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Executive Summary

Background and Objectives

This research study aimed to provide the Commission with a solid platform of information about health consumers’ knowledge, behaviour and attitudes regarding the safety and quality of the health care system, particularly in relation to the areas that the Commission can impact under its role.

In a broad sense, the results will provide input into decision making regarding which areas to prioritise within the strategic plan; the best way to address the issues of importance to ensure improvements; the type of information consumers will require; and, how that information should be delivered.

Research Design

The design included a series of mini groups and in depth interviews as follows:

- n= 30 mini groups amongst health consumers in four states;
- n= 2 mini groups amongst Indigenous health consumers (1 metro, 1 rural);
- n= 2 mini groups amongst carers, (1 with carers of an aged person, 1 with carers of a person with a disability);
- n= 9 paired in depth interviews amongst those from culturally and linguistically diverse backgrounds (CALD); and,
- n= 6 telephone in depth interviews with remote health consumers.

Key Findings

The research has indicated that in an overall sense, health system users have a high degree of confidence and trust in the innate safety and quality of the health services available in Australia. CALD and Aboriginal and Torres Strait Islander participants also appeared to be very confident with these aspects, with many of those from other countries drawing positive comparisons with what they had available in their home country.

There was a feeling that the standard of health professionals was very high, and the availability of Medicare and the emergency services available meant that all those really in need could access care. There was also an assumption that the right processes were in place and that ‘the government’ had sufficient regulations to ensure quality and safety were upheld.

The main negatives to emerge with regard to the health system, amongst most participants were the waiting times (either experienced or heard about) in Emergency Departments and for elective surgery, and also regarding the quality of aged care services and accommodation.

There was also some mention of some public hospital facilities being run down, and the overcrowding leading to the need for shared wards and bathrooms, which were of concern to women in particular.
Any breakdown in processes and in the standard of service provided in public hospitals in particular, tended to be blamed on short staffing, with nurses and doctors having to work longer hours with fewer staff than in the past. Some, particularly older heavier users and families, felt that they had to take out private health insurance to ensure they had access to care when they needed it, without waiting.

Most participants in the research believed there was a need to take responsibility for their health; to be proactive in asking the right questions, and to gain an understanding of the medications being subscribed etc.

To that end many, even the older participants were ‘Googling’ their conditions and medications to gain a further understanding, and to help them in asking the right questions of GPs and specialists.

There was a concern however for those who were not particularly health literate and did not know the right questions to ask. Some CALD participants found that this was difficult, and often exacerbated by language problems.

There was a range of specific indicators that impacted on perceptions about the quality and safety of the services received; across GPs, specialists, hospitals and other services.

Communication emerged as an important indicator, with the key to satisfaction being a sense of being sincerely listened to, treated with respect as an ‘intelligent’ person and not a number, and with time taken to ensure consideration of all aspects which might be impacting the diagnosis.

CALD participants in particular, sometimes felt there were cultural insensitivities which caused a sense of concern, for example for Muslim women in physical examinations.

Language problems also were a problem in communication for CALD participants, and there was a concern that people with language difficulties (in particular older CALD people) were not always told as much as they should be.

Some ATSI people felt that they were sometimes spoken down to, and not given the explanation necessary as it was assumed they would not understand. Many preferred to use the Aboriginal medical services for this reason, and they spoke positively about these services.

Communication could help alleviate concerns in crowded situations such as in Emergency Departments, with the communication of the prioritisation process, and a patient’s place in the queue helping to provide a sense of certainty for those waiting.

Similarly, explanations of ‘what is going to happen and when’ went far to reduce anxiety and a feeling of being ‘lost’ at all stages in the hospital system, from admission to discharge and beyond.

Some mentioned the need for more privacy in communication, particularly in hospital wards where sometimes sensitive subjects were discussed with patients in earshot of everyone in the ward.
In addition to the quality of communication throughout the health system, observable physical aspects also helped people decide whether they felt they would receive safe, quality care.

Indications of cleanliness through the GP waiting rooms (clean toys and magazines, separate areas for contagious people) and in hospitals (freshly painted modern looking wards and furniture, clean floors, no food or other rubbish left visibly around) contributed to a feeling of confidence. Also observation of health professionals and others washing their hands, being encouraged to use antiseptic gels and using modern up to date equipment suggested cleanliness regimes were being upheld, and the service was of quality.

Processes to help ensure health services ran smoothly and that patients received appropriate care and medications were seen as obviously important in underpinning safety and quality; however most preferred to feel that the processes were operating effectively ‘behind the scenes’. They were only noticed when the process broke down, and often as mentioned this was attributed to understaffing and staff not having time to keep to all the processes.

Given that, most participants in the research did not want to be told exactly what the processes were, seeing the detail as more of an administrative background aspect. However, sometimes an explanation of why something was being done (for example, the repeated asking and rechecking of patient details) helped them understand and reassured them of the thoroughness of the process and the system.

Conclusions and Recommendations

Some clear and consistent directions have emerged from the research in relation to consumer expectations regarding quality and safety, and to the performance of the health system in this regard.

Outlined below are some areas where the Commission may be able to have some impact in ensuring this trust is maintained.

It would firstly appear there could be a benefit in the Commission making consumers aware of its role. Consumers tend to currently have trust in the system, and do assume that there are adequate controls and regulations in place, without really knowing that this is the case.

Whilst they do not want to hear about the detail of the processes or the regulations, it may be useful for them to know about the Commission and its ‘charter’ to ensure safety and quality is maintained. This could possibly be achieved through posters and brochures distributed through the system at the various touch points where consumers interact, such as GP surgeries, hospitals etc. It ideally would also be translated to ensure CALD users know what to expect.

This should also be available online on the website, and reachable via ‘google’ searches.

Secondly the findings suggest that effective communication at all stages of the health system interaction can significantly contribute to perceptions of quality and safety in the system.
Where possible, the Commission could encourage health providers to deliver the type of communication described through this study as being required at all stages.

Cleanliness regimes particularly in hospitals should be implemented and monitored wherever possible, as well as other processes to ensure careful administration of treatment and medications etc.

To help empower health system users and their families and carers, we suggest also it would be helpful for the Commission to have some guidance for them available through the Commission’s website.

This could include the sorts of questions to ask of GPs and specialists regarding symptoms and medications, and possibly some assistance and guidelines about what to look for when searching the internet, and what sort of sites can be trusted.

Methods of driving consumers to the website for this information could be achieved through the use of posters and/or brochures outlining the role of the Commission as suggested above, distributed through surgeries and hospitals.
Detailed Report
1. Introduction and Background

This report contains the findings of a qualitative investigation of community views concerning perceptions of safety and quality within the health system. It was conducted for the Australian Commission on Safety and Quality in Health Care (ASQHC).

The study was required to help provide strategic directions for the future, with guidance regarding areas of focus for improvement, and the information needs of consumers.

The Commission is a government agency that leads and coordinates national improvements in safety and quality in health care across Australia. Its aim is to support healthcare professionals, organisations and policy makers who work with patients and carers.

In 2011, the Federal Parliament passed the National Health Reform Act 2011 (the NHR Act) which established the ACSQHC as an independent statutory authority under the Commonwealth Authorities and Companies Act 1997 (the CAC Act). The Commission’s governance structure is determined by these Acts, with its role being to lead and coordinate improvements in safety and quality in health care across Australia.

The ACSQHC works in a number of areas to support patients and carers in receiving safe and quality care, and in the first half of 2014 the Commission was undertaking a process to develop a new strategic plan.

The Commission acknowledges that patients and carers have an important role to play in the safe delivery of health care, and that they should be involved in aspects such as making decisions for service planning, developing models of care, measuring service and evaluating systems of care. It is also acknowledged that they should participate in making decisions about their own health care, and for this they will need to know and exercise their healthcare rights.

To assist in the actionable development of the 2014 plan, the Commission required a sensitive understanding of which aspects of safety and quality are of most concern to consumers currently, of how the Commission could best act to address concerns where it is possible, and about what information is required by consumers regarding safety and quality aspects.

Sensitive exploratory research was therefore required to provide a detailed view of the directions in which the Commission would be best placed to focus effort to ensure consumers feel comfortable with the health system, are empowered and informed, and confident that they are receiving quality health care.

This document contains the findings of a research study carried out by Woolcott Research to inform the direction for the plan.

Appended to the back of this report are the research instruments utilised, along with recruitment instructions.
2. Objectives

The overall objectives of this study were to provide the Commission with a solid platform of information about health consumers’ knowledge, behaviour and attitudes regarding the safety and quality of the health care system, particularly in relation to the areas that the Commission can impact under its role.

This information was to contribute to decision making about:

- which areas will require prioritisation in the strategic plan;
- the consumers’ feelings about the best way to address the issues of importance to ensure improvements;
- what sort of information consumers will require; and
- how that information should be delivered.

The study included the following areas of exploration. Although not all the issues explored will be able to be addressed by the Commission under its role, they were included in order to provide a holistic view of where safety and quality ‘sits’ in relation to other aspects such as waiting times and access to services and treatments.

The broad areas of discussion therefore included:

- initial brief introductory open exploration of views regarding living in Australia and the sorts of services we have, particular positives and negatives, in order to assess the extent to which health is mentioned at this top of mind level;

- views regarding the health system overall in Australia currently, what works well, what doesn’t, why, why not, what needs to be improved, how could it be improved, what are seen to be the respective roles of Government at various levels, hospitals, health professionals, and the community itself;

- overall levels of confidence in the health system currently, what elements of the system drive opinions regarding that; where does safety and quality in care fit within that;

- specific probing regarding the safety and quality of the health system; how satisfied are people regarding this, what aspects do they feel work well, what not so well;

- feedback of consumer experiences and examples with regard to safety and quality, their descriptions of times (if any) people have ever felt concern about safety or quality, in regard to general practice, with other health professionals, with medications, in emergency situations, in hospitals, with elective surgery etc.

