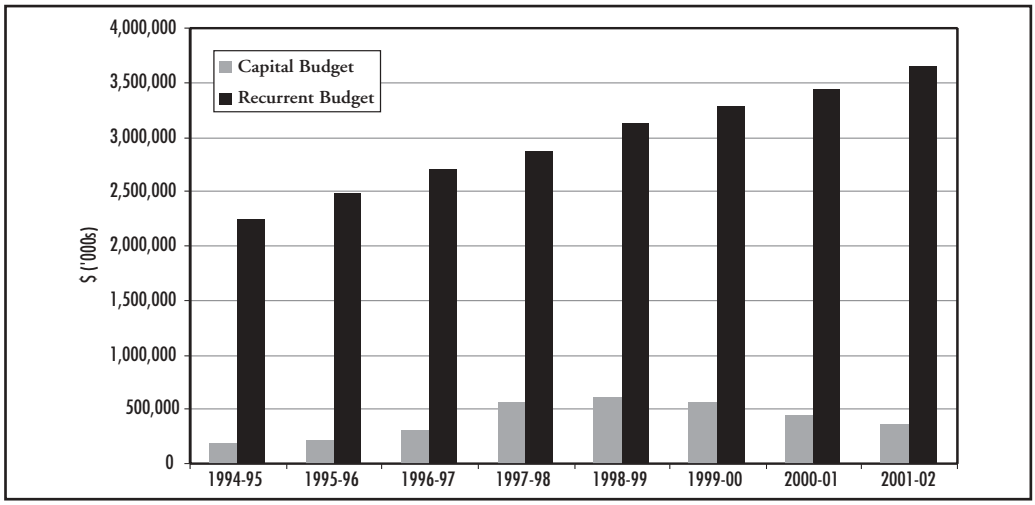
Table 14: Queensland Health Budget 2001-2002 by output group

Output	Total Cost S'000	Sources of Revenue S'000			
		Output Revenue	User Charges	Commonwealth Revenue	Other Revenue
Treatment and Management (Acute Inpatient Services)	2,022,597	1,074,443	122,042	806,099	22,475
Treatment and Management (Non-Inpatient Services)	960,942	582,849	4,888	364,285	10,096
Integrated Mental Health Services	385,036	365,593	3,437	14,725	1,760
Health Maintenance Services	484,409	215,351	22,621	245,007	1,899
Public Health Services	206,433	106,581	103	99,340	557
Total	**4,059,417**	**2,344,817**	**153,091**	**1,529,456**	**36,787**

Source: 2001-02 Queensland State Budget – Ministerial Portfolio Statement – Queensland Health (http://www.budget.qld.gov.au/html/mps.htm#health)

Queensland Health's recurrent budget continues to grow each year (Figure 6). However, the level of capital funding has gradually declined during the past three years, as the decade-long Statewide Health Building Program (which commenced in 1993) draws to a close. This $2.8 billion program involved 50 major projects and more than 100 smaller projects to rebuild public hospitals and health care facilities throughout the State.

Figure 6: Recurrent and capital funding under Queensland health budget



Source: Queensland State Budget Papers

Queensland Health's funding arrangements

Queensland's public hospitals are allocated budgets on the basis of historical funding, activity, and new investments and incentives. The allocation of these resources is operationalised through Queensland Health's zonal management structure. Each zonal management unit is responsible for establishing individual budgets and service agreements with their respective Health Service Districts. Zonal management units are also responsible for monitoring and evaluating budget performance to address specific health outcomes, priorities and targets.

In 1999-2000, Queensland public hospitals provided 690,120 episodes of care in and the Southern Zone provided 42 percent (288,918) of these, followed by the Central Zone (39 percent) and the Northern Zone (20 percent)

Casemix funding

The application of casemix in Queensland Health was driven primarily by directions from the Commonwealth to establish a nationally consistent casemix system, but also from directions at a statewide level to achieve micro-economic reform across the health sector. It is important to highlight that Queensland Health does not use casemix based funding for its pubic hospitals. Instead, Queensland Health uses casemix as a management and information tool to achieve a "fair, accessible, comprehensive and cost-effective public health system". Although casemix budgets are provided to public hospitals, these are used mainly to allow benchmarking and encourage performance improvement. The three objectives of casemix in Queensland are as follows:

1. To improve the quality of care patients receive because of being able to benchmark across a range of clinical and organisational indicators.
2. To achieve efficiencies across the system which can be redirected into priority areas of service development.
3. To effect significant strategic change by supporting the need for an appropriate mix of health services.

