FINANCIAL AUDIT REPORT 20 January 2026

Health 2025

Report 9: 2025–26

Queensland Audit Office
Better public services

As the independent auditor of the Queensland public sector, including local governments, the Queensland Audit Office:

- provides professional audit services, which include our audit opinions on the accuracy and reliability of entities' financial statements
- provides insights on entities' financial performance, risk, and internal controls; and on the efficiency, effectiveness, and economy of public service delivery
- produces reports to parliament on the results of our audit work, insights, and advice, and provides recommendations for improvement
- connects our reports to regions and communities with graphics, tables, and other visualisations
- conducts investigations into claims of financial waste and mismanagement raised by elected members, state and local government employees, and the public
- shares wider learnings and best practice from our work with entities, our professional networks, industry, and peers.

We conduct all our audits and reports to parliament under the *Auditor-General Act 2009*.

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The Honourable P Weir MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

20 January 2026

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*.

Rachel Vagg
Auditor-General

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Contents

Acknowledgement

The Queensland Audit Office acknowledges the Traditional and Cultural Custodians of the lands, waters, and seas of Queensland. We pay our respects to Elders past, present, and emerging.

Report on a page

This report summarises the audit results of Queensland Health entities, which include the Department of Health (the department) and 16 hospital and health services (HHSs). It also summarises the audit results for 13 hospital foundations, 5 other statutory bodies, and 3 entities controlled by other health entities.

Entities face challenges in managing the cost of services

Queensland's population has continued to grow, placing additional pressures on the public health system. The number of elderly Queenslanders has also increased, which has a direct impact on demand for health services.

The Queensland public health system has responded by providing an 11.7 per cent increase in services this year. The increased activity has come at a financial cost, with the department and HHSs reporting a combined financial deficit of $960.6 million for the year, higher than ever previously reported.

The financial deficit reflects additional expenditure on employee costs, supplies and services, and asset maintenance and construction. The number of staff employed by the department and HHSs increased by 5.6 per cent this year. This, along with operating expenses, is expected to continue increasing in coming years as the department responds to the additional demands of a growing and ageing population.

Queensland Health is responsible for maintaining hospitals and related assets valued at $19 billion. It is also responsible for planning for future needs, constructing new hospitals, and expanding existing ones. HHSs report that the cost of the maintenance they have deferred on their assets grew by a further 28.9 per cent to $2.6 billion as at 30 June 2025. The maintenance that is being deferred is impacting on the delivery of some health services. This includes delaying patient treatment or requiring patients to be diverted to other locations for treatment. The government has committed additional funding to address historic shortfalls in funding.

Financial statements are reliable, but controls over information systems still need to be strengthened

Health sector entities' financial statements are reliable and their internal controls are also generally effective. However, we continue to find deficiencies in information technology (IT) access and security controls. Health entities are considered attractive targets by cyber criminals, due to the personal information they hold and the potential for profit. We therefore consider these access control deficiencies as significant. While management is working to address these complex issues, they need to take more timely action to resolve the deficiencies.

Addressing demand for health services

Emergency departments continue to not meet the 4-hour target to treat and discharge patients, as is the case with other states and territories. The performance of emergency departments also impacts on ambulance services, where time is lost due to delays in transferring patients from ambulances into hospital care. Queensland Ambulance Service response times are better than in other jurisdictions but still below Queensland's target.

Queensland Health referred more specialist outpatients for treatment during the year than last year, but it continues to fall behind on its time targets, and the number of outpatients classified as 'long waits' has grown by 15 per cent this year.

1. Recommendations

We have made one recommendation for hospital and health services (HHSs).

Development of a plan for managing conflicts of interest for HHS board members
1. We recommend that the 16 HHSs should each develop a plan for managing conflicts of interest for board members who are employed as clinicians at the HHS. Preferably, the plan should be developed in consultation with the Integrity Commissioner and set out how conflicts of interest are managed and reported.

We also found control weaknesses that require further action on the security of information systems used by health entities. We reported these weaknesses to the Department of Health. Further details relating to the weaknesses in information systems have been included in our report *Information systems 2025* (Report 6: 2025–26).

Further action needed on prior year recommendations

Theme	Summary of recommendation	Health report
Governance and internal controls	Review the status of outstanding audit issues and ensure they are resolved promptly. (Chapter 3 in this year's report)	Report 12: 2020–21
Asset management	Address inconsistencies in calculating deferred maintenance. (Chapter 5 in this year's report)	Report 6: 2023–24
	Address the backlog of asset maintenance, prioritising high-risk maintenance. (Chapter 5 in this year's report)	Report 12: 2020–21
Employee expenses	Improve controls over rostering and approval of overtime, including finalising the current rollout of the electronic rostering system and extending it further. (Chapter 3 in this year's report)	Report 6: 2023–24
Information systems	Strengthen information and cyber security controls, including progressing the identity and access management maturity project and strengthening password controls. (Chapter 3 in this year's report)	Report 10: 2022–23
	Strengthen the security of information systems by assigning only the minimum level of access to staff, monitoring the activity of users with privileged access, and implementing strong password controls and multi-factor authentication. (Chapter 3 in this year's report)	Report 12: 2020–21
Procurement and contract management	Strengthen procurement and contracting controls, including by having contract management systems and maintaining up-to-date contract registers. (Chapter 3 in this year's report)	Report 12: 2021–22

We have included a full list of prior year recommendations and their status in Appendix E.

Reference to comments

In accordance with s. 64 of the *Auditor-General Act 2009*, we provided a copy of this report to relevant entities. In reaching our conclusions, we considered their views and represented them to the extent we deemed relevant and warranted. Any formal responses from the entities are at Appendix A.

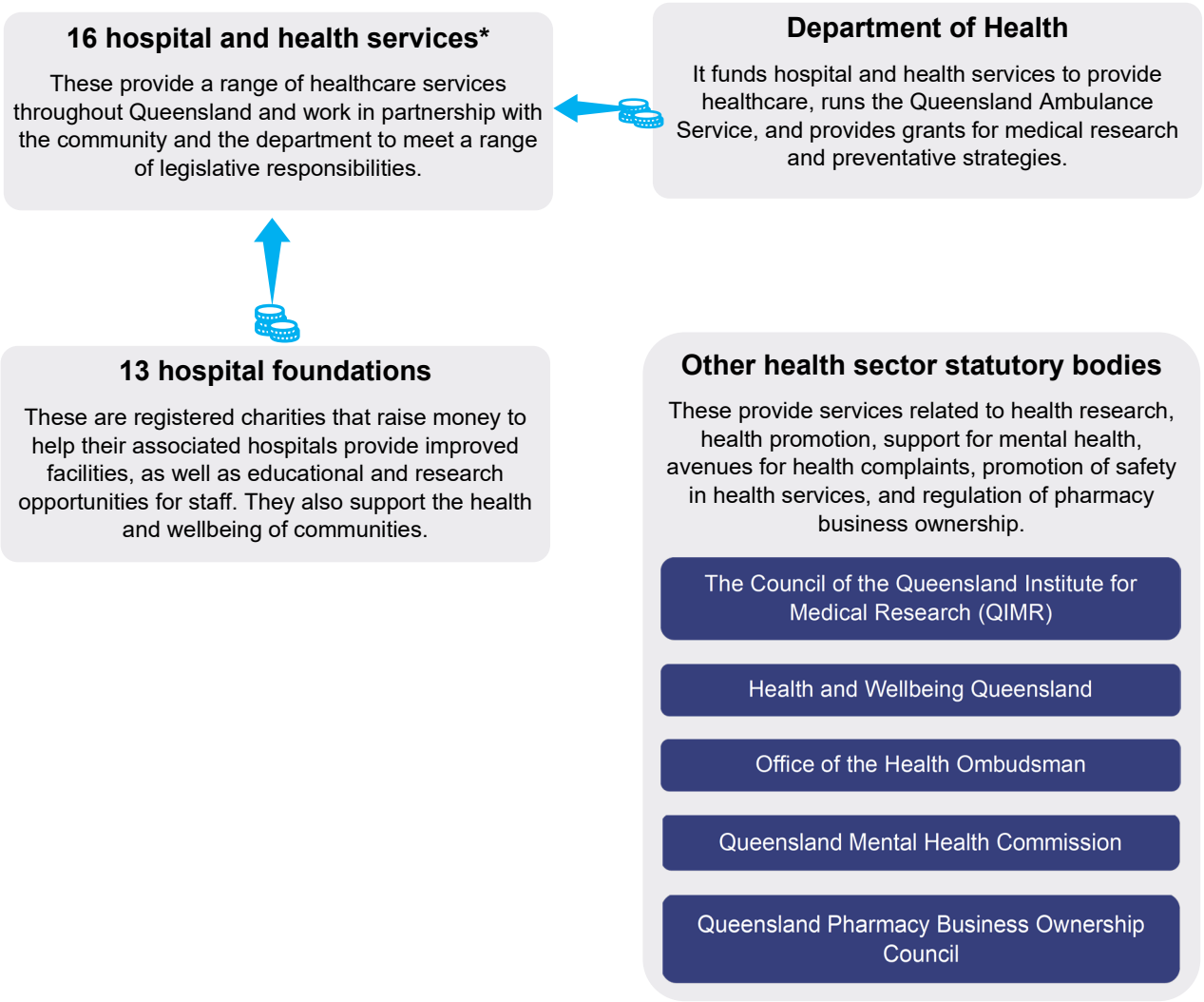
2. Entities in this report

This report summarises the financial audit results for health sector entities.