- what exactly has led to the concerns, is it one or more physical indicators, perceived manner or knowledge of a health provider, or an aspect of communication, feedback or delivery, is it a ‘one-off’ event versus an observation relating to the whole system, etc.
• how better could that service have been delivered, what would need to improve;

• descriptions of particularly good experiences with regard to safety and quality in healthcare, and what individual aspects have led to the feeling of safety and quality; and,

• development of a hierarchy of importance regarding safety and quality, including exploration of what aspects are viewed as ‘absolutely essential’ which are ‘not absolutely essential but are still important’ and which may ‘not be necessary but which would be nice to have’ and help result in peace of mind for the consumer, and which aspects, if any, are ‘unnecessary’.

In addition a range of other associated issues were explored including:

• attitudes to new initiatives such as e-Health, feelings regarding its effectiveness in improving communication and in turn safety and quality and the reasons for those views;

• whether patients have access to enough information currently with regard to safety and quality, what information they use, how they access information, and the sources they use and trust in this regard;

• key information needs, and how this varies by segment and by service being provided; how much information is needed, what factors need to be covered; and,

• how best to provide information and the channels of communication thought to be most helpful, sources considered credible and reliable.
3. Research Design

As summarised in the table below the study consisted of n= 34 ‘mini’ group discussions of 4-6 participants each (including n= 2 groups amongst carers; one amongst carers of an aged person and one amongst carers of someone with a disability). Participants were recruited according to life stage, health system usage, gender and socioeconomic group.

The study also included n= 2 mini groups amongst Indigenous health consumers, one in a metro area and one in a rural/remote area, and n= 9 paired in depth interviews amongst people from a range of language groups (including those who are more newly arrived as well as longer term residents), and n= 6 in depth telephone interviews with a range of health consumers from remote areas in WA, NT and Queensland.

<table>
<thead>
<tr>
<th>MINI GROUPS</th>
<th>TOTAL NO. OF MINI GROUPS</th>
</tr>
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<tbody>
<tr>
<td>LIFESTAGE</td>
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</tr>
<tr>
<td>Young Single</td>
<td>2</td>
</tr>
<tr>
<td>Young Couple - No Children</td>
<td>3</td>
</tr>
<tr>
<td>Family/Single Parent - younger children</td>
<td>6</td>
</tr>
<tr>
<td>Family/Single Parent – older children</td>
<td>6</td>
</tr>
<tr>
<td>Adult Children at home/empty nester under 65 years</td>
<td>6</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>7</td>
</tr>
<tr>
<td>GENDER</td>
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</tr>
<tr>
<td>Female</td>
<td>15</td>
</tr>
<tr>
<td>SOCIO – ECONOMIC GROUP</td>
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</tr>
<tr>
<td>Upper</td>
<td>6</td>
</tr>
<tr>
<td>Mid</td>
<td>8</td>
</tr>
<tr>
<td>Low</td>
<td>10</td>
</tr>
<tr>
<td>Mixed Socio-Economic Status</td>
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<td>HEALTH SYSTEM USAGE</td>
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</tr>
<tr>
<td>Light</td>
<td>8</td>
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<td>ABORIGINAL &amp; TORRES STRAIGHT ISLANDER</td>
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<td>CARERS</td>
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<tr>
<td>REMOTE TELEPHONE IN DEPTH INTERVIEWS</td>
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</table>

The detailed spread of the mainstream groups and in depths by area is outlined overleaf, with
gender indicated by ‘M’ and ‘F’ notation, and health system usage as ’HV’ (Heavy), ‘ME’ (Medium), and ‘LI’ (Light). In some areas and segments (mainly in regional areas and smaller segments), usage groups and socioeconomic groups were combined to include, for example Medium and Heavy users or mixed socioeconomic groups, because in these areas and segments it was not realistic to divide down to each level.

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
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<td>Mixed SES</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Young Couple – No Children</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Upper SES</td>
<td>1 M/HV</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Med/Low SES</td>
<td></td>
<td>1 F/ME</td>
<td>1 M/HV</td>
<td>2</td>
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</tr>
<tr>
<td>Total</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Family/Single Parent Mainly Infant/Primary School Children</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper SES</td>
<td></td>
<td></td>
<td>1 F/HV</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Med SES</td>
<td>1 F/ME</td>
<td>1 F/LI</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Low SES</td>
<td>1 M/LI</td>
<td>1 M/ME</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mixed SES</td>
<td>1 M/ME-LI</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td>1</td>
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<td>1</td>
<td>6</td>
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<tr>
<td>Family/Single Parent Mainly Teens Under 18</td>
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<tr>
<td>Upper SES</td>
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<td>1 F/ME</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Med SES</td>
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<td>1 M/ME</td>
<td>1 F/HV</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Low SES</td>
<td></td>
<td>1 M/ME</td>
<td>1 F/LI</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mixed SES</td>
<td></td>
<td>1 M/LI</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Adult Children/Empty Nester Aged Under 65 Years</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper SES</td>
<td>1 F/HV</td>
<td>1 M/LI</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Med SES</td>
<td>1 F/ME</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Low SES</td>
<td>1 M/ME</td>
<td>1 F/HV</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mixed SES</td>
<td>1 F/ME</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Empty Nester over 65 years (incl. Spec. Over 70)</td>
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<td></td>
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<tr>
<td>Upper SES</td>
<td>1 F/HV</td>
<td></td>
<td></td>
<td>1</td>
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</tr>
<tr>
<td>Med SES</td>
<td>1 F/HV</td>
<td>1 M/LI</td>
<td>1 F/ME</td>
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<tr>
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<tr>
<td>Mixed SES</td>
<td>1 M/ME</td>
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<td>1</td>
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</tr>
<tr>
<td>Total</td>
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<td>2</td>
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<tr>
<td>TOTAL MAINSTREAM</td>
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<td>2</td>
<td>5</td>
<td>2</td>
<td>30</td>
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</table>

The detailed split and locations for the CALD and Indigenous component is as follows:
<table>
<thead>
<tr>
<th>COMMUNITY</th>
<th>SEGMENT</th>
<th>LOCATION</th>
<th>RESEARCH METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>Aged +55</td>
<td>Melbourne</td>
<td>Mini-group</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Aged +55</td>
<td>Ballina</td>
<td>Mini-group</td>
</tr>
<tr>
<td>Chinese</td>
<td>Parent w/ young children</td>
<td>Sydney</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Chinese</td>
<td>Parent w/ teenagers</td>
<td>Sydney</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Horn of Africa</td>
<td>Parent w/ young children</td>
<td>Melbourne</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Lebanese</td>
<td>Parent w/ young children</td>
<td>Melbourne</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Lebanese</td>
<td>Parent w/ young children</td>
<td>Melbourne</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Parent w/ teenagers</td>
<td>Sydney</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Aged 60+</td>
<td>Sydney</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Italian</td>
<td>Aged 60+</td>
<td>Melbourne</td>
<td>Paired depth</td>
</tr>
<tr>
<td>Italian</td>
<td>Aged 60+</td>
<td>Melbourne</td>
<td>Paired depth</td>
</tr>
</tbody>
</table>

A total of 206 participants took part in this qualitative study, 177 within the mainstream groups (including the carers), 11 in the Aboriginal and Torres Street Islander component, and 18 in the CALD component.
4. Detailed Findings

4.1 The Health System in Context

4.1.1 Services Available in Australia Today

The health system was spontaneously and consistently brought up amongst other broad issues in the initial discussion about the quality of services in Australia, with it generally being mentioned in a positive light, particularly compared to other countries around the world. The high standard of health services and the current general affordability as a result of Medicare and bulk billing were raised as the key positive aspects.

Following the introduction, the groups and interviews began with a brief discussion about ‘what we feel about living in Australia and the sorts of services we have available to us….what are the good things, and what are the things that are not so good?’

Participants felt there were a large number of aspects that were positive, and that worked well, whilst there were also some negative issues. In an overall sense however, Australia was felt to be in a better position than many other countries around the world, particularly in terms of health care.

“In Australia we expect a lot and take it all for granted”

The health system was frequently raised in a positive sense without prompting, in particular in relation to the perceived affordability. Medicare and the access to many free medical services and to bulk billing were aspects consistently commented on. The generally high standard of the health system was felt to be a positive, particularly with regard to the expertise and standard of training of health professionals.

“Our doctors are brilliant”

In the cities the availability of accessible medical services such as after-hours medical centres was also raised as a positive.

The other aspects and services that were spontaneously raised as positives about living in Australia included socially related aspects such as our welfare system; (there were felt to be systems in place at least for those who really could not look after themselves) and the relatively high standard of police and safety services.

“There are no real political hassles here, no violence, you feel safe”

The climate and the clean environment were also consistently commented on (including parks, gardens, beaches and bush); as was the standard and availability of public education.

“Students get a good start here”
There were however some concerning areas raised about some services in Australia, and as much of the research was conducted immediately after the Budget announcements in May, there was some uncertainty about the future. Talk of a Medicare co-payment, and the media attention given to budget cuts generally in areas such as education and welfare had led to some questions. The introduction of a Medicare co-payment was particularly concerning to carers of older people who felt that it would discourage them from going to their doctor.

Some perceived less positive aspects of the health system were raised in the initial discussion, including the long waiting times experienced by some in elective surgery in public hospitals and in Emergency Departments; and there was some mention of the conditions in some public hospitals, such as crowded mixed gender wards, busy stressed staff, and poorly kept old facilities in some cases.

“Waiting times for operations is bad, particularly in the public system”

“Some of the wards really need to be upgraded, they might be clean but because they are old they look bad”

The quality and availability of aged care services was also raised by some as a concern, particularly by older participants who were dealing with their parents’ needs in this regard, or thinking about their own future needs. The growth in the aged population was raised, and there were questions about how the current system would cope.