Hospital funding model

The casemix "budgets" that are provided to Queensland public hospitals are calculated using the Hospital Funding Model. The Model establishes a framework for the management of hospital services based on outputs, and for monitoring and evaluating performance as well as for developing new service strategies which aim to improve access and the quality of health outcomes in Queensland. It is a mechanism for all hospitals to achieve efficiencies and best practice benchmark prices.

The Model has experienced seven iterations since first introduced on 1 January 1995. What follows is a brief overview of the 2000-2001 Hospital Funding Model. Further details of the components of this Model, including the prices and funding parameters that apply to the derivation of hospitals' Casemix Budgets, are available on Queensland Health's Internet site (http://www.health.qld.gov.au).

The Hospital Funding Model for 2000-2001 calculates hospital budgets through a number of variable and fixed components. Variable components are dependent on targets or forecasts of hospital throughput in the relevant service area and associated statewide average prices. Fixed components however, are not dependent on throughput, but are determined at the commencement of the funding period and do not change throughout that period.

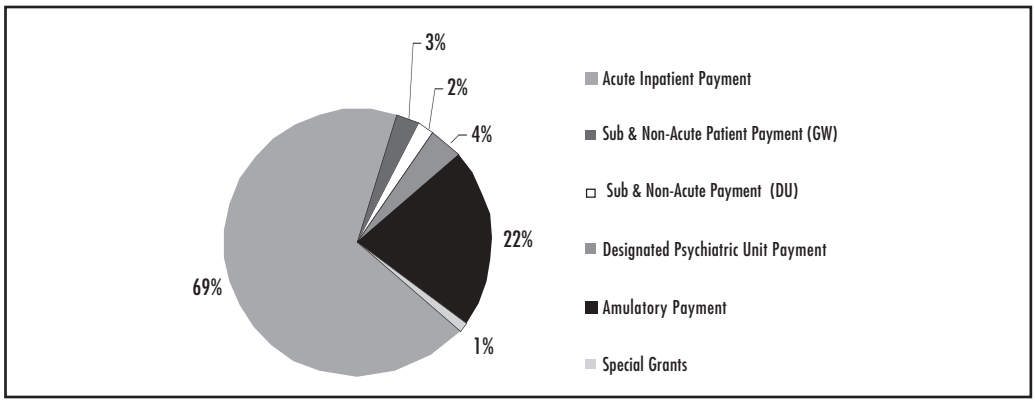
Table 15: Components of the hospital funding model 2000-2001

Variable Component	Fixed Component
Acute Inpatient Payment	Special Grants
Sub and Non-Acute Patient Payment (General Wards)	
Sub and Non-Acute Patient Payment (Designated Units)	
Designated Psychiatric Unit Payment	
Ambulatory Payment	

Source: Hospital Funding Model For Queensland Public Hospitals: Technical Paper and Supplement 2000/01

The acute inpatient payment is the largest component and accounts for almost 70 percent of the casemix budget (Figure 7). The acute inpatient payment a hospital receives depends on the hospital group, the average weighted separation price (set at $1,000 for 2000-2001) and acute weighted separation target, the average length of stay for each DRG and the hospital's length of stay for each DRG (with adjustments for outliers), and the public/non-public mix of the hospital.

Figure 7: Casemix budget by fixed and variable components



Source: Queensland Hospital Admitted Patient Data Collection.

Ambulatory payments are the second largest component accounting for 22 percent of the casemix budget. Payments to hospitals for ambulatory services are based on the ambulatory hospital groupings (which are aligned with the hospital groupings utilised for the acute inpatient payment) and the benchmark prices derived for each clinical type.

The sub and non-acute patient (SNAP) payment for both designated units and general wards represents 5 percent of the casemix budget. Hospitals are allocated a payment based on the Occupied Bed Day (OBD) rate for any SNAP activity that occurs in designated units on the basis of SNAP class type and class number.

For general wards, the OBD payment rate is based on the revised National Health Data Dictionary care types. Payment for all patients treated in a Designated Psychiatric Unit represent 4 percent of the casemix budget, with the payment depending on the OBD rate for the days spent in the Unit.