The Department of Health (the department) is responsible for the overall management of Queensland's public health system. It works with hospital and health services, which are independent statutory bodies, to deliver health services. It contracts with each hospital and health service's board through annual service agreements. These establish the health services the department is buying, and the funding that will be provided to each board for delivery of those services.

Figure 2A outlines the main entities and the relationships between them. Appendix F provides a complete list of the health sector entities for which we have issued an audit opinion.

Figure 2A
Queensland public health sector



Note: * Mater Misericordiae Health Service Brisbane also provides public health services under a service agreement with the Department of Health.

Source: Queensland Audit Office.

3. Results of our audits

This chapter provides an overview of our audit opinions for entities in the health sector. It also provides conclusions on the effectiveness of the systems and processes (internal controls) the entities use to prepare financial statements.

Chapter snapshot

38 unmodified opinions

The financial statements of all health entities we audited this year are reliable

More timely action is needed on audit recommendations

3 significant deficiencies and 22 deficiencies from last year remain unresolved

We have 1 new recommendation for HHSs

To manage conflicts of interest for clinician board members

Payroll overpayments are increasing

This money is still considered recoverable, but the department can no longer automatically recover it

Audit opinion results

We issued unmodified audit opinions for all health sector entities in Queensland, including the Department of Health (the department), the 16 hospital and health services (HHSs), the 13 hospital foundations, 5 other statutory bodies, and 3 controlled entities. This means that their financial statements can be relied upon. We issued an unmodified audit opinion with an emphasis of matter for 2 controlled entities – we include an emphasis of matter to help users better understand issues in financial statements. It does not change the audit opinion.

All entities reported their results within their legislative deadlines, except for Mackay Hospital Foundation and Queensland Mental Health Commission. Both entities had delays in meeting their legislative deadlines due to resourcing challenges within their financial accounting teams. We signed our audit opinion for Mackay Hospital Foundation 4 days after the legislative deadline, and Queensland Mental Health Commission 10 days after. Appendix F provides detail about the audit opinions we issued for 38 entities in 2025.

Entities tabled their annual reports by the legislative deadline

The timely publication of annual reports, which include audited financial statements, enables parliament and the public to assess the financial performance of public sector entities while the information is still current.

The department, the HHSs, hospital foundations, and other health statutory bodies all tabled their annual reports prior to the legislative deadline of 30 September 2025. Their tabling dates were as follows:

- The department, 13 HHSs, all 13 hospital foundations, and 4 other health statutory bodies tabled on 26 September
- The remaining 3 HHSs and one other health statutory body tabled on 29 September.

We continue to qualify our audit opinion for compliance statements regarding Queensland Health's aged care facilities

We issued a qualified audit opinion for the annual prudential compliance statement for Queensland Health's aged care facilities. In this statement, Queensland Health is required to outline to the Australian Government how it has managed refundable accommodation deposits, accommodation bonds, and entry contributions from aged care residents.

We issue a qualified opinion for the annual prudential compliance statement when Queensland Health has not complied with the requirements of the *Aged Care Act 1997* (the Act), with the exceptions noted in the opinion. We qualified our audit opinion because of 2 non-compliance issues with the Act. We identified instances where:

- Queensland Health had not complied with the requirement to enter into accommodation agreements within 28 days of a person's entry to an aged care facility
- we were unable to determine whether refunds were paid within the time period required by the Act where the resident had passed.

We have qualified our opinion on this every year since 2017–18.

Changes to the aged care annual prudential compliance statement (APCS)

The Commonwealth *Aged Care Act 1997* requires that approved aged care providers who hold refundable accommodation deposits submit an annual prudential compliance statement. These statements help the Commonwealth monitor the financial health and compliance of aged care providers. The department is an approved provider under the Act and prepares a consolidated APCS in relation to the residential aged care facilities that are operated at 5 HHSs.

The Commonwealth *Aged Care Act 1997* has been replaced by the Commonwealth *Aged Care Act 2024*, which came into effect on 1 November 2025. The new Act brings many changes, including more detailed reporting as part of the APCS.

This new legislation expands the reporting requirements for providers, including a requirement to report on care minutes – which are a record of the actual time spent delivering direct care to aged care residents. From 2025–26, all residential aged care providers will be required to submit an audited care minutes performance statement, which provides detailed information on:

- direct care minutes delivered by registered nurses, enrolled nurses, and personal care assistants
- associated labour costs
- monthly registered nurse coverage percentage (the proportion of the month where there is a registered nurse on site and on duty at the facility)
- occupied bed days.

From 1 November 2025, approved provider status will transfer from the department and will be required for each of the 5 HHSs that operate aged care homes that accept refundable accommodation deposits. This change means that the department will no longer be responsible for preparing and submitting the APCS. The responsibility for preparation and submission of the APCS will move to each of the 5 HHSs. In 2025–26, we will provide a separate auditor's report on the APCS for each HHS that operates an aged care facility.

Appendix G lists the other audit and assurance opinions we issued.

Some entities do not prepare financial statements

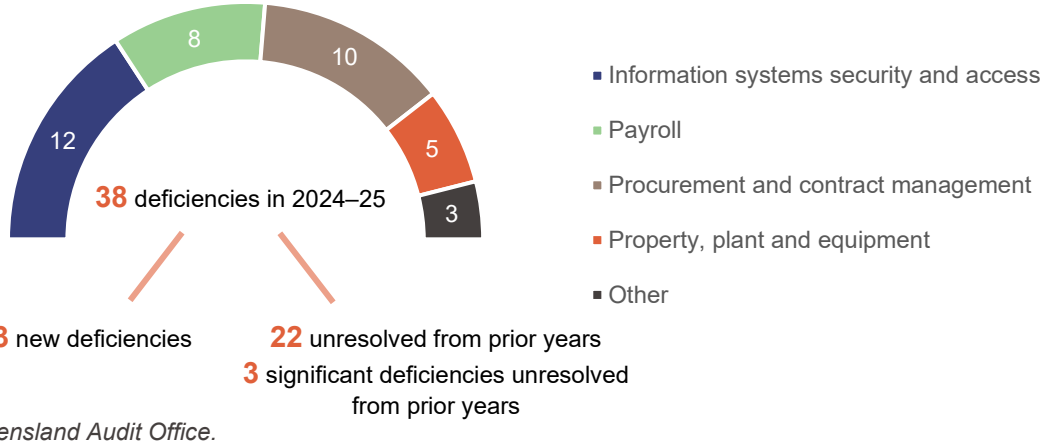
Not all entities in the health sector produce financial statements. Appendix H lists the entities not preparing financial statements and the reasons why.

Generally effective internal controls

Section snapshot

Types of deficiencies in internal controls in 2024–25

This figure shows the types of deficiencies we identified. It includes unresolved deficiencies from prior years, as of 30 June 2025. We discuss the main deficiencies in this chapter.



Source: Queensland Audit Office.

We assess whether the systems and processes (internal controls) entities use to prepare financial statements are reliable. We report any deficiencies in the design or operation of those controls to management for their action. The deficiencies are rated as either:

- significant deficiencies, which are those of higher risk that require immediate action by management, or
- deficiencies, which are those of lower risk that can be corrected over time.

Overall, to the extent that we tested them, we found the internal controls that health sector entities have in place to ensure reliable financial reporting are generally effective, but they can be improved.

While we were able to rely on the internal controls for the purposes of our audits, we continue to identify deficiencies in information systems controls at the department. There are also unresolved deficiencies from prior years.

These deficiencies indicate the entities need to strengthen controls to manage cyber security risks and prevent inappropriate access to the information they hold. We acknowledge the complexity of the systems, and that the department may need extra time to resolve these issues.

During our audits in 2024–25, we communicated with those charged with governance the need for them to give greater priority to resolving these issues within the agreed time frames.

This year, we have reported 3 significant deficiencies – all of which remain unresolved from prior years – and 35 deficiencies – 13 new and 22 that remain unresolved from prior years.

The significant deficiencies that remained unresolved from prior years relate to:

- control of access to information systems at the department – first raised in 2023–24
- our qualified audit opinion of the aged care annual prudential compliance statement – qualified each year since 2017–18
- ineffective controls over staff overtime payments at one HHS – first raised in 2022–23.

We continue to obtain updates from management on how they are addressing the significant deficiencies.

The department and HHSs should continue to work towards resolving these significant deficiencies within the time frames they have set for themselves.

Health sector entities have room for improvement in several areas

Information systems controls and cyber security

In our *Health 2024* (Report 8: 2024–25) report, we identified 13 control deficiencies in relation to security of and access to information systems at the department. Of these, 12 remain unresolved as at 30 June 2025. We also identified one new deficiency at the department in 2024–25.

We have provided further details of information systems deficiencies, including the reasons why deficiencies remain unresolved, in our *Information systems 2025* (Report 6: 2025–26) report.

Procurement and expenses – contracts

The department and HHSs have worked to resolve several procurement control deficiencies, but we continue to identify new weaknesses in their processes. There are currently 10 outstanding deficiencies relating to procurement controls. We raised 4 deficiencies this year. Of these, 4 were resolved during the year; 10 remain unresolved.

The nature of the procurement issues we reported this year include:

- non-compliance with the Queensland Government procurement guideline, which requires entities to publish details of significant contracts they have awarded
- procurement processes and policies that do not cover documenting alternative options to engaging a consultant or contractor.

Property, plant and equipment

We also continue to identify deficiencies in property, plant and equipment processes at the HHSs. We raised 4 deficiencies this year. All remain unresolved.