Other negative comments were made about services such as childcare availability, which was felt to be coming more and more expensive:

“It’s not worth it, even with the rebates”

At a lower level, in the cities in particular, public transport was raised as perhaps in need of improvement, particularly compared to other countries where it was perceived to be easier to access and more flexible and reliable.

Across the research with CALD participants the quality of life in Australia was considered very high, with the quality of, and access to, government services seen as fundamental to this. Australia was viewed as having an accessible and comprehensive service landscape, where all necessary services are available to all people.

Australia’s accessible and quality health system emerged unprompted as one of the key government services that contributed to a high quality of life in Australia.

“If you have no money you can still get access to good healthcare, unlike our countries of origin.”

(Lebanese parent)

CALD Participants contrasted this with other countries where participants believed either healthcare was prohibitively expensive or simply unavailable for those without high incomes. Specific countries identified as having inferior healthcare compared to what is available in Australia were Vietnam, China, Lebanon, and the US.
Aboriginal and Torres Strait Islander participants found discussion about living in Australia a little difficult as they were Aboriginal people who had never lived anywhere else. Despite this Aboriginal and Torres Strait Islander participants generally spoke positively about quality of life in Australia, particularly in terms of safety and freedom compared with other countries.

“Yes, I love living in Australia, it’s one of the safest countries in the world.”

“I can’t talk for Central Australia, but here in Victoria we get very good services that work closely with the community to understand the needs of our people.”

There was some discussion about people living in remote areas not having the same level of access to services as people in urban areas.

The quality of the health system was generally seen as high, and the availability of Aboriginal health services were seen as central to this.

“Aboriginal Health Services ensure they make people feel welcome, both Aboriginal and non-Aboriginal people. They have an open door policy, work closely with the local community and provide a safe and healthy environment for families.”

4.1.2 The Health System- Spontaneous Positives

Following on from the general discussion, participants were asked specifically what they thought about the standard of the health system currently, and the perceived positives and negatives.

Again, many positive aspects were raised with regard to aspects as mentioned above such as the Medicare system, and how it resulted in care being accessible to all, and not just those with money.

“My newborn had hearing problems, and in the public hospital he can get all his hearing tests for free”

Bulk billing was also mentioned as being helpful in that regard, although there was a concern that costs were rising, and that many GPs in particular will charge on top of the Medicare cost.

“There seem to be different rules between GPs in charging”

There was a feeling that the quality of ‘our’ general practitioners (GP’s) and specialists was at a very high level overall (although sometimes variable depending on the individual health provider), with the length of time and standard of the training they receive and the eligibility criteria for being able to study medicine seen as contributing to this.

However, relatively recent media reporting of mistakes made by doctors from overseas had led to some concerns in the non CALD groups about overseas trained doctors, and there was some comment that their training was not of the same standard.

“We are paying them to come here instead of training them here”
Whilst the access to services under Medicare was seen as a positive, some of the older, heavier users of the health system believed that it was essential to have private health insurance. Private health insurance was mainly felt to make a difference in relation to waiting times for elective surgery. Others believed that if hospital care was needed urgently it would nearly always be made available.

In that sense, the overall hospital emergency system was raised and it was thought it was a positive in the sense that it was available and effective in a true life threatening situation.

“Great to take a child to emergency in a panic and be seen straight away”

There were however as mentioned also some criticisms of it with regard to the waiting times and overcrowding at certain times.

The health related technology available in Australia was also felt to be of a high standard, and there was a feeling that in most hospitals and health services the technology was generally very up to date and impressive.

“We have all the latest machines for all the sorts of testing needed”

Other positive aspects regarding the health system which spontaneously emerged included a perceived emphasis on preventative health and on immunisation and screening for various diseases. In some areas, the access to telephone health lines to talk to GPs or nurses for help was mentioned, particularly by mothers of young children who had found that assistance very reassuring.

Amongst CALD participants, the research suggests a certain degree of gratitude among CALD participants toward the health system in Australia, particularly when compared with other countries. The strong view that prioritisation was based on need rather than ability to pay emerged as a key factor driving positive attitudes toward the health system in Australia.

The Chinese, Vietnamese and Lebanese participants in particular believed that the quality of health care in Australia was considerably higher than what they had experienced in their home countries.

“If I compare it to Lebanon we are amazing here. In Lebanon you go to hospital with one thing and come out with something else. Here we are very clean, safe and we can trust the services. Good processes in place. Quality assurance is good.” (Lebanese parent)

Some CALD participants also highlighted the availability of and encouragement to use free preventative/early intervention health checks such as pap smears, breast screening, blood tests for diabetes, etc. as illustrative of the quality of the health system.

Health care professionals were generally perceived as appropriately qualified, and educated with good communication skills.
Amongst Aboriginal and Torres Strait Islanders cultural appropriateness: the existence of Aboriginal specific services, which work closely with Aboriginal communities for better outcomes for Aboriginal people was felt to be a definite positive.

Accessibility to allied health services and preventative health was also mentioned, for example ATSI community dental services, sexual health services, mental health and outreach services.

Access to a variety of specialists such as ear and eye specialists through the Aboriginal community health system was also raised by a number of participants.

A number of Aboriginal and Torres Strait Islander participants discussed good mechanisms for follow-up through the health system – “the doctors at the service call you to check how you have been going.”

4.1.3 The Health System- Spontaneous Negatives

When asked specifically about negative aspects, a number of issues were raised.

Waiting times for elective surgery in the public system emerged again as a large concern, along with waiting times in emergency, particularly amongst those without children, who perhaps have needed to use the service at busy times like weekends.

“Babies get priority over people in a worse state”

Waiting times in GP surgeries were also seen to be a problem for some participants, along with the feeling that GPs are often overbooked and as a result “push you though” without listening to the problem properly.

In some geographic areas there were spontaneous negative comments about “old, tired looking public hospitals” and other aspects such as the lack of nutritious food for patients. Many from the higher socioeconomic groups felt that private hospital facilities were much better and worth the cost of private health insurance.

Some, (again more likely to be heavier users) felt the high patient to nurse ratio was leading to some lack of care in public hospitals, with nurses unavailable when required to carry out routines, leaving patients without help at times, for example, when wanting help to get to a bathroom etc.

Non-English speaking doctors, particularly in regional areas were raised as a negative, not only because of some quality concerns which had been reported in the media, but also because their English skills were sometimes thought to be poor and this affected the ability to communicate with the patient. Older people were finding this aspect most difficult.

Other negatives had been raised previously and these included the perceived rising costs threatening the affordability of the system, and concerns about the aged care and end of life care sector. The quality of many aged care facilities was felt to be inadequate and very under
resourced, with the lack of willingness of suitable staff to work in the area seen as a problem, as it was perceived to lead to a poorly trained workforce.

Carers of those with a mental illness were quite critical about the provision of support outside the hospital setting and hospitals discharging patients too quickly. One participant, with a partner who had been diagnosed with psychosis in 2006, had found the initial care in hospital and for the following two years after this to be quite good. However, since then he felt he had received very little support. For example, he found that the only way to get the medications reviewed, without going to a private psychiatrist (which they can’t afford), is to go to hospital, even though his wife does not need that level of care. This situation has resulted in him often reviewing the medications and making decisions to increase or lower the dose himself, without any medical training. It was suggested that the system should fund a regular (three monthly) review for those with chronic mental health conditions.

Carers of those with mental illnesses also said that often they find themselves in the situation where they have to go to the Emergency Dept. because they feel there is no other option in the event of an acute situation.

“Carers are stressed to the max. We are worried about getting physically or mentally sick ourselves and this just makes it more stressful.”

Carers also mentioned the high costs associated with numerous visits to the GP or specialists, which are often needed in the care of those with chronic physical or mental health conditions. This was only thought to get worse with the planned introduction of Medicare co-payments.

Transportation was spontaneously mentioned by carers of older people as an issue. They felt that the family is relied upon heavily to do the driving to and from appointments. This was felt to be very stressful for both the patients and the families. The question was also asked about those who do not have family living near them.

Carers felt that they had to do a lot of advocating and researching themselves about what support and information there is available for the patient. Often they did not know what questions even needed to be asked, so therefore support can be missed.

As mentioned there was a general feeling that health service expectations in Australia are very high and that we tend to take our good system for granted. In general more negatives emerged about the health system amongst some of the heavier users as they had a greater level of familiarity with it. However in an overall sense, there were more spontaneous positive comments than negative ones amongst the heavier users and across the study.
4.2 The Key Contributors to Perceptions of Safety and Quality

Health consumers within the research were able to discuss in some depth indicators they used when assessing the safety and/or quality of a service within the health system.

Often, however, the degree to which they felt confident that they had received a ‘quality’ and ‘safe’ service was a result of more of an intangible feeling or sense of trust. To some degree this feeling appeared to be the result of the way they had been treated or communicated with, or because of certain physical aspects or actions they had observed.

The more tangible indicators of safety and quality included aspects such as the perceived depth of communication between health provider and patient, (and between providers); physical elements associated with the condition of facilities; observance of certain actions by staff (such as hand washing); as well as a general sense that the right overall processes were in place to protect against errors or mistakes.

Lighter users of the health system were less involved and less able to discuss quality and safety in detail, and were generally fairly satisfied; whereas the heavier users were more polarised in their views, with some being very positive and satisfied whilst others had some concerns when questioned in detail.

Overall, although there were particular tangible indicators mentioned, most trusted the system to provide them with quality and safety, and assumed that it would perform well by and large.

Following the spontaneous discussion about the positives and negatives of the health system, participants were asked to discuss in detail what all the indicators of quality and safety were for them, their experiences, and how satisfied they are with the various aspects.