Although the Hospital Funding Model has not been fully implemented, casemix is being used by Queensland Health to improve data collection, management and classification as well as to gain a better understanding of hospital costs and efficiencies. For example, District Health Services, through Service Agreements, are required to achieve activity targets for acute inpatients, expresses in terms of weighted separations. In this way, funding has been tied to the achievement of specified activity levels. However, there is not intention to use casemix to purchase base levels of throughput for each DRG.

Casemix information has been utilised to estimate recurrent budget requirements for Queensland Health's capital works program, distribute funds to address inappropriate waiting times for elective surgery, and also to guide contract negotiations for high cost specialist services (e.g. Lithotripsy) that may be outsourced to the private sector. Also, the contractual arrangement between Queensland Health and the Department of Veterans' Affairs specify that payments from 2000-2001 to the end of the agreement (30 June 2004) will be based on a casemix funding model. In addition, new financial management and human resource management systems are currently being implemented in all large public hospitals that will support casemix based funding and management in Queensland's public hospital system.

Other funding arrangements

Queensland Health also provides grants to various bodies and organisations and maintains funding agreements with specialised service providers. These additional funding arrangements are integral to the provision of hospital services. During 1999-2000, a total 897 bodies and organisations received funding from Queensland Health to the value of $424.7 million. Additionally, Queensland Health allocated $13.87 million to the Queensland Ambulance Service (QAS) to provide inter-hospital road transfers for hospital patients. This funding has been increased to $17.87 million for 2000-2001, and funding for subsequent years will be determined on the basis of a service agreement between Queensland Health and the QAS. Queensland Health

also has a funding agreement with The Royal Flying Doctor Service for emergency air retrievals and patient transportation, with the 2001-2002 budget including a $4.4 million capital grant for a fully equipped plane.

Emergency services

Queensland Health maintains a funding agreement with the Queensland Ambulance Service (QAS) to provide inter-hospital road transfers for hospital patients. Almost $18 million has been allocated for 2000-2001, and funding for subsequent years will be determined on the basis of a service agreement between Queensland Health and the QAS. Queensland Health also has a funding agreement with The Royal Flying Doctor Service for emergency air retrievals and patient transportation, with the 2001-2002 budget including a $4.4 million capital grant for a fully equipped plane.

Home and community care services

Queensland Health has recurrent budget of approximately $360 million per annum for community based health services. This funding is used to purchase health services through nine hundred external providers, and over 2000 associated projects are negotiated, managed and evaluated each year by Queensland Health.

Queensland Health manages the Home and Community Care (HACC) program that is jointly funded by the Commonwealth (almost 65 percent) and Queensland governments (35 percent). The HACC program provides support and maintenance services for frail aged people as well as younger people with moderate to severe disabilities so they can continue to live at home and avoid premature admission to residential care. As there is increasing demand for these services, growth funding is provided to the HACC program each year based on a resource allocation formula that is aimed at achieving equitable funding levels within each of the seven HACC planning regions in line with the identified regional and statewide priority areas.

Mental health funding

Queensland's Mental Health Unit purchases mental health services consistent with the Ten-Year Mental Health Strategy and Districts negotiate budgets, output targets, and quality and effectiveness measures.

The total mental health budget is estimated at $385 million for 2001-2002, including increased funding of $8.3 million from the previous year's budget to enhance services provided in facilities throughout the State. This increased funding comprises of $3.4 million for community mental health services across the adult, child and youth, psychogeriatric and forensic programs, and $4.9 million toward acute inpatient mental health services.

Conclusion

At the start of this 21st Century, the planning for, provision and evaluation of hospital services in Queensland is increasingly complex and constrained. The funding of the public hospital sector, although important, is only one part of the complexity. Besides the normal range of industry challenges alluded to earlier, the paradigms for hospital services are changing rapidly. The health world is moving on. Models of service provision that consider total episode of care/service provision, management of patients with a chronic disease or National Health Priority condition, or in certain age categories are under examination. Integrated service delivery solutions are being planned. A priority is to work in harmony with other government departments and with Indigenous peoples to try improving Indigenous Health. This is seen as a key performance indicator for the portfolio. At this time, many models and strategies may exist at a policy level only. In the future, and consistent with state and national reform agenda, some models may incorporate funding and program changes. Whatever the future holds, be it the ideology of governments, market place driven imperatives, or new Commonwealth - State arrangements, the Queensland tradition of reliance on the government for the provision of a wide range of health services, particularly for their more complex health needs, is likely to continue and be met competently by the public sector.

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