The nature of the property, plant and equipment issues we reported this year include:

- errors in the reporting of leased assets
- delays in recording buildings once construction had been completed.

Payroll rostering and overtime

In *Health 2023* (Report 6: 2023–24), we identified a significant deficiency at one HHS relating to ineffective controls over the approval of unplanned overtime. This specifically related to the approval of rosters and timely approval of attendance variation and allowance claim forms. These controls are important in managing unplanned overtime and penalties and in helping to prevent overpayments. This issue remains unresolved from 2023.

We also reported deficiencies at 3 other HHSs relating to the approval of rosters and overtime. These remain unresolved from last year. While the respective HHSs are continuing to address these issues, they had not yet been resolved by the time we completed our 2024–25 audits.

During the year, we identified an additional instance at another HHS where controls over the approval of roster changes, including allowances and overtime, were ineffective.

As a result, there are now:

- 2 HHSs with issues relating to ineffective controls over paper-based roster variation forms
- 4 HHSs with ineffective controls over rostering approvals.

Another payroll issue that we have reported this year includes a lack of controls for ensuring human resources (HR) delegations set up in the payroll system are consistent with the approved HR delegations.

The department and 16 HHSs should continue to strengthen overtime and payroll controls and implement our recommendations. As discussed further below, the extension of the electronic rostering system will help.

Payroll overpayments

The department's 2024–25 financial statements reported outstanding payroll overpayments of $85.1 million, up from $67.6 million last year. This is an increase of $17.5 million, or 25.8 per cent.

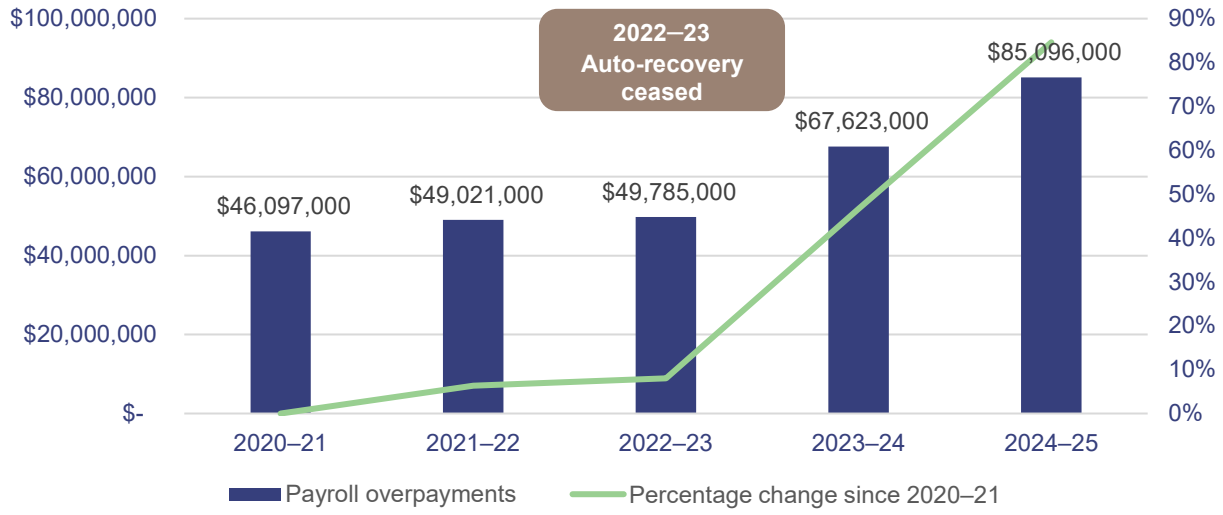
The medical and nursing/midwifery cohorts make up the largest proportion of the overpayment balance, representing approximately 41 per cent and 35 per cent respectively.

Figure 3A shows that these overpayments have increased by $39 million or 84.6 per cent over the last 5 years, with a steep increase first occurring in 2023–24. In addition, the department wrote off $2.7 million of overpayments as unrecoverable this year.

The department's payroll system was previously programmed to auto-recover payroll overpayments. However, the department stopped its automated recovery of payroll overpayments during 2022–23 to ensure compliance with the *Industrial Relations Act 2016*. That Act allows employers to recover overpayments related to absences from work, but other types of overpayments require an employee's consent to recover.

The ceasing of automated recovery of overpayments, and the resulting need to obtain employee consent to enter repayment plans, has contributed to the growth in the total outstanding balance reflected in Figure 3A.

Figure 3A
Payroll overpayments owed to the department from 2020–21 to 2024–25



Source: Queensland Audit Office, from Department of Health financial statements.

There are approximately 116,000 full-time equivalent employees across the department and HHSs. Approximately 91.5 per cent of these full-time equivalent employees work at HHSs and the Queensland Ambulance Service (QAS). The nature of HHS and QAS rostered work means these employees attract a large volume of shift penalties, overtime, and other allowance payments.

The department continues to closely monitor and report on trends in payroll overpayments, including reasons for overpayments, and actions taken to recover them. Its reporting shows that the average value of new overpayments each fortnight in 2024–25 was $1.4 million ($1.2 million in 2023–24).

The department estimates that 75 per cent of payroll overpayments are due to the late submission of approved payroll information, and it is working on strategies to address this. Among these is the rollout of an electronic rostering system – the Integrated Workforce Management (IWFM) system – described below.

Integrated Workforce Management system

In 2024–25, the department finalised the rollout of its electronic rostering system, IWFM, across all HHSs for nursing and midwifery staff. This group represents approximately 40 per cent of the HHS workforce and 38 per cent of the total cost of employee expenses. The IWFM system removes the need for forms to be completed manually and simplifies the roster-to-pay processes.

The department plans to implement IWFM in a staged approach across the HHSs for other occupational groups, including doctors/medical officers, starting in 2025–26. Eight HHSs are expected to begin implementing this before 30 June 2026, with 4 of these expected to go live by that date. Medical officers account for approximately 12 per cent of the HHS workforce, and 24 per cent of the total cost of employee expenses.

Our initial testing of the IWFM system, specifically over the nursing and midwifery cohorts, indicates that the electronic rostering system has strengthened controls over the timeliness and appropriate delegation of roster approvals and roster variations. By replacing the previous non-IWFM roster approval processes and paper-based forms, the system reduces the risk of salary overpayments and supports more timely processing of rosters and variation forms.

HHSs should continue to focus on resolving control deficiencies with roster and paper-based roster variation form approvals

As IWFM has not yet been implemented across the doctors and medical officer cohort, HHSs should continue to maintain strong controls over roster approvals and paper-based roster variation forms during this transition, and work to resolve these control deficiencies.

Management of conflicts of interest

The *Hospital and Health Boards Act 2011* (the Act) was amended in 2025. As of 1 April 2026, it will require at least one member of each HHS board to be a clinician who is employed or engaged by that HHS. Previously, each HHS was required to have one clinician on its board, but this change now requires HHSs to commence including a clinician from their *own* HHS.

This change is aimed at giving frontline staff a voice in how HHSs are run. However, when a clinician employed by a HHS is also a member of that HHS's board, there is potential for conflicts for them in both their employee role and board role. It is not common in the Queensland public sector for employees to be on the board, as one of the functions of a board is to provide independent oversight of the entity. For HHSs, this includes managing strategic issues, overseeing the HHS's performance, developing and monitoring service plans and strategies, and responding to critical issues in the HHS.

There may be instances when a board member's role will conflict with their duties as an employee of that HHS. For example:

- there will be a conflict between a clinician's operational responsibilities for an area of a HHS where they may report to the HHS chief executive, and their board role, where they will oversee their chief executive's performance
- a clinician responsible for managing risks and incidents in a clinical area will have a conflict when that is subject to oversight by the HHS board.

HHS boards are required to comply with the *Code of Conduct for the Queensland Public Service*, which requires any actual, potential, or perceived conflicts of interest to be identified and managed. The Act provides specific guidance to HHS boards on how to deal with disclosure of interests at meetings.

HHS board members are designated persons under the *Integrity Act 2009* and may request written advice from the Integrity Commissioner on an ethics or integrity issue

This includes any conflicts of interest that arise from them being both a board member and an employee of the same HHS.

Recommendation for the 16 HHSs

Development of a plan for managing conflicts of interest for HHS board members

1. We recommend that the 16 HHSs should each develop a plan for managing conflicts of interest for board members who are employed as clinicians at the HHS. Preferably, the plan should be developed in consultation with the Integrity Commissioner and set out how conflicts of interest are managed and reported.

Self-assessments against the Queensland Audit Office's Risk management maturity model

In 2024–25, as part of our annual audit, we asked the HHSs to self-assess the maturity of their risk management processes using our *Risk management maturity model*. This self-assessment tool helps entities to identify the maturity level they want to achieve and focus on key areas for development.