The findings regarding this suggest that the quality and safety indicators can be grouped into four broad categories, (these being communication, physical aspects, processes and overall trust) with variations in perceptions regarding these across the different health services such as GPs and specialists, hospitals, emergency departments, and other health services.

These categories and the aspects of importance within each are discussed in detail below

4.2.1 Communication

Communication emerged as a key influencer of quality and safety perceptions amongst users of the health system, across all areas. Most health consumers in the study wanted to feel they were in control of their health and that they understood what is happening and why actions are being taken, across all stages of their experience. The communication between them and their provider therefore was an integral part of this.

“It’s your life and it is important you know what is going on”
The more informed people felt they were, the more they felt the service was providing good quality.

Carers mentioned that healthcare professionals should direct their communications to the patient rather than to them; even if it is perceived that the patient may not understand. It was felt to be an important factor in treating the patient with dignity and respect.

Some believed communication was inadequate between the different services, e.g. between the hospital and GP. One patient gave an example of the hospital deciding to change the medications that the patient was on, without consulting the GP first. The GP later contacted the hospital and told them not to change it.

The individual aspects of communication within each element of service were wide ranging, and are discussed below.

Communication within General Practice

There were a number of communication elements that were considered to contribute to the feeling that a GP had provided a safe and quality service, and which left the patients feeling informed and in control regarding their health.

The feeling of being treated as a ‘person not a number’, and being given what was believed to be personal service and attention was a key factor. Adequate time spent in the appointment was also felt to be important in giving the opportunity for the patient to explain what was wrong, and ensuring that the GP had time to consider options for treatment.

Whilst most claimed they personally ensured that they asked about what they wanted (sometimes writing lists of questions prior to their appointment), some reported however that ‘others’ such as the elderly can get confused, and were more likely to miss pieces of information if they were rushed. Some accompanied their elderly relatives to appointments for this reason.

“They always cut it short, and I don’t have time to ask what I want to ask”

Further to having enough time spent, was the need for the GP to show genuine empathy toward the patient, and ideally to build a relationship, particularly if the patient was a repeat visitor, and if the problem was more than just a script renewal or simple issue.

“The best doctors ask you lots of questions”

Empathy was reportedly more likely to be achieved if the GP had eye contact, and treated patients in a respectful, polite and personable manner, and as an intelligent person.

“The doctor needs to sit comfortably in their chair and consider what you are saying, not looking distracted and as if they are going to get up at any minute”

The perceptions of quality communication from a GP also included the provision of proactive suggestions regarding preventative health. Looking at personal history records, and reminding or
suggesting screening or blood tests as necessary was felt to be very helpful and again an indicator that the GP cared about the patient and their ongoing health.

 Appearing to be very thorough in assessing a patient was also an indicator of quality and safety in the GP environment, for example by doing a comprehensive physical examination and explaining the sorts of symptoms that are being looked for where relevant, rather than just administering prescriptions.

“My baby just wouldn’t stop crying, and I knew something was wrong. My GP was very thorough, asking me lots of questions and finally diagnosing a bladder infection, whereas other doctors would not have been as thorough.”

 Patients also wanted some communication about the prescriptions they were being issued with, and what they could expect. Some GPs printed off information sheets containing that sort of detail for the patient to take away, which was felt to be useful.

Note: With regard to prescriptions, there was some comment about the degree to which GPs are working with the pharmaceutical companies and receiving benefits from prescribing certain medications, but this was mainly felt to impact on price paid for medications, rather than on quality or safety.

The degree to which the desired level of communication was being delivered to provide a feeling of quality and safety within the general practice environment varied amongst participants and they believed it very much depended on the individual practice or GP within a practice.

Many felt that they had found through trial and error, a GP who was able to deliver on most of the communication related aspects and spoke highly of them as a result; however there was a perception (and anecdotes regarding past experiences) that there were GPs in the system that did not offer this level of service.

Word of mouth was often a source of awareness regarding ‘good’ GPs; otherwise it was a matter of trying various GPs until one that fits the needs of the person was found. It was generally felt there was enough choice available in most areas to be able to ‘shop around’ to a degree; although in some areas certain GPs were reportedly not taking on new patients, which made it more difficult to have choices.

In the country areas, there was more mention of the prevalence of GPs from non-English speaking backgrounds, and therefore more communication difficulties were cited as a result of the language and accents.

Communication within Specialist Services

Many of the same ‘ideal’ communication dimensions mentioned above for GPs applied to the specialists, however participants tended to have lower expectations with regard to aspects such as personal empathy and relationship building, unless they had a chronic problem, or required multiple appointments.
It was assumed that specialists would “*know what they were doing*” and that they were highly qualified, and whilst a good ‘bedside manner’ and communication was important, this did not indicate quality and safety to any extent.

> “Some of the best surgeons are really gruff and rude”

> “Specialists can be rude, but hey I’d prefer to trade off rudeness for expertise!”

Overall however, given that the reason for visiting a specialist may be a serious one it was very important that the specialists communicated clearly and in as much detail as possible, in plain English. Patients wanted all the risks and the details of any suggested procedures to be very carefully explained along with what to expect afterwards, the recovery and rehabilitation courses etc.

Again ideally they would like to feel they can ask questions, and they appreciated being provided with information sheets which they could take home and read. Some specialists had set up their own websites which contained explanations of procedures and what could be expected at each step, and this was felt to be very useful in helping the patient to feel fully informed.

The level of effective communication provided reportedly varied considerably amongst specialists, however as mentioned, many people were willing to trade off the lack of communication because of a specialists reputation, and the overall trust in their ability and experience.

**Communication within the Hospital System**

There were many aspects of communication within the hospital system that contributed to overall perceptions regarding quality and safety, across all stages from admission through to discharge and post discharge.

Research participants indicated that being able to understand what would happen and when during admission was very important to help lessen anxiety and to reduce the feeling of being ‘pushed around’ and left in limbo without understanding what was happening.

Communication and provision of a clear explanation of the processes that are necessary during admission was therefore required, along with information about the next steps and expected wait times during admission. For example, many wondered why they had to provide the same information about themselves multiple times during admission, and initially felt it was an indication of inefficiency at the hospital. However if it was explained that this assisted in providing a check for safety purposes it was reassuring and very well regarded.

> “Why do they have to keep asking the same thing over and over...seems inefficient?”

> “I had no idea when I would finally get into a ward”

Once admitted, then patients (and their families) wanted to understand what the next steps would be, when surgery would happen, and also when they could expect to be seen by a doctor or specialist both prior to and after surgery, where relevant.
Otherwise there is a feeling of being left in limbo and possibly ‘forgotten about’, which can raise anxiety levels and cause restlessness. It was reported that nurses are often busy and rushed, and cannot answer questions. They instead try to be reassuring with statements such as ‘not long to go now’ without any real feedback on actual timings.

Whilst nurses within hospitals were generally highly regarded and seen as being as helpful as they can be, it was felt their work load meant that they could not always be as attentive as is necessary, and could not listen to the patient to the degree required, or communicate with them effectively. This sometimes led to discomfort, and anxiety.

“I was bustling to go to the toilet but the nurse wouldn’t listen to me”

Communication between shifts within hospitals was also an area of importance, and thought to have definite implications with regard to the safety of the services provided. For example the heavier, more experienced users of the hospital system felt they had to take some responsibility in telling new shift nurses what medications they were meant to have and when they were meant to take it.

Nurses were felt to be often too rushed to be briefed thoroughly between shifts and it was felt this could lead to mistakes being made.

“I am like a watchdog; I have to watch every shift”

“I have to be very aware of what medications I need in hospital because they have made mistakes”

Some carers also felt responsible for telling nursing staff what medications their loved ones were on and when they needed to take them. They said that they often had to remind nursing staff about when their next dose was due.

There was also concern about the lack of privacy at times, when sensitive issues may have to be discussed, particularly in crowded public wards when curtains around the bed are the only privacy provided.

“When I was in hospital the Chinese lady in the bed next to me was being told she had cancer and I could hear every word”

Updates regarding the likely timing of discharge and the processes which will occur at that time were also felt useful, and helped the patient understand what was happening and when.

On discharge, provision of further detailed information was important, including the sorts of post-operative medication which was prescribed, and what the purpose of it was, and detail regarding rehabilitation processes. Ideally this would be written communication with clear instructions in plain English.

Participants who had been in hospital or who had close family who had, tended to feel that on many occasions patients were left wondering about what was happening next and why they were waiting, and as mentioned, that this was frustrating for a sick person who may already be anxious.
Communication within the Emergency Departments

Emergency departments were often said to be chaotic and rushed, and people understood they may have to wait for some time. In some hospitals there was some communication provided regarding where a person was in the queue, and how long it might be before they are seen, and this helped people waiting settle to some degree.

If there were changes in this, then it also helped to be told why there was a wait time, for example if a sudden life threatening emergency situation had been brought in.

In addition, an explanation regarding the transfer-to-ward process where relevant, and the length of time it might take, again helped to reduce anxiety, and provide more of a feeling that the hospital was efficiently run.

“They left me on a trolley in a corridor for hours; I didn’t know what was happening”

It was felt the degree to which this communication occurred varied greatly depending on what time of day it was or what day of the week. The general feeling amongst participants was that the emergency departments were often very under staffed which impacted their ability to communicate in the desired manner.

Communication within other services (Radiography, Radiology and Pathology)

As discussed above, communication during procedures about what to expect, why they are required to move in a certain way, and what to expect (will it hurt, how long it will take), and next steps for the results, helped users of these services feel in control and properly informed.

Reported experiences in this regard were generally very positive, with many of these services apparently taking the time to communicate in some detail.