DEFINITION

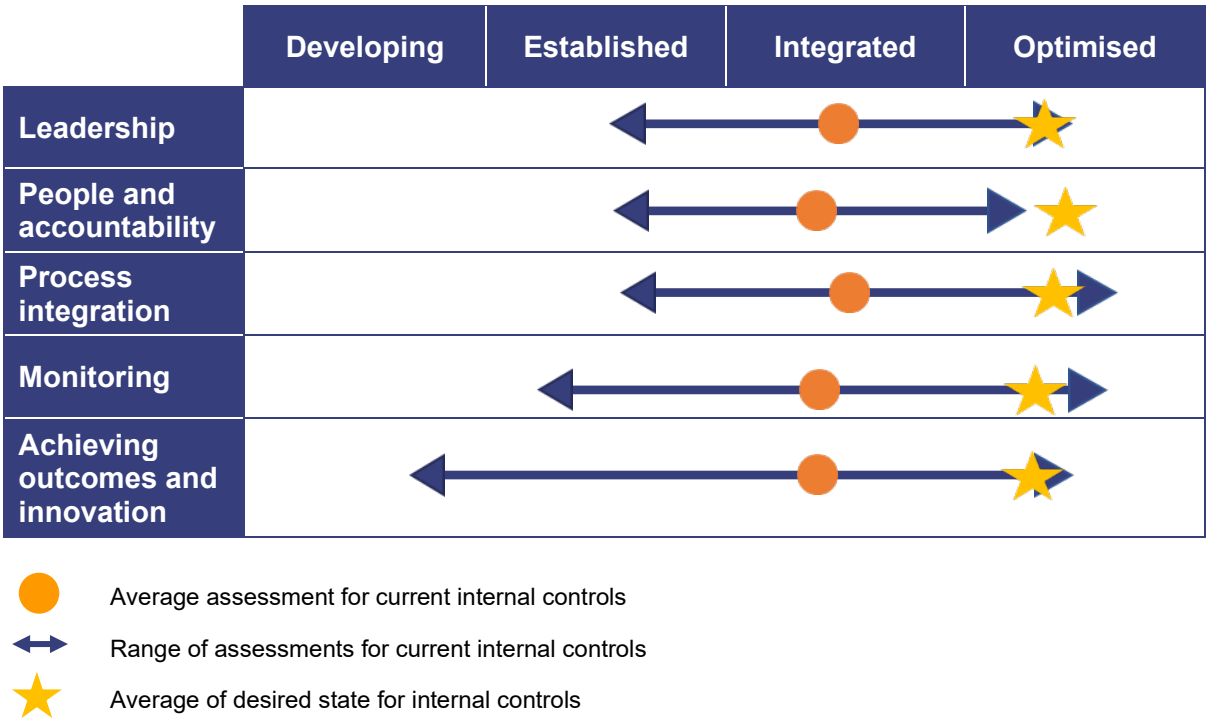
The 4 levels of maturity are as follows:

Optimised	an entity is a leader of best practice for risk management
Integrated	an entity's risk management practices are fundamentally sound; however, some elements could be improved
Established	an entity shows basic competency in risk management
Developing	an entity does not have key components of risk management, or they are limited

In Figure 3B, we show the self-assessed maturity levels for the HHSs per region for each key attribute of risk management. All regions show similar maturity levels, except in 'Achieving outcomes and innovation'.

This measures how the entity's culture supports well-managed risk-taking to foster improvements and innovation. It is important that staff are supported by management in building an innovative and well-managed risk-taking culture, in order to seize opportunities. We include our key observations on strengths and opportunities for all HHSs from the completed maturity models below Figure 3B.

Figure 3B
Hospital and health services' self-assessed average level of risk management maturity



Source: Hospital and health services' completed self-assessments against the Queensland Audit Office Risk management maturity model – 2025.

OBSERVATIONS

Strengths

- Executive management groups and audit and risk committees focus on risk at each meeting.
- Risk is centrally managed, and expectations are clearly defined in the HHSs' risk frameworks and policies.
- Risk processes are integrated, and treatments are assessed for effectiveness.
- Monitoring and reporting processes are in place.
- Management is committed to ensuring risk outcomes are considered for project outcomes.

Opportunities

- There is an opportunity to include risk as a goal in the performance management process. This could involve cascading risk responsibility to directors and managers through their performance goals.
- Additional training could be provided for risk managers and leaders.

4. Financial performance and sustainability

This chapter analyses the financial performance, position, and sustainability of Queensland Health entities, which include the Department of Health (the department) and the 16 hospital and health services (HHSs). In our discussion of sustainability, we consider financial matters as well as emerging issues relevant to the sector.

Chapter snapshot

Queensland Health is experiencing significant financial pressures

The department and 10 HHSs posted deficits in 2024–25

The HHSs exceeded their expenditure budgets by $1.72 billion

They will receive an additional $2 bil. in funding in 2025–26

HHSs are delivering more activity than ever

However, their cost of delivering healthcare is increasing and the HHSs are not meeting the efficiency benchmark

Operating results summary

The department and 16 HHSs continued to experience financial pressures in 2024–25, posting a total deficit of $960.6 million (2023–24: $14.1 million). This is a significant deterioration in the operating result compared to prior financial years, including the period when hospitals were experiencing the peak of the COVID-19 pandemic.

Figure 4A
Drivers for 2024–25 operating results at the Department of Health and hospital and health services

Entities	Drivers for operating result
Department of Health **$689.1 million deficit** for 2024–25 (2023–24: $22.9 million deficit)	This result was driven by the department's role as manager of the health system and 16 HHSs. It gave a significant amount of funding to the HHSs to provide better clinical outcomes and relieve cost pressures. The department's budget to support HHSs was in a deficit position at the start of the year due to funding commitments to HHSs being greater than the available budget. The position worsened during the year as the department approved further funding for HHSs. This included $220 million for HHS initiatives targeting specialist outpatient appointments (Smart Referrals) and planned surgeries (Planned Care). This funding was also used to help reduce ambulance ramping-delays in offloading patients from the ambulance to the emergency department doctors and nurses. **Other financial implications:** The department was at risk of exceeding its approved overdraft limit due to the payments to HHSs and capital works being greater than budgeted. Queensland Treasury provided $800 million to the department to address cash flow challenges across the health system.
Hospital and health services **$271.5 million deficit** for 2024–25 (2023–24: $8.8 million surplus) 10 of the 16 HHSs posted a deficit in 2024–25	This was primarily due to continuing cost pressures from increasing clinical demand, limited capacity to address the increase in demand, and inflation. HHS full-time equivalent employee numbers increased by 5.9% during the year in order to respond to growing demand. The cost of these additional employees, including locums and contractors, has contributed to the operating deficits. **Other financial implications:** Six HHSs were at risk of exceeding their approved overdraft limits due to the size of their deficits. The department provided $123 million in additional financial support to them to address ongoing cash flow issues.

Source: Queensland Audit Office from information provided by the Department of Health.

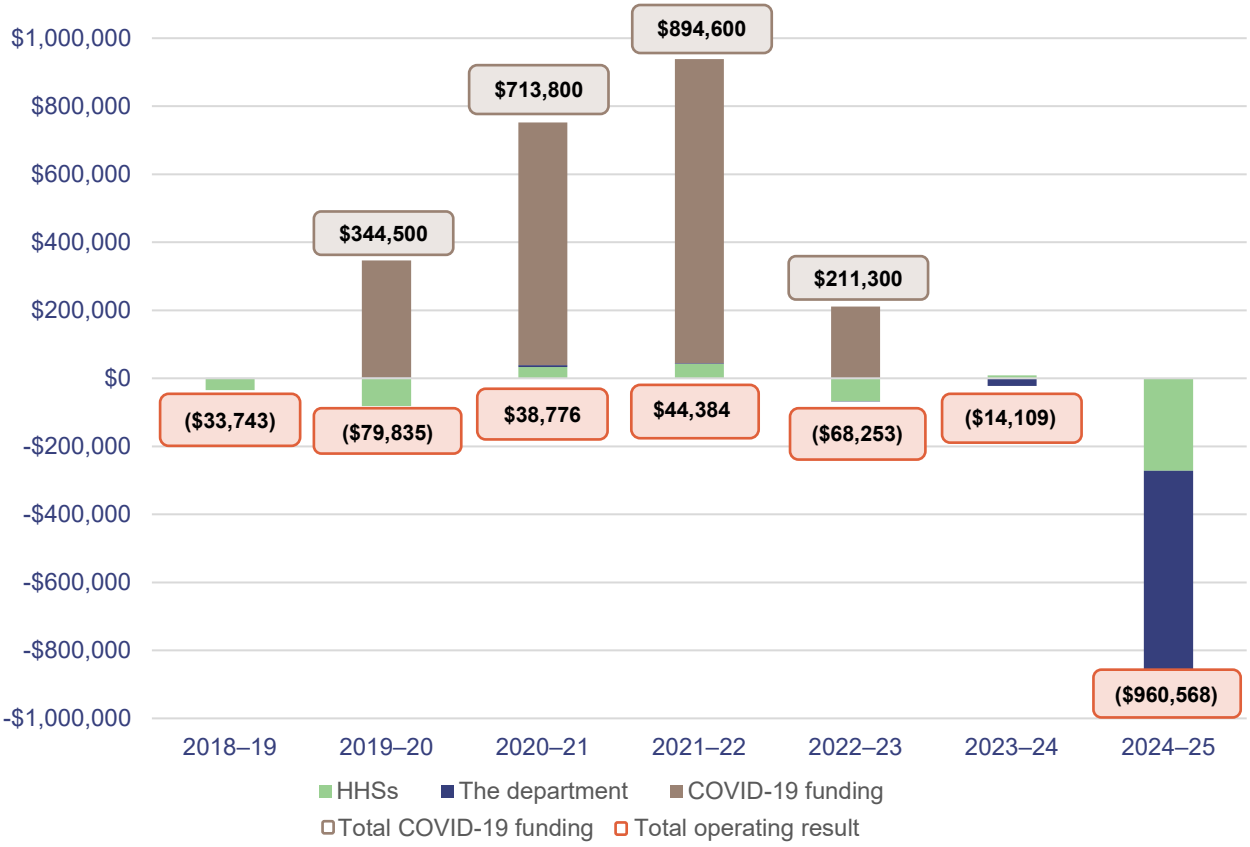
HHSs exceeded their expense budgets by $1.72 billion or 7.8 per cent (2023–24: $1.95 billion or 9.8 per cent). The high expenditure reflects the higher volume of services they delivered this year, increased employee costs, and the impact of inflation on the costs of goods and services. HHSs reported an 11.7 per cent increase in the health services they delivered (2023–24: 6.1 per cent increase).

As noted above, HHSs received more funding, enabling them to deliver additional activity and offset the impact of inflation on costs. Revenue for the health sector was 6.6 per cent higher than budgeted (2023–24: 9.9 per cent higher).

Employee-related expenses were $887.2 million higher than budgeted (2023–24: $1 billion higher than budgeted), reflecting the increase in the number of employees, as well as the outcomes of enterprise bargaining agreements.

From 2019–20 to 2022–23, the department received additional COVID-19-related funding totalling $2.16 billion. As this funding ceased in December 2022, the department and HHSs need to find alternate revenue sources or reduce expenses.

Figure 4B
System operating results (in thousands) from 2018–19 to 2024–25



Note: From 2018–19 to 2022–23, the department had operating results very close to nil which are not clearly visible on the figure (2018–19: $632; 2019–20: $2,180; 2020–21: $5,384; 2021–22: $2,163; 2022–23: -$440).

Source: Queensland Audit Office, from Queensland health entities' financial statements.

The pressure on hospital and health services' operating budgets is increasing

The 2024–25 state budget expected each HHS and the department to break even during the year, with total income equalling total expenditure. Yet, the department and 10 HHSs reported operating deficits.

The 2025–26 state budget again has an expectation that the department and all HHSs will break even. To assist the department and HHSs in achieving this, the budget is providing an additional $2 billion in funding compared to last year's budget.

Despite this, achieving a break-even result may be challenging, as cost increases and demand for health services are unlikely to ease. This year's budgeted funding is 11.4 per cent higher than last year's budget. This is 8.3 per cent higher than last year's actual funding.

Analysis of health sector expenditure

Total expenditure at the department increased by 8.6 per cent this year, from $38.4 billion to $41.8 billion. This spending was 5.7 per cent higher than budgeted.

The largest increase was in health services expenditure, which was $797 million higher than budgeted. Health services expenditure is the funding the department provides to HHSs and other health service providers for the delivery of health services across the state.

Total expenditure incurred by HHSs increased by 9.3 per cent this year, from $21.8 billion to $23.8 billion. All HHSs incurred expenses higher than their budgeted amounts, with variances between 4.3 per cent and 12.9 per cent.

The reasons for increased expenditure this year included:

- additional funding to support HHS Planned Care, Smart Referrals, Surgery Connect (public patients receiving surgical procedures in private hospitals), and initiatives to address ambulance ramping
- the increased staff numbers required to address the growth in demand for healthcare services, resulting in higher employee-related expenses
- pay increases for staff in line with enterprise bargaining agreements, and increased expenses relating to sick leave, overtime, reproductive leave, and COVID-19 leave
- outsourcing to private sector health providers to reduce waitlists
- use of external contractors to cover staff on leave and staff vacancies
- increased expenditure on supplies and services due to the increased level of activity delivered during the year
- price increases on certain supplies and services, particularly drugs and pathology.

Workforce pressures are increasing

Queensland Health's *Health Workforce Strategy for Queensland to 2032* includes projections for population growth, ageing, increased hospital activity, and the impact on the required workforce. The strategy projected that from 2023, the workforce would need to increase by 45,000 or 30.3 per cent to meet these demands. From 2026, approximately 36,000 additional employees will need to be onboarded to meet this target based on the number of full-time equivalent employees reported in the 2024–25 financial statements.

Adding to the challenge of recruiting new staff is the need to replace staff who leave due to retirement and other reasons. The department projects that within the next 10 years, 20 per cent of the existing workforce will reach retirement age. The health sector has experienced an increase in turnover since 2020, with higher turnover in rural and remote areas, where it is 9.5 per cent (4.5 per cent for metro areas).

Leave balances remain high, but are decreasing

Recreation leave balances have trended downwards across all HHSs and are at the lowest level for the last 3 years. Balances decreased by 2.3 per cent in 2024–25 (3.3 per cent decrease in 2023–24).

In *Health 2022* (Report 10: 2022–23) we reported that recreation leave balances increased from 2019–20 to 2021–22 due to the impact of COVID-19 affecting the ability of staff to take leave. Since then, the ability of staff to take leave has improved.

Overall, sick leave taken and overtime worked have both increased by 5 per cent this year compared to last year. This increase can be attributed to the 5.63 per cent increase in the number of full-time equivalent employees.

COVID-19 leave and reproductive leave

In addition to sick leave, in 2024–25 health staff were also eligible to take special leave if they were unable to work due to COVID-19, and up to 10 days of reproductive leave – which started from 30 September 2024.

As reproductive leave resets on 1 July each year (10 days per year) and does not require any evidence to be claimed, there was a large uptake of this leave in June 2025.

In 2024–25, health staff took:

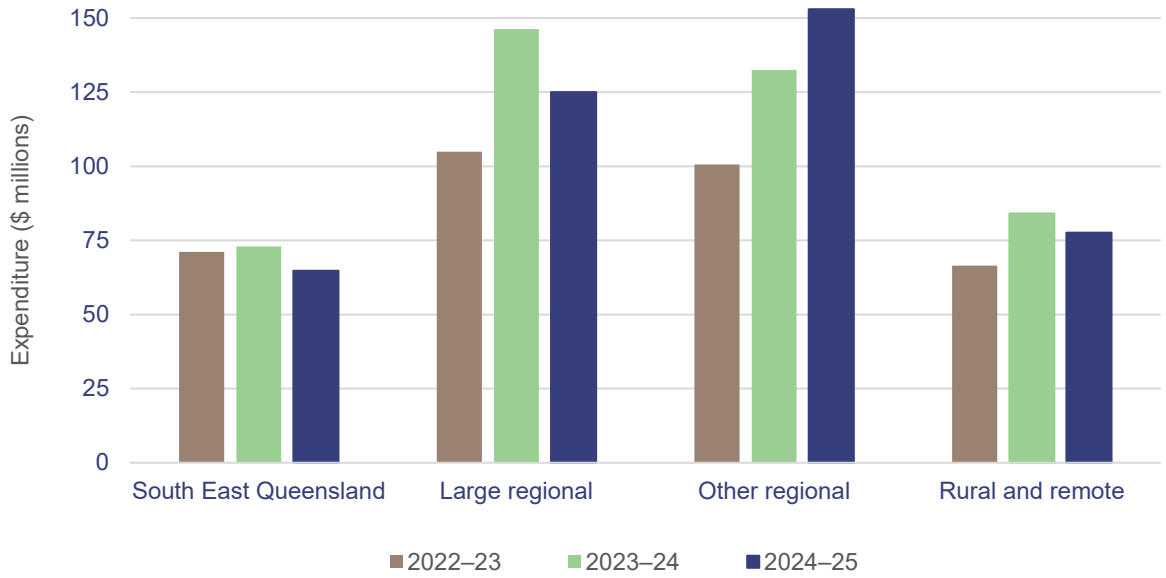
- approximately 563,000 hours of special leave due to COVID-19 – a 37 per cent decrease from the prior year
- approximately 174,000 hours of reproductive leave from 28 April to 30 June 2025, which cost approximately $8.9 million. We are unable to report reproductive leave prior to 28 April, as this leave type was mixed with other leave types in the payroll system from October 2024 to 27 April 2025.

Expenditure on frontline contractors is decreasing in most regions

In 2024–25, Queensland Health recorded a 3.6 per cent decrease in expenditure for frontline contractor staff, for example, nurses and other clinical contractors – a decrease of $15.6 million. All regions show a decrease in expenditure on frontline contractors except for 'Other regional' HHSs, whose expenditure on this increased by 15 per cent. Most of this increase is from the West Moreton region where there is significant population growth and demand for services.

Figure 4C shows expenditure on this across the HHS regions.

Figure 4C
Expenditure on frontline contractors by hospital and health service region from 2022–23 to 2024–25



Source: Queensland Audit Office, from Department of Health data.

Expenses for supplies and services have increased in line with activity

HHS expenditure on supplies and services was $6.1 billion this year (2023–24: $5.6 billion), an increase of 7.7 per cent ($433 million) over last year. HHSs delivered 11.7 per cent more activity in 2024–25, requiring more clinical supplies and services.

There was a 9 per cent ($124.9 million) increase in clinical supplies and services and an 8 per cent ($78.4 million) increase in pharmaceutical expenses. The increase in clinical supplies and services is in line with the increase in activity, and higher than the 2.1 per cent increase in the consumer price index (CPI) from June 2024 to June 2025.

Efficiency of health service delivery

HHSs' income this year was 6.6 per cent above budget (2023–24: 9.9 per cent above budget). The income of all HHSs individually was higher than projected in the state budget.

TYPES OF FUNDING FOR HHSs

The 4 main funding sources for HHSs are:

- **state funding** – received from the Queensland Government
- **federal funding** – received from the Australian Government
- **grants and contributions** – including specific purpose grants, such as nursing home and home support program grants; and contributions, such as corporate support services provided by the department
- **own-source revenue** – revenue that HHSs generate through the sale of goods and services. This includes user charges, for example, billing private patients for hospital services; reimbursements from the Australian Government for medicines listed on the Pharmaceutical Benefits Scheme; and other non-patient revenue, such as retail proceeds.