Language and Cultural Needs

The capacity of the health system to meet the language needs of CALD communities did not emerge as a key theme of the research in relation to quality. However, good general communication skills were consistently identified as an essential component of quality by CALD participants (i.e. being treated with dignity and respect, and open two-way communication between clinician and patient).

“They need to treat you with respect and dignity. I must admit I have had a few doctors, especially when I take my mother who doesn’t have good English, who don’t treat her with respect and dignity. They treat you like you are dumb; don’t want to give you details of what they are treating you for as though you wouldn’t understand anyway. I can tell you lots of stories about this kind of treatment.” (Lebanese parent)

Overall very few negative comments were made in relation to language needs. However, a few participants mentioned having difficulty understanding or being understood by hospital staff due to poor English language proficiency (of staff or of patient........) and not having access to
bilingual staff or interpreters. This resulted in feeling that their safety was compromised because they were not fully able to understand what was going on.

A few participants identified the availability of interpreters as an indicator of good quality, and mentioned that where required interpreters had been offered to them at hospitals and specialist clinics.

Only one participant (a covered Muslim woman) cited examples of a lack of cultural competence in communication which resulted in her feeling unsafe. On one instance a male GP had closed a door and asked her to remove her top in order to check her heart and blood pressure. She understood he was offering her privacy, but the closed door had made her uncomfortable, and resulted in her leaving the consultation quite upset. She complained to the clinic manager and suggested that staff undergo cultural training.

This same participant gave birth to a daughter in Australia with cerebral palsy. She explained that when staff at the hospital told her that her daughter had cerebral palsy, she had not heard of the condition, so she didn’t know what to say and ‘kept quiet’ although she was very concerned. She said that nobody explained what it was to her, and that she looked it up on the internet when she was discharged. She later read the doctor’s report which stated that she “took the news very well and did not appear worried”.

Some newly arrived migrants with poor English-language skills reportedly felt less confident to ask for information or support, particularly if they did not know what information or assistance was available, or what they should expect from the system.

Throughout discussions with Aboriginal and Torres Strait Islander participants, the idea of cultural ‘safety’ emerged as an important factor influencing perceptions of safety and quality. Where Aboriginal and Torres Strait Islander participants felt their cultural needs were understood and catered for they had a lot more confidence and trust in the service.

The aspects of service delivery that contributed to ATSI participants’ feeling of being culturally safe included professionals who can display knowledge and understanding of the unique issues facing Aboriginal people; use of plain English and limited use of jargon; an informal and relaxed atmosphere; and avoiding stereotypes on topics such as alcohol use, smoking, illicit drug use, family violence, etc.

The majority of Aboriginal and Torres Strait Islander participants used Aboriginal health services as their first point of contact with the health system. The very high use of Aboriginal-specific health services was indicative of the importance of cultural safety in health service delivery for Aboriginal and Torres Strait Islander people.

Communication was intrinsically linked to quality by Aboriginal and Torres Strait Islander participants. Good communication was categorised by friendly, attentive and respectful staff, and a welcoming and relaxed environment.
Participants felt that health care workers with good communication skills were those who made an attempt to build a relationship, ‘understand your story’, explain treatment/procedures, and provide follow up.

Generally experiences of poor communication tended to occur in association with lack of resources, for example at Emergency Departments when wait times were often long.

“The overall quality of the health system is very good, however at mainstream services such as hospitals you can get treated like a number rather than a person. Whereas at the Aboriginal health service they treat you with a bit more respect and have a lot more understanding of your situation.”

ATSI experiences of poor quality were often linked to perceptions of not being kept appropriately informed (particularly when staff were busy).

“I took a young fella to hospital who had been self-harming. We waited in ED for a long time and then when they moved us, we were taken into a white room, where the door was locked. No one even talked to us. The young fella freaked out because he thought we were going to leave him there.”

The research suggests that if ATSI people feel respected, and appropriate rapport is built, they have a higher tolerance of any limitations of the system.

“We want to know we have been seen.”

4.2.2 Physical Indicators

The physical aspects of the facilities being used and the observable actions of the health professionals played an important role in influencing the perceptions regarding the quality and safety of the service being provided. The look of a facility, i.e. whether it looked clean and modern and some of the routines of the health professionals, along with a number of other visual cues, led the user to feel either comfortable and confident or alternatively concerned about using the service.

In that sense, being able to observe physical indicators (such as clean looking hospitals, health professionals hand washing or using sterilised equipment, actual cleaning being done,) was considered of much greater importance than hearing about or being told the processes and protocols that might be in place to ensure these things happen.

Physical Indicators within General Practice and Specialist Services

The physical aspects within the general practice environment which contributed to a feeling of safety and/or quality firstly included the overall cleanliness of the waiting rooms. The waiting rooms did not have to have a clinical feel, but it was important that they generally looked clean and fresh.
It was also felt preferable if people, who appear sick and possibly infectious, for example sneezing or coughing, should perhaps be seated in a separate area.

“I hate sitting amongst the germs”

Observing the GP washing their hands before the consultation, wearing newly opened gloves where necessary, and opening new packets of sterilised equipment were also positive indicators, as was the presence of other ‘clean’ looking equipment.

It appeared most users of GP surgeries felt that the waiting rooms were currently generally clean and some apparently already had separate areas for those who appeared to be contagious.

Most observed their GP’s washing their hands when necessary, and most it seemed used new equipment as required.

The main criticism of the GP experience was regarding the state of the toys and magazines available for patients and their children. These were felt to be grubby looking sometimes, causing concerns about touching them, and the germs they might be harbouring.

“What a party of germs the magazines are!”

“I always bring my own toys for my child”

The experience with specialists appeared very positive, with quieter waiting rooms, and often much better surroundings, newer and more impressive equipment and the specialist themselves generally appeared knowledgeable and professional.

Physical Indicators within Hospitals

The physical appearance of the hospital appeared to have quite a strong bearing on the extent to which patients and their visitors felt the service being provided was safe and of quality. Concern about catching a ‘nasty’ infection in hospital was quite high, and therefore it was important that the hospital was seen to be doing everything it could to counteract this.

Interestingly none of the hospital users in the research had been infected in hospital, but many had ‘heard of’ someone else who had, or had read stories in the media about outbreaks in certain hospitals.

Within the hospital environment the ideal was for the hospital to appear relatively modern, with fresh paintwork and particularly clean up to date bathrooms. A high level of general cleanliness was also expected, and it was reassuring to see someone regularly cleaning, vacuuming or mopping in an effective manner, using disinfectant to counteract any concerns about infections.

“The wards might have been clean, but because they looked shabby and run down it made me nervous”

It was also important to have no rubbish left around and no overflowing bins, food scraps, left over meals on trolleys for any length of time.
The placement of dispensers of hand disinfectant at relevant points was also important along with signage to encourage use of these. Observing staff washing their hands, wearing gloves and using the dispensers also added to a feeling of cleanliness and avoidance of the spreading of infections. Again observing the opening of sterilised or new packets of equipment was a positive indicator, as were sterilisation machines where relevant.

“It is good to see doctors scrubbing their arms up to the elbows”

Some participants felt more comfortable if the doctors within the hospitals wore white coats over their day clothes, and it was expected that the nurses too should look well-dressed neat and clean.

“I think the doctor doing the colonoscopy just had day clothes on – her high heels and a skirt”

Heavier users of the public system discussed the need for separate wards and bathrooms for males and females, with females in particular feeling that having to share added another layer to their unease and discomfort.

Other aspects contributing to a safe and quality feel included having effective theft prevention methods in place, with safes or secure cupboards.

Also, the general quality of food and the need for healthiness and freshness in the food options contribute to a safe and quality feel

The degree to which participants felt the quality and safety aspects considered important were being delivered was felt to very much depend on the individual hospital, and even in some cases depending on the ‘wing’ of the hospital.

Private hospitals were seen as generally newer and cleaner than some public hospitals.

The general consensus was however that it is better to spend as little time as possible in any hospital, because of the risk of infection of some type.

“Hospitals are the best place to get sick”

“Our hospital is renowned for sending you home with something”

The older buildings or wards in some hospitals led people to feel that they could be more inclined to harbour germs.

In addition whilst hand gel was felt to be very readily available in most hospitals, few hospital users had seen many doctors using them or visibly washing their hands. In addition it was felt the use of the gel was not particularly encouraged or suggested to patients or visitors.

A further criticism was that bathrooms in public hospitals were often felt to be unclean and not cleaned frequently enough.
Some shared public wards were also reported to have scratched floors, dirty curtains, ripped upholstery on chairs, and whilst the hospital may be clean, these aspects gave the impression of shabbiness and a lack of care.

**Physical Indicators within Emergency Departments**

Whilst Emergency Departments were seen to be sometimes crowded and stressed, and therefore more difficult to maintain, the cleanliness and maintenance of the waiting area and the furniture and walls was seen as important in creating a feeling of confidence in the care that would be provided.

Ideally there would be ample and comfortable seating, space to spread out where possible and to escape from other sick and sometimes offensive and possibly dangerous people.

A sense of order and efficiency led to the feeling that despite the very busy setting, there are processes to keep things under control.

Some also mentioned the importance of having a security guard present at certain busy times, such as weekend nights.

Inadequate parking and security around hospitals and other health services was also raised. A number of participants had felt unsafe going from the car park to the Emergency Department at the hospital, particularly late at night:

“To many people loitering around the hospital ... I hear a lot about young people attacking older people. It makes me feel unsafe when I see a group of them sitting in one area. Especially in the hospital areas, you don’t want strangers everywhere.”

Overall those who had experience with these Departments felt that many of the large public hospitals in the cities in particular, were often very overcrowded, chaotic, and stressful, with shabby grubby furniture and uncomfortable seats, and it was felt many improvements could be made in this regard.