The main types of government funding for HHSs are:

- **activity based funding (ABF)** – This is based on the price and 'weight' (complexity) of a service, and the number of services provided to patients. Classification of these variables is based on a national schedule, with modifications for the Queensland health system.
- **block funding (small hospitals)** – This is discrete funding for small rural, low volume, or specialist hospitals and facilities where the activity-based model is not suitable.
- **block funding (services)** – This is mainly for teaching, training, and research in the public health sector; eligible services for patients who are not admitted to hospital (for example, mental health services); highly specialised therapies; and other public hospital programs.
- **other funding** – This is for areas that are not covered by the other funding types, including depreciation, population-based community services, and specific funding arrangements for prison health services and third-party health providers.

Hospital and health services delivered more activity than last year

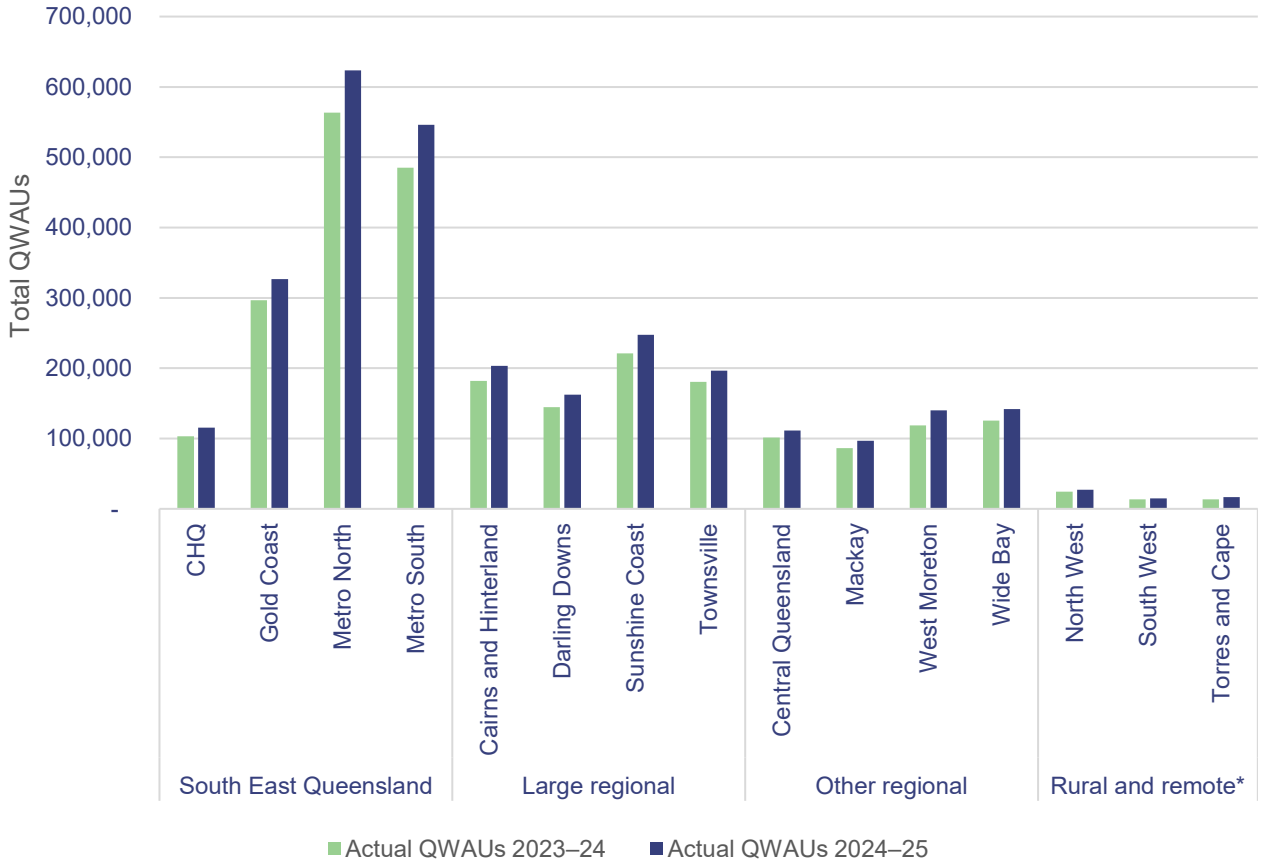
Service agreements are negotiated between the department and each HHS. The agreements outline the services the department purchases from each HHS, the volume, and the amount it pays for those services.

The HHSs receive ABF and/or block funding (for services beyond the scope of ABF). Of the 16 Queensland HHSs, 15 are funded primarily by ABF. The Central West HHS receives block and other funding rather than ABF. This is because it operates smaller public hospitals, where the technical requirements for ABF are difficult to apply.

Under the service agreements, the department and HHSs measure service activity using Queensland Weighted Activity Units (QWAUs), which tie into ABF.

Figure 4D shows that activity delivered by HHSs increased by 11.7 per cent this year to 2,969,967 QWAUs (2023–24: 2,659,070 QWAUs). This was 7 per cent higher than the total volume of activity the department agreed with HHSs for 2024–25.

Figure 4D
Total Queensland Weighted Activity Units (QWAUs) delivered in 2023–24 and 2024–25 – by hospital and health service and region



Note: * Central West HHS did not report on activity in 2023–24 and 2024–25 as it did not receive activity based funding in those years. CHQ – Children's Health Queensland.

Source: Queensland Audit Office, from hospital and health service annual reports 2023–24 and 2024–25.

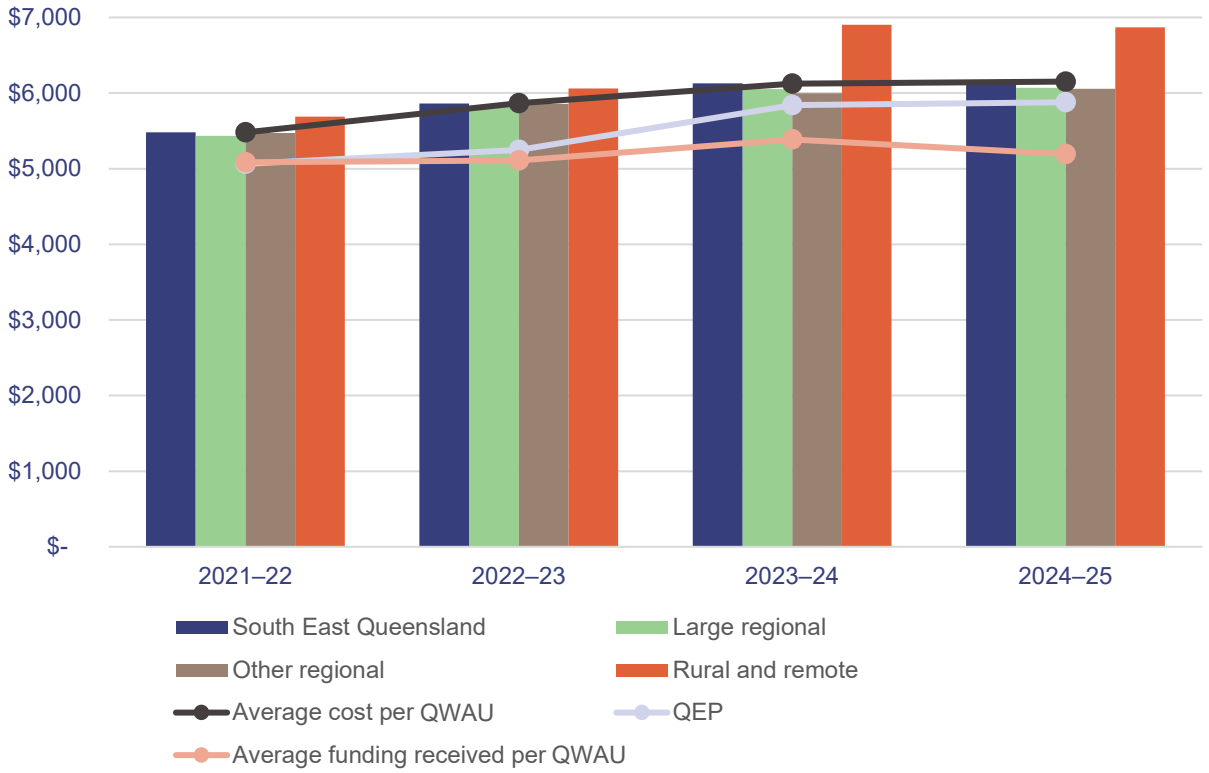
The HHSs' performance in delivering activity efficiently can be measured against the Queensland Efficient Price (QEP). The QEP reflects the benchmark cost for Queensland to purchase one unit of activity based on the total funding available that year.

Figure 4E shows that the QEP has increased over time; however, the actual average cost per QWAU has exceeded it each year. This means that while the HHSs are delivering more activity, they are not meeting the efficient cost benchmark.

The change in healthcare activity costs has been very closely aligned to movement in CPI since June 2022. The average cost per QWAU has increased by 12.26 per cent since 2021–22 and CPI has similarly increased by 12.37 per cent in the same period. Comparatively, the average amount of funding received per QWAU has only increased by 2.12 per cent since 2021–22.