**Physical Indicators within Other Services**

The requirements for the waiting rooms for other services such as radiology or radiography, pathology etc. were similar to those for GP surgeries.

However slightly more importance was placed on the appearance of equipment within these facilities, and whether or not it looked clean and new, modern, and working properly.

The staff working within these services were also expected to look very professional, with many suggesting that white coats helped to project that look.

Generally these sorts of services were felt to be of a high standard, many with new looking ‘hi tech’ equipment and professional and efficient staff. The emergence of shared premises particularly designed for a number of health services all under one roof were felt to be a positive step.
"Where I went for my x-ray looked very hi tech and impressive"

An area of concern amongst ATSI participants, in particular about the safety of health services, was violence. A number of Aboriginal and Torres Strait Islander participants linked this to the escalating use of ice.

Dirty health service transportation vehicles with drivers smoking were mentioned by a few Aboriginal and Torres Strait Islander participants, but it was generally agreed that there has been considerable improvement in the quality of such services over recent years.

### 4.2.3 Management and Processes

Interestingly whilst the existence of processes and management protocols were understood to be important in underpinning the safety and quality of the health system overall, health consumers did not feel they needed to be informed of their existence in detail. They instead gained confidence from observing the outcomes from the processes in practice.

**Management and Processes within General Practice and Specialist Services**

It was assumed that the appropriate processes would be in place for things like record keeping, disposal practices, and privacy and cleanliness procedures within the GP environment.

The implementation of specific processes to ensure the GP was following the history of the patient was suggested by some. In that sense, the sending of proactive reminders was also felt to be important, to prompt patients to come in for a check-up, or to undertake screening and other tests.

Some also suggested GPs should have a mechanism or process in place to remind them to carry out basic health checks on patients from time to time, such as blood pressure, cholesterol tests, along with the suggestion of other preventative measures such as diet or quitting smoking as required.

As mentioned, it was assumed that GPs have to have the right processes in place to be allowed to operate. However the extent to which all GPs were carrying out the basic regular checks reportedly varied a great deal.

‘Good’ GPs did do this, and were proactive about reminding patients of any necessary updates, and this resulted in a sense of confidence in the integrity of the GP and also created loyalty.

Specialists were assumed to have all the right processes in place, and were not questioned in that regard.

**Management and Processes within Hospitals**
Processes were felt to be very necessary along the various stages of the hospital experience, however again users did not want to necessarily know exactly what procedures there were, they just wanted to feel confident the hospital was being run efficiently and effectively in a safe manner.

At admission, the careful recording of all relevant important information (with an explanation of why it is necessary to ask about and record it) imparted some peace of mind for the patient.

It was also felt important to appear to have a process set in place for the efficient allocation of a bed, and not leaving the patient left waiting for long periods of time without knowing what was happening.

During the stay the management and procedures which clarify exactly what medications the patient needs and when they need to take it were thought of high importance, particularly amongst some of the older more chronically ill, who may have several medications to manage. In particular, fail safe processes for the recording of the medication regime, and for ensuring accurate communication across shift changes, was vital.

“They just gave me all my medications at once, without telling me when to take them. I knew they were meant to be spaced out”

Other procedures to ensure no mistakes are made were recognised as very necessary, for example the patient being asked what procedure they are in the hospital for, with everything checked and rechecked against the records. Some get tired of this rechecking however, and feel it is a simplistic approach until they are told why it is necessary.

Further physical indicators that the processes are being adhered to were also of value, for example having a chart on the wall of toilets indicating when cleaners last cleaned, and being able to see nurses and doctors carefully rechecking your form or record, and taking the time to appear to think about it was further reassurance.

On discharge, it was felt there was a need for processes to be in place regarding the communication of what is required when you leave hospital, what to look out for, and for who to call if any issues. Ideally handouts would be provided with the above information as a reminder, along with advice about other services that may be required.

It was also felt important that the patient was properly seen by the doctor before being discharged and that there was a process in place to ensure that takes place.

Experiences on discharge were apparently variable. Some had experienced being let go ‘too early’/without a doctor’s permission, with little or no information or ‘follow up’.

Most however had experienced lots of questions being asked of them, and were satisfied with procedures that were in place for discharge.

Management and Processes within Emergency Departments
The prioritisation in the queue for attention were seen as most important with regard to emergency treatment, and the observation of the existence of some process in this regard helped provide those waiting with a sense that their turn would come. Without a clear process there was sometimes a perception of bias and haphazardness.

Further to the prioritisation process, it was felt important for there to be some clear process in place for admission from Emergency into a hospital bed where necessary.

As mentioned on occasion violence can be a problem in Emergency Departments, and therefore processes for dealing with these situations were of importance.

It appears the desired processes discussed above did not always appear to be in place in ED’s, and many had not experienced any particular prioritisation process or procedures, and had wondered why their case appeared to take longer than others to be seen to.

Many also reported themselves or friends and family having been left on trolleys at crowded times before being admitted to a ward, and whilst this was understood to a degree, it did give the impression the hospital was a little out of control.

Those who had seen security guards in action believed them to be very responsive and professional, and they seemed to have a process for eliminating the threatening situation, but they were not always present.

**Management and Processes within Other Services**

Processes for the accurate recording of patient history and for linking the patient to the right results were important if tests were being carried out. In addition processes to ensure safe disposal of things such as syringes, and to sterilise all equipment, were seen as mandatory for these sorts of services.

The majority assumed these processes must be in place within these facilities, or else there would be more cases of mistakes made reported in the media.

Others had observed checking processes such as the writing of names and dates of birth on blood vials and checking them with the patient, and this assisted in suggesting care was being taken.

**4.2.4 Confidence and Trust**

In addition to the quite specific and tangible elements of importance in the delivery of safety and quality in health care discussed above, many of the health system users in the research consistently talked of the overall level of implicit ‘trust’ they felt about the system and the people in it.

Many felt they made their judgements about the safety and quality of a service based on intuition, and if they did not ‘feel’ confident about a service they would choose another.
Certainly the level of confidence felt could be impacted by the right type of communication, and by physical aspects and observation of processes, as discussed, but some users could not further define exactly what contributed to their assessment.

Many of the heavier users in particular felt that they themselves had a responsibility to ask questions and take an interest in their own health. Heavier users had ‘worked the system’ to a degree and felt confident enough to do push for answers and perhaps get second opinions.

There were however, some concerns that certain people in the community are reluctant to ask the right questions – e.g. those from non-English speaking backgrounds or some older people. And it was felt some people needed help to know what to ask.

Although there were some aspects of the public hospital experience that could be improved from the perspective of the users, most in the research had an innate trust in our ‘system’ to provide a certain level of safety and quality; and they in fact assumed government regulations and/or accreditation criteria were in place to ensure this. They were not always clear about the exact body that might be responsible, although there was an assumption that it was more of a state responsibility for the hospitals.

The main concern was that the staff numbers within hospitals were not always high enough to deliver on the regulations or criteria that might be in place, and that this then impacted on the delivery of quality and safety.

Most did not want to read about or view the detailed regulations or accreditation criteria; they preferred to see the result of them in practice.

Interestingly, there was spontaneous discussion around whether or not a rating system should be applied to GPs and hospitals, but it was dismissed as fraught with danger and open to rorting. There was also a feeling that our health system was above this and was too important to be rated at the patient level.

“It would be like Trip Advisor for doctors, like they have in the US”

While a general level of confidence and trust was consistent across the CALD component of the research, one of the participants from a Horn of African country clearly had a high level of mistrust of the Australian health system.

“How do we know how safe we are in the hands of the doctors and how do we know we are getting the right diagnosis? I don’t know. Safety in terms of clean and washing hands I am sure is good, but how do we know the rest. This is why so many of our community are going overseas for a second opinion. They are not very confident in the doctors here so they go and get an opinion from doctors in Dubai, Turkey, Egypt and other countries.”(Horn of Africa, parent)

While this is an outlier example, it should be noted. What it illustrates is that in some newly arrived communities, people can feel very alienated by the health system in Australia, and there is a period of time post-arrival when some people may feel quite wary of the quality of health
care in Australia. This needs to be understood by health professionals, and taken into account in their provision of services to people from newly-arrived communities.

For Aboriginal and Torres Strait Islander participants trust and confidence was strongly influenced by the extent to which they felt culturally safe, demonstrated by the preference for attending Aboriginal health services by the majority of participants.

4.2.5 Quality and Safety Commission Prompts

Participants in the various components of the research were asked to consider various aspects of health service provision in terms of which are *absolutely essential*; which are *not absolutely essential but are still important*; which may *not be necessary but which would be ‘nice to have’*; and which aspects are *unnecessary*.

The table below displays the various health service aspects in descending order of relative importance, as rated on average across the research.

The health aspects that were considered most important related to systems that have quality and safety as cornerstones; skills and capacity of healthcare providers; being treated with respect and dignity; and basic hygiene. The aspects that were considered least important were those that related to information – both in terms of information to inform research and continuous improvement, and information for health care consumers.

The table below summarises the groupings.