Figure 4E shows this growing gap between the cost of delivering health services and the funding received for this activity.

Figure 4E
Average cost per weighted activity unit compared to the Queensland Efficient Price – from 2021–22 to 2024–25



Note: Rural and remote only includes North West HHS, as the other HHSs do not record this efficiency measure.

Source: Queensland Audit Office, using activity data from hospital and health service annual reports and the Queensland Efficient Price published by Queensland Health.

Health's energy consumption

According to data published by Queensland Treasury, Queensland Health is responsible for roughly 51 per cent of the total Queensland Government greenhouse gas emissions. Figure 4F shows this has stayed consistent over the past 4 years (2020–2024), with between 91 to 93 per cent of these emissions coming from electricity over this period.

The emissions data reported does not capture all emissions from all Queensland Government agencies. We expect the accuracy and quality of reporting on emissions will improve as agencies standardise their definitions and methodologies for these calculations. Several HHSs have published sustainability and climate-related strategies. These plans have generally identified similar key themes: waste, energy, water, procurement, and transport. These HHSs have created their own strategies and some have set their own targets in advance of specific requirements being placed on them.

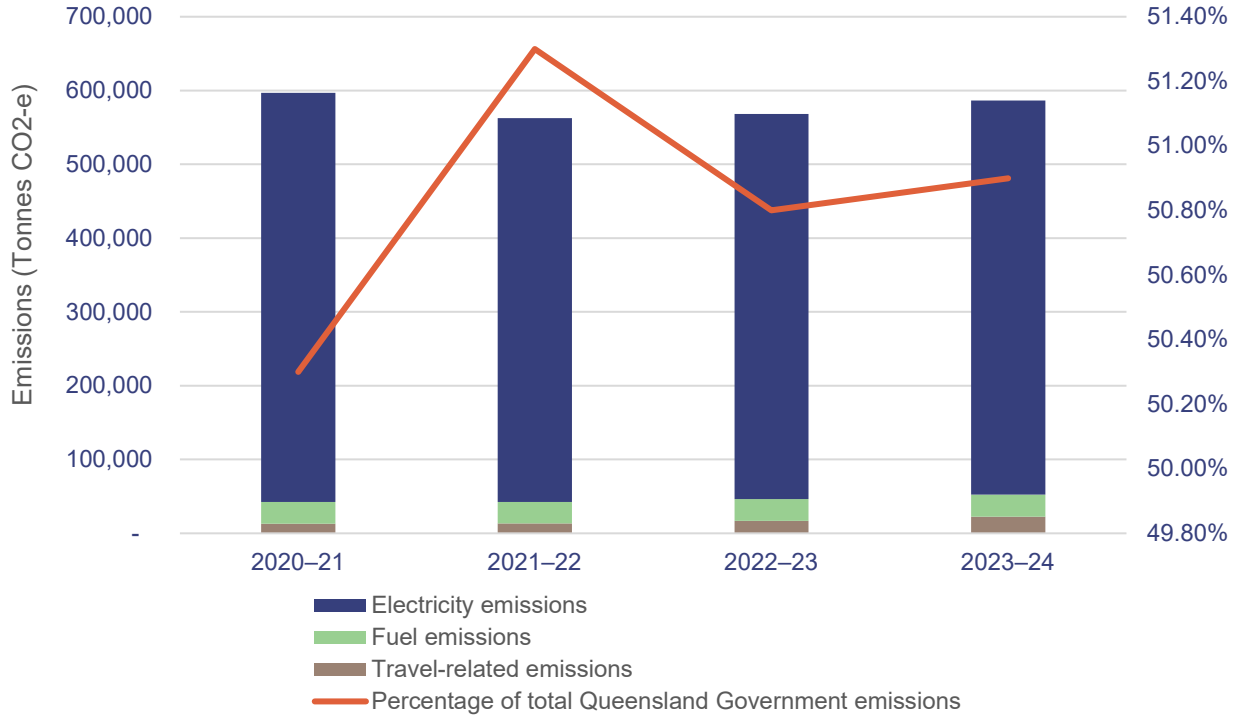
EMISSIONS DEFINITIONS

Queensland Treasury states that:

Scope 1	covers direct greenhouse gas emissions from owned or controlled sources.
Scope 2	covers indirect greenhouse gas emissions from the generation of purchased electricity, steam, heating, and cooling consumed by the reporting entity.
Scope 3	includes all other greenhouse gas emissions that occur upstream and downstream in an entity's value chain.

Reporting on Scope 2 emissions is more straightforward than Scope 1 and Scope 3 as this information can be obtained directly from the suppliers. Despite this, there are still challenges due to the high volume of suppliers providing these services in the health system. This contributes to a lack of consistency in reporting, especially where many suppliers cannot provide tailored reporting.

Figure 4F
Queensland Health-reported greenhouse gas emissions for the last 4 years



Note: Tonnes CO2-e stands for carbon dioxide equivalent, which is the standard unit to measure greenhouse gas emissions.

Source: Queensland Audit Office from the Queensland Government open data portal.

5. Asset management in health entities

Health entities need to effectively manage their assets to ensure they deliver high quality, efficient healthcare services. This includes planning for future needs by considering factors such as demand for services, and population age and growth.

To balance value for money with optimal health outcomes, health entities and Health Infrastructure Queensland (a division of the Department of Health), need to closely integrate how they manage and maintain existing assets with how they plan and construct new ones.

Chapter snapshot

A growing and ageing population is increasing the need for hospitals and health assets

Significant funding has been committed by the government for new capital infrastructure and maintenance of existing assets, which are valued at $19 billion

HHSs report:

- 28.9% increase in maintenance needs
- $2.6 billion overdue asset maintenance (89% of this is postponed capital maintenance)

Reducing backlog maintenance will continue to be challenging for HHSs over time

due to rising costs and budgetary pressures

The impact of population growth and ageing on the need for hospitals and other assets

Queensland has 20.5 per cent of Australia's total population. The state's population has been growing steadily, and in 2025, it had the third highest growth of any state or territory, with an increase of 1.75 per cent or 98,600 people (2024: 2.5 per cent growth).

Consistent with other Australian states and territories, and many countries around the world, Queensland has an ageing population. The Australian Bureau of Statistics' Quarterly Population Estimate shows that the number of Australians aged 65 years and older grew by 36 per cent from the first quarter in 2015 to the first quarter in 2025.

As at 31 March 2025, 17.5 per cent (956,000 individuals) of the Queensland population was aged 65 years and older. Projections indicate that this number could exceed 1.3 million by 2036 (a 36 per cent increase over an 11-year period). By 2071, people aged 65 years and older are projected to make up between 25 per cent and 27 per cent of the Queensland population.

This, together with the overall growth in population, will place more pressure on the healthcare system.

The health sector needs sufficient infrastructure to meet the demands of the growing and ageing population. It also needs to plan and replace or renew existing infrastructure as it reaches end of life.

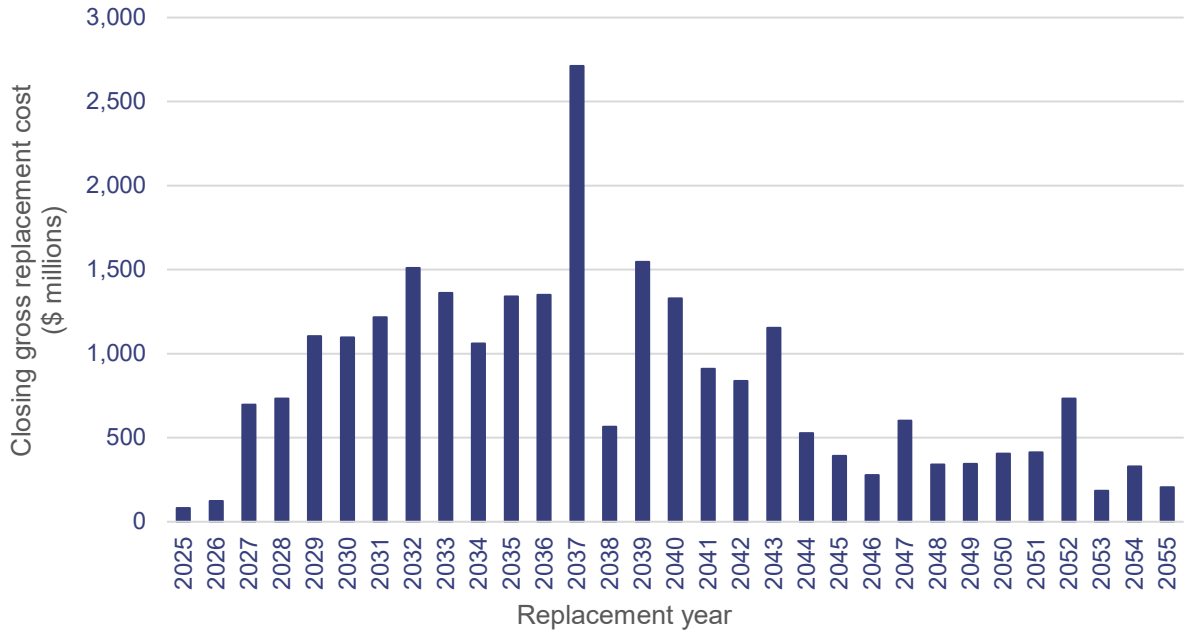
Figure 5A shows the value of assets that need to be replaced each year over the next 30 years. Approximately 39.9 per cent ($10.3 billion) of buildings currently owned by the Department of Health (the department) and the 16 hospital and health services (HHSs) are due to be replaced within the next 10 years.