<table>
<thead>
<tr>
<th>HEALTH SERVICE ASPECT</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can get safe and high-quality healthcare when I need it</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>Healthcare providers have the right skills and knowledge so that I receive safe and high-quality care</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>Healthcare providers clean their hands so that I don’t get an infections</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>The health system is designed to provide safe, high-quality care for me, my family and my carers</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>I can discuss my care with my doctor so that we can make decisions together that are best for me</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>I am treated with dignity, respect and consideration when I receive healthcare</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>My healthcare is well co-ordinated. The doctors, nurses and managers all work together</td>
<td>Abs. Ess.</td>
</tr>
<tr>
<td>My health service has processes in place to ensure that the care I receive is safe</td>
<td>Imp.</td>
</tr>
<tr>
<td>HEALTH SERVICE ASPECT</td>
<td>Imp.</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>If I have concerns about my care they will be addressed</td>
<td></td>
</tr>
<tr>
<td>My healthcare is based on the best knowledge and evidence</td>
<td></td>
</tr>
<tr>
<td>I can participate in making decisions about the way that health services are planned</td>
<td></td>
</tr>
<tr>
<td>and delivered</td>
<td></td>
</tr>
<tr>
<td>I can access information about healthcare I can understand. It helps me make</td>
<td></td>
</tr>
<tr>
<td>decisions about my health and health care</td>
<td></td>
</tr>
<tr>
<td>The outcome of my treatment and my experiences are used to help and improve health care</td>
<td></td>
</tr>
</tbody>
</table>

CALD participants were very similar to mainstream groups in their rankings, whilst amongst ATSI participants the health aspects that were considered most important related more to being treated with respect and dignity. Aboriginal and Torres Strait Islander participants believed that on the whole they felt secure if they go to an Aboriginal health service, insofar as both their professional and cultural needs will be catered for.

Aboriginal and Torres Strait Islander participants also believed that there were opportunities available to them to participate in making decisions about the way the health service is planned and delivered.

“There are at least 3 community meetings per year to have a say in how the service operates.”

“At hospitals they have questionnaires that ask certain questions about your time in the hospital.”

Similar to other groups the aspects that were considered least important were those that related to information – both in terms of information to inform research and continuous improvement, and information for health care consumers.
4.3 Information Sources

The health consumers in the study were often proactively seeking information about their particular condition and the treatment of it, to further their feeling of being in control of their own health, and in understanding what their issues may be.

They generally did not seek information with which to question or doubt a doctor or specialist’s advice, but sometimes they wanted to be sure they were asking all the right questions and needed help or suggestions about this.

Information sources used currently appeared to be mainly word of mouth discussions with friends or family, or the internet - ‘Dr Google’

Interestingly, even many of the older heavier users were quite computer literate in this regard.

Most did not visit particular websites or government sources, instead tending to ‘Google’ the condition or medication.

Some visited pharmaceutical company websites for advice on a particular prescription.

Few were looking up information about individual hospitals or about health professionals; they were more likely to be searching for symptoms, medications, side effects and so on.

Occasionally some looked up the internet to check on a specialist’s credentials or areas of expertise if a large operation was likely, just to reassure themselves.

Often the information websites visited were American, and whilst some seemed more ‘professional’ than others and run by doctors, many participants were quite cynical about the information as mentioned, using it as a basis for questioning, rather than as a real information source.

Some GPs and specialists did provide handouts about medication, or about procedures and this was felt to be very useful. Some hospitals also provided take home information on discharge, which was also well received.

One area where participants felt there was a lack of information was regarding where to go for help, or to complain if an element of the health system had been satisfactory.

There was some mention of a medical Ombudsman, but this was at a very low level.

Most change provider if the experience they have had is bad.

The only difference to emerge amongst CALD participants was mention of a Chinese website called ‘Today Sydney’ that has a community forum whereby people post and talk about health issues and healthcare services.

Amongst ATSI people there was low demand for additional information, with most feeling that doctors, hospital staff and Aboriginal health services provided them with sufficient information.
Some participants mentioned that the local Aboriginal health services send out information to its members about various programs. It was noted that Aboriginal health services run community forums for elders, men, women, youth, children and parents.

There was also high recall of various health promotion material delivered through community activities and events held throughout the year. Among the few participants who felt that specific information on health safety and quality issues would be useful, a few suggestions were made with regard to format.

Pamphlets, posters and websites distributed through Aboriginal health services that were specifically branded as targeting Aboriginal and Torres Strait Islander people were suggested, to increase uptake.

Information delivered face-to-face via Aboriginal health services, through consultations, community meetings and through existing community groups was also felt useful.
4.4 Information Needs regarding Safety and Quality

Toward the end of the discussions, participants were asked about the sort of information they felt they needed about the safety and quality of the health system.

As mentioned, the majority of the participants did not want access to detailed information about the system and the processes that were in place; they tended to assume this was being controlled and were comfortable in the knowledge that the system had to adhere to regulations.

At the high level however they wanted to be reassured that there are some systems in place which ensure high standards are implemented and met.

“You have faith if you know processes are in place”

The concept of individual performance ratings was not appealing as it was felt to raise concerns

“America has a star rating for their Doctors, - that’s ridiculous!”

As discussed, some felt they needed help with knowing what questions to ask of their health professionals, and would appreciate for example lists of ‘FAQs’ with answers, possibly on a government website that they could access.

Other indicators which were often noticed subconsciously and which added to the feeling of trust, included the existence of the health professionals’ qualifications being displayed on the wall, which were often noticed and it was felt they provided added assurance and confidence if recognisable as genuine and from Australia or the UK in particular.

Amongst CALD participants in-language brochures were felt useful.
4.5 Awareness of and Attitudes toward e-Health

Awareness of the concept of e-Health was very mixed amongst the mainstream and CALD participants. Some had heard of it, and a minority had registered, but indications suggested that it was not being proactively suggested or followed up by many health services providers.

There were still many heavy and particularly lighter users who had not heard of it at all.

When the concept was explained in a broad sense, there was a generally positive reaction, however there were numerous concerns regarding cyber security – and who might have access to the sensitive information.

The idea was well regarded in relation to travelling and accidents or sickness, and also thought to be helpful for those with chronic health issues.

There were also seen to be advantages in the exchange of information and in handovers between GPs and specialists.

The logistics were of some concern, with confusion over how you would control who could see what and how the information is updated, etc.

“Big brother is watching you”

“There’s no guarantee who will access it”

“Everything is hackable”

Carers were particularly positive about eHealth and it came up spontaneously in both groups. They were particularly concerned about what will happen if and when they are not there to care for their loved ones.

At least with eHealth, they could be reassured that their condition and medications would be shared amongst health professionals and could be found easily in an emergency. It was also thought to be a positive development because it would take away the unease felt by many mentally ill patients when having to repeat their medical histories. They just wanted reassurance that eHealth will be promoted and awareness increased amongst the general public, and that doctors will actually use it.

The majority of Aboriginal and Torres Strait Islander participants had not heard of e-Health. Once explained, reactions to e-Health were quite mixed. Some thought it was a good idea, particularly in an emergency situation where someone is unable to answer questions about their medical history. However, a number of ATSI participants were initially quite suspicious of the initiative, and were not keen to have their personal health information shared with other service providers.
“I would prefer to tell my story each time. I wouldn’t like to have personal information about my health so easily accessed.”

Others thought it would be used to crack down on people ‘doctor shopping’.
5. Conclusions and Recommendations

The research suggests that health system users in Australia have a high level of existing trust in the system as it stands, expecting it to provide them with good health care when they need it, and they appear to believe that it is generally designed to provide this safe, high quality care.

Where the delivery of services is not of a high standard, often it is thought to be the result of understaffing issues, particularly in the public hospital system.

Overall, the findings indicate consumers want to continue to feel confident that the system is based on best practice, with a high standard of knowledge amongst health professionals. They want to feel up to date equipment is being used, operated under certain processes and regulations to ensure safety and quality. Some reassurance in an overall sense that this continues to be a priority of governments would therefore help maintain that ‘faith’ in the system.

To help with this reassurance, it could be useful for the Commission to provide information online regarding what should be expected of a health provider with regard to quality and safety, along with some broad information and reassurance that there is monitoring of process and practices.

Other communication tools such as posters, brochures, a quality and safety ‘charter’ outlining what the health consumer should expect, may also have potential, ideally with translated and culturally specific material, and with directions to the Commission’s website and the information which would be contained there.

The research has highlighted a number of key indicators that are used to help a person decide if they are receiving the right level of safety and quality or not, across all services, and many prefer to be able to gauge this themselves, through observation and experiences, rather than being provided with any detailed information about the system and the controls within it. The detail regarding processes and safeguards is seen to be more of an administrative and theoretical aspect, rather than being of importance to health consumers, and we therefore suggest that there is no need for the Commission to communicate this detail.

Clearly the most important facet of the health system was to continue to be able to feel sure the treatment provided is going to cure or solve whatever the problem is, in the most effective manner.

As mentioned they want to feel processes are in place to ensure this, but they also want to observe the outcomes of the processes, and there are a number of key physical aspects and actions which they would like to view in action, (particularly in public hospitals). These include:

- Hand washing, use of gels by all staff and patients, signs encouraging usage;
- Clean modern looking surroundings, fresh paintwork, clean bathrooms, indications that there is a cleaning regime (such as a checklist on bathroom doors), rubbish and used items being taken away quickly;
Staff, particularly in hospitals checking and rechecking the details about a patient and their condition, and making sure the patient understands why this is being done;
- Clear shift changeover instructions/processes to ensure treatment and medication is consistently provided;
- Within waiting rooms (GPs) hand washing gels, clean toys and fresh magazines, separation of possibly contagious patients; and,
- Visible use of fresh, packaged sterilised equipment.

Where possible the Commission should use its role to encourage health providers to implement and manage the regimes set out above.

In addition to effective processes to ensure the above basic needs with regard to quality and safety are being met, it has also emerged that communication between provider and patient, and between providers, can work very effectively to provide peace of mind to a health consumer, and ensure that they feel in control and empowered, and an equal player in their treatment.

It was important that any interaction between provider and patient was conducted in a caring empathetic manner, with honesty and sensitivity. The consumer must feel properly informed about what is happening and why, with regard to recommendations and medications.

This was particularly important in the GP relationship, but also from other providers, and in hospitals during admission, when in care and on discharge. The aspects which make a difference in communication include:

- Ensuring the patient feels listened to and treated as an intelligent participant, having eye contact;
- Ideally forming a professional relationship where relevant, reviewing patient history, with proactive suggestions for preventative measures with repeat patients;
- The provision of information (fact sheets) or sources for further information if required;
- Clear explanation of next steps, ensuring they are understood;
- Ideally allowing enough time to cover all aspects, without rushing or confusing the patient;
- Keeping hospital patients informed of what is happening and what they can expect at all stages through admission to discharge;
- Ensuring those patients in Emergency Departments understand the priority system and where they sit; and,

Again where possible the Commission could encourage health providers to maintain a high standard of communication with the patient at all stages, to help facilitate the important feeling of empowerment for consumers.

A resource for consumers provided by the Commission (online or as a brochure) with information about the sorts of questions they should be asking in various situations and a FAQ type checklist would also assist in this regard.
Further to the above more fundamental aspects, ensuring a certain level of dignity and respect for patients was considered important in a civilised society and whilst not a fundamental contributor to the quality and safety of a health service, it was felt that it should be strived for. This was particularly important amongst CALD and Aboriginal and Torres Strait Islander participants.

This often came up in relation to aged care services, in the facilities and the standard of care provided, and with regard to crowded public hospitals with mixed wards and bathrooms which were upsetting for some, particularly women, and those with serious and personal illnesses.

It also emerged however amongst those with particular cultural needs, (some CALD and ATSI people) and amongst those who at times are not health literate or able to participate in decisions regarding their health.
Appendices

APPENDIX A. RECRUITMENT SCREENER

PLEASE EXCLUDE: Nurses, Doctors and other Health Professionals

Q1. GENDER: CHECK QUOTA
   Male  1
   Female  2

Q2. LIFE STAGE: CHECK QUOTAS
   Which of the following best describes your stage of life?
   Aged 18-30, single, no children
   Aged 18-30, Married/De Facto, No Children
   Parent, with children who are mainly infants/toddlers, or in primary school
   Parent, with mainly teenage children under 18
   Aged less than 65 years, with no children under 18 living at home
   Aged over 65 years with no children under 18 living at home.

Q3. SOCIO-ECONOMIC GROUP: CHECK UPPER, MID AND LOW QUOTAS.
   a) What is the highest level of education you have completed?
      Primary school
      Year 10 or below
      Year 11 or below
      Year 12 or below
      Trade/apprenticeship
      Other TAFE/Technical Certificate
      Diploma
      Bachelor Degree
      Post- Graduate Degree
      Other (Specify) ________________
      Refused

   b) What is your current employment status?
      Employed full-time
      Employed part-time
      Unemployed
      Retired or on a pension
      A full-time student
      Engaged in home duties
      Other (Specify) __________________
      Refused (DO NOT OFFER)

   c) What is the occupation of the main income earner in the household? Check coding – see classification below

      Title ________________________________
      Duties ______________________________
Recruit for ‘low’ socio-economic group if the participant is in upper or lower blue-collar occupations, without tertiary qualifications, and as ‘mid’ socio-economic group if in lower white-collar occupations, or in blue collar occupations with tertiary qualifications. ‘Upper’ SES is those in upper white collar or professional occupations.

**OCCUPATION CLASSIFICATIONS:**

**Professional/Senior Management:**
Includes: doctors, lawyers, engineers, company directors/senior managers, judges, politicians, university lecturers, etc.

**Upper White Collar:**
Includes managers and supervisors, teachers, nurses, ministers & priests, business owners/self-employed people, scientists, administrators, etc.

**Lower White Collar:**
Includes: other non-manual workers, such as clerks/office workers, sales reps/assistants, artists, actors, etc.

**Upper Blue Collar:**
Includes: skilled tradespersons (trades which have apprenticeships and/or trade certificates), carpenters, electricians, hairdressers, mechanics, bakers, chefs, butchers, etc.

**Lower Blue Collar:**
Includes: unskilled manual workers, such as garbage collectors, farm hands, waiters, machinery operators, factory hands, bus & train drivers, labourers, etc.

**Q4.HEALTH SYSTEM USAGE:**

**CHECK HEAVY, MEDIUM AND LIGHT USER QUOTAS.** The formula is split, with one specification for young singles, young couples with no children and older single empty nesters, and one for those with children, and older couple empty nesters.

**USE EXCEL SPREADSHEET AND ENTER:**

*How many times in total over the past twelve months have you...?*

- Visited a GP, dentist, or optometrist for treatment or advice for you or for a close family member (i.e. parent, partner child), WRITE IN____ (1 point per visit)

- Visited a medical specialist, hospital, or other place for treatment or tests, for yourself or for a close family member, WRITE IN ___(2 points per visit)

- Visited a hospital emergency department for yourself, or with a close family member, WRITE IN ___ (2 points per visit)

- Been admitted to hospital for one or more nights, or had a close family member admitted. WRITE IN ___(5 points per visit)

**Young Singles, Young Couples, Older Singles**

10 points or less = light user, 11-15 points= medium user, more than 15 points= heavy user.

Note: Heavy groups must contain at least 3 or more group members who have been in hospital

**Those with children**

- 20 Points or less = light user, 20-35 points = medium user, more than 35 points = heavy user

Note: Heavy groups must include at least 3 who have been, or whose children/partner has been in hospital.
APPENDIX B. TOPIC GUIDE

INTRODUCTION

Put everyone at ease; explain that this is a study being done by the Australian Government to ensure they understand peoples’ needs and how the community feel the sorts of services we have here in Australia.

Reassure everyone that it is an open discussion, all comments welcome, definitely no right or wrong answers, and that we are independent and don’t have a view one way or another. Their individual comments or identities will not be revealed.

Also let them know that they have been grouped together with people who probably have relatively similar attitudes, so they can feel very open about saying how they feel at any time.

Also inform them that people might be viewing, and that we will be recording for our purposes only.

THE HEALTH SYSTEM IN CONTEXT

- Firstly let’s just briefly discuss what we feel about living in Australia and the sorts of services we have available to us….what are the good things, and what are the things that are not so good?

- And thinking about health services and the health system generally, what do you think about the standard we receive generally?

- What do you see as particularly good about the health system we have? PROBE What makes you feel that way?

- What are the negatives if any, PROBE what has led you to feel that?

OVERALL SAFETY AND QUALITY

- Overall how confident are you in the quality and safety provided by our health system currently?

- What leads you to feel that way?

QUALITY IN DETAIL (ROTATE WITH SAFETY SECTION)

- (MODERATOR NOTE….we will keep quality and safety separate in the first few groups, but if they can’t differentiate well between quality and safety, combine the two and go through the areas below, then probe specifically on aspects such as communication, hand washing and cleanliness, getting the right diagnosis, getting the right care etc.)

- Thinking particularly about the quality of the health services in Australia, that is services including local GPS, medical centres, public and private hospitals with emergency or elective surgery or other illnesses, radiology, radiography, and all of the other types of services…. how satisfied do you think people are with the overall quality of the health system,
Consumer Research Regarding Safety and Quality in Health Care
June 2014

- What do you feel are the indicators of **good quality** in health services? How do you know if you are getting good quality? What are some examples of good quality in health services that you can think of for example in regard to general practice, with other health professionals, with medications, in emergency situations, in hospitals, with elective surgery etc?
- And what are the indicators of **poor quality**?
- Tell me about some of your experiences with regard to what you felt was good **quality** in health services? When and what type of service, and what made you feel that way?
- What about any times where you have experienced **poor quality**? PROBE what happened etc.
- What exactly led to the concerns, was it something you saw or heard? Or the manner or knowledge of a health provider, or something about the communication, what else gave you that feeling?
- How better could that service have been delivered, what would need to improve;

**SAFETY (ROTATE WITH SAFETY SECTION)**

- Now thinking particularly about the **safety** of health services in Australia, that is again including everything from local GPS, medical centres, public and private hospitals with emergency or elective surgery or other illnesses, radiology, radiography, and all of the other types of services.... how satisfied do you think people are with the overall **safety** of the health system,
- What do you feel are the indicators of **safety** in health services? How do you know if you are getting **safe** services? What are some examples of **safety** in the provision of health services that you can think of again in regard to general practice, with other health professionals, with medications, in emergency situations, in hospitals, with elective surgery etc.
- And what are the indicators of **poor safety**?
- Tell me about some of your experiences with regard to what you felt was good **safety** in health services? When and what type of service, and what made you feel that way?
- What about any times where you have been worried about the **safety** of the health services you receive? PROBE what happened etc.
- What exactly led to the concerns, was it something you saw or heard? Or the manner or knowledge of a health provider, or something about the communication, what else gave you that feeling?
- How better could that service have been delivered, what would need to improve to make you feel safer;

**REACTIONS TO QUALITY AND SAFETY COMISSION INITIATIVES**

On these cards are a number of aspects about the provision of health services which may be of importance to people. I would like you to firstly tell me what you would expect it would mean to you, and whether you think it is happening currently.
SHOW CARDS (ROTATE) GO THROUGH EACH BRIEFLY ...
CARDS SORT
Now can we agree on a sorting of those things into four piles.....What aspects do you feel are absolutely essential with regards to quality, which are not absolutely essential but are still important and which are not be necessary but which would be ‘nice to have’ and which aspects, if any, are unnecessary.

- Are there any other things that should be on that list? What else? And how important are those things?

OTHER ASPECTS

- Have you heard of e-Health? Where you can agree to have all your health records kept electronically so that a number of health providers can access them, if you give permission?
- Do you think that might help improve the safety and quality of the healthcare you receive? Why is it you think that?
- Do you feel you have access to enough information currently with regard to safety and quality, what information do you use, what are the sources you use and trust in this regard;
- Is there any other information you are not getting about safety and quality in the health system and that you would like to have access to?
- how best could information be provided to you, what means do you think would be most helpful, what sources would be considered credible and reliable; (probe for brochures, websites, posters etc.)

THANK AND CLOSE