This is based on their recorded remaining useful lives. 'Useful life' is the number of years an entity expects to use an asset – not the maximum period possible for the asset to exist. Within the next 12 years, more than 56 per cent of the current buildings – equivalent to $14.3 billion – will need to be replaced.

DEFINITION

Closing gross replacement cost is the estimated cost to construct a similar asset, without adjustments for the age and condition of the existing asset, as of 30 June each year.

Figure 5A
The cost of replacing health sector buildings – by asset replacement year



Source: Queensland Audit Office, from Department of Health and hospital and health service asset registers 2025.

Figure 5A shows a significant peak is expected in 2037, when $2.7 billion worth of buildings will be due for replacement.

However, as of last year, buildings are now expected to last longer. This is due to HHSs extending the useful lives of their buildings. The department anticipates that buildings will last longer than their recorded remaining useful lives currently indicate, due to planned refurbishments, redevelopments, and other capital maintenance projects (subject to suitable funding being provided). This also depends on HHSs adequately funding repairs and maintenance to prevent premature deterioration of existing assets.

The Queensland Government has increased the capital budget for the health sector

The *Queensland Budget 2025–26 – Budget Capital Statement* identifies significant investments that will be made in the health sector over the next 5 years. These are to address the pressure on ageing infrastructure caused by growing demand for healthcare services.

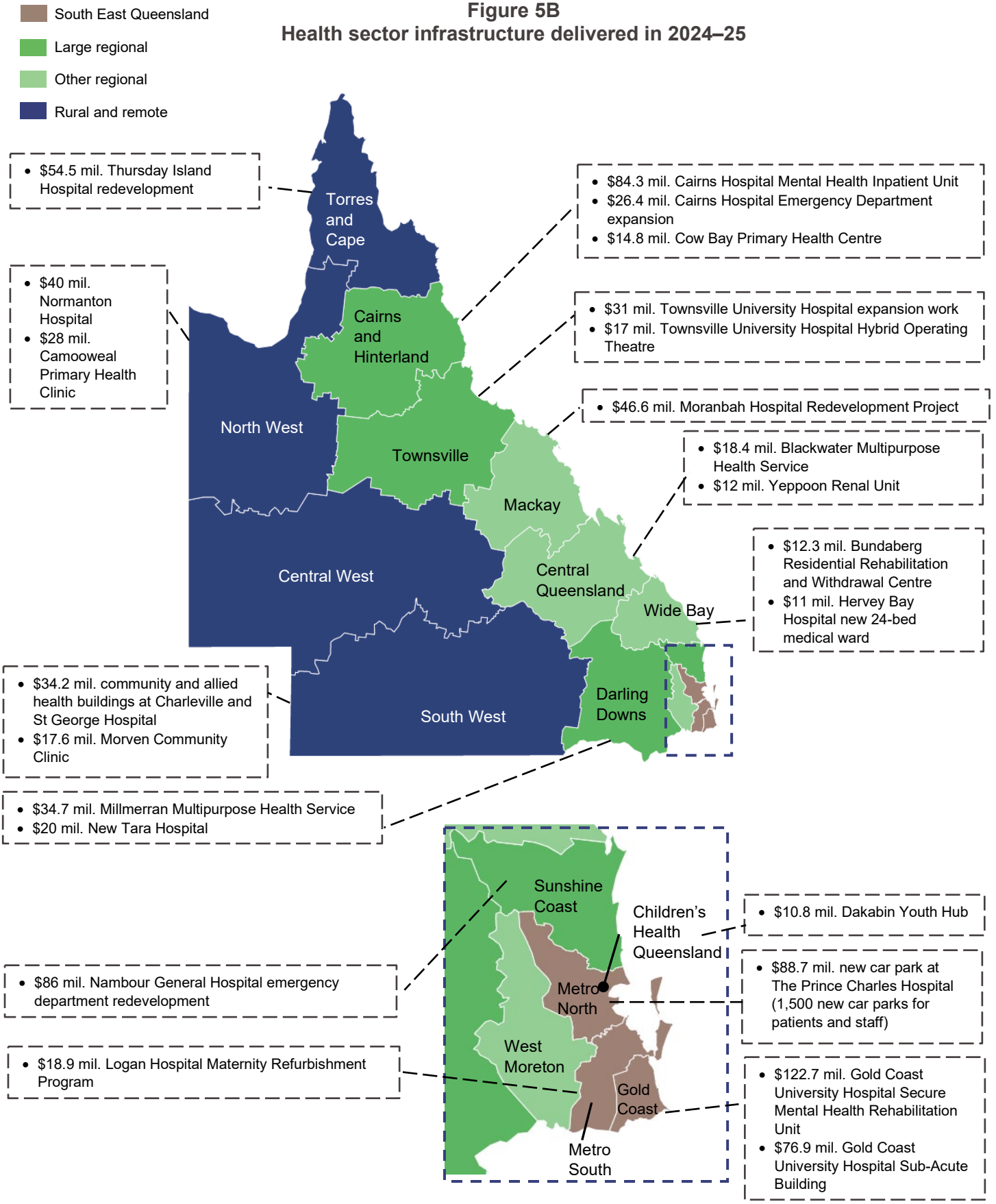
In 2025–26, the total capital investment program for the Queensland Health portfolio is $3.67 billion (2024–25: $2.17 billion), which is significant. This increase has been in response to an independent review the Queensland Government commissioned of the Queensland Health capital program.

The most significant programs outlined in the 2025–26 budget include:

- $3.159 billion over 5 years ($664.1 million in 2025–26) for the *Hospital Rescue Plan* to support the *Timely Investment Infrastructure Program*, which provides for maintenance, replacement, and refurbishment of Queensland Health's existing assets
- $1.783 billion (for 2025–26) as part of the total $16.9 billion for major hospital infrastructure. This includes works at Bundaberg, Coomera, and Toowoomba, the new Queensland Cancer Centre, a new cardiac hybrid theatre in Rockhampton to provide Central Queenslanders with enhanced cardiac services closer to home, and major hospital expansions at 10 sites across Queensland, including Brisbane, Cairns, Hervey Bay, Ipswich, Logan, Mackay, Redcliffe, and Townsville.

In 2024–25, the budgeted capital expenditure target was $2.17 billion. The health sector actually spent $2.55 billion – 17.5 per cent over the budgeted target. As shown in Figure 5B, it delivered several infrastructure projects across the state last year.

Figure 5B
Health sector infrastructure delivered in 2024–25



Note: We have only included those completed projects above $10 million.

Source: Queensland Audit Office, from the hospital and health services' annual reports and Department of Health records.

Over the past 5 years, rising costs and shortages of materials and labour have delayed the completion of major health projects. Over the next 7 years, these pressures will increase, as many major projects are rolled out across Queensland, including for the Olympic and Paralympic Games, as well as transport, energy, and water initiatives.

Effectively managing challenges such as a tight labour market, industrial disputes, and rising supply costs will be essential to delivering these projects on time and on budget, as laid out in the *Hospital Rescue Plan*.

We have reported on these competing infrastructure projects in *Major projects 2025* (Report 8: 2025–26).

Reporting on maintenance needs of assets

In the 2024–25 annual reports, HHSs reported a 28.9 per cent increase in maintenance needs (40 per cent increase in 2023–24), with a total of $2.6 billion of assets requiring maintenance. This amount includes both operational and capital maintenance that has been deferred.

Most health entities are using consistent terminology for deferred maintenance

In *Health 2024* (Report 8: 2024–25), we highlighted the lack of clarity and consistency in how HHSs reported deferred maintenance in their annual reports.

In response, during 2024–25:

- The department finalised and issued its *Asset Management Key Terms* paper. The department requested HHSs follow the guidance in the paper to ensure greater consistency in asset management reporting.
- HHSs reported their deferred maintenance using the new categories. Fifteen of the 16 HHSs reported details of deferred maintenance and postponed capital maintenance in their annual reports. One HHS only reported details of its deferred maintenance.

DEFINITION

- **Deferred maintenance** (which comes from operational expenditure – OPEX) is unfunded operational works expenditure for building-related elements/services needed in the current financial year. It is maintenance that has not yet been carried out, but is necessary to prevent the deterioration of an asset or its function. OPEX refers to the ongoing costs required for the day-to-day functioning and maintenance of assets, so they remain in good operating condition.
- **Postponed capital maintenance** (CAPEX) is unfunded capital works expenditure for building-related elements/services needed in the current financial year. It is defined as capital works that are required to bring the condition of building assets to a required standard to meet service delivery needs. CAPEX involves investments that either extend the lifespan of an asset or replace significant components of it, such as major parts of machinery or infrastructure.
- **Forecast life cycle replacement, renewals, and refurbishments** are unfunded capital works identified for future years. They are required to maintain assets over their life, and include refurbishment, extensions, and new assets to deliver healthcare services. (They include work required to change the use of assets.)

Source: Queensland Audit Office, adapted from Department of Health Asset Management Key Terms paper – 9 May 2025.

This improved consistency of reporting by HHSs in their 2024–25 annual reports. Most HHSs are now applying the department's revised asset management terminology and acting on its guidance. Of the 16 HHSs, 12 referred to 'deferred maintenance' (up from 9 in 2024), while 4 used the term 'anticipated maintenance' (down from 7 in 2024) when describing 'deferred maintenance'.

'Anticipated maintenance' is a legacy term. Its continued use by some HHSs suggest they need more communication and guidance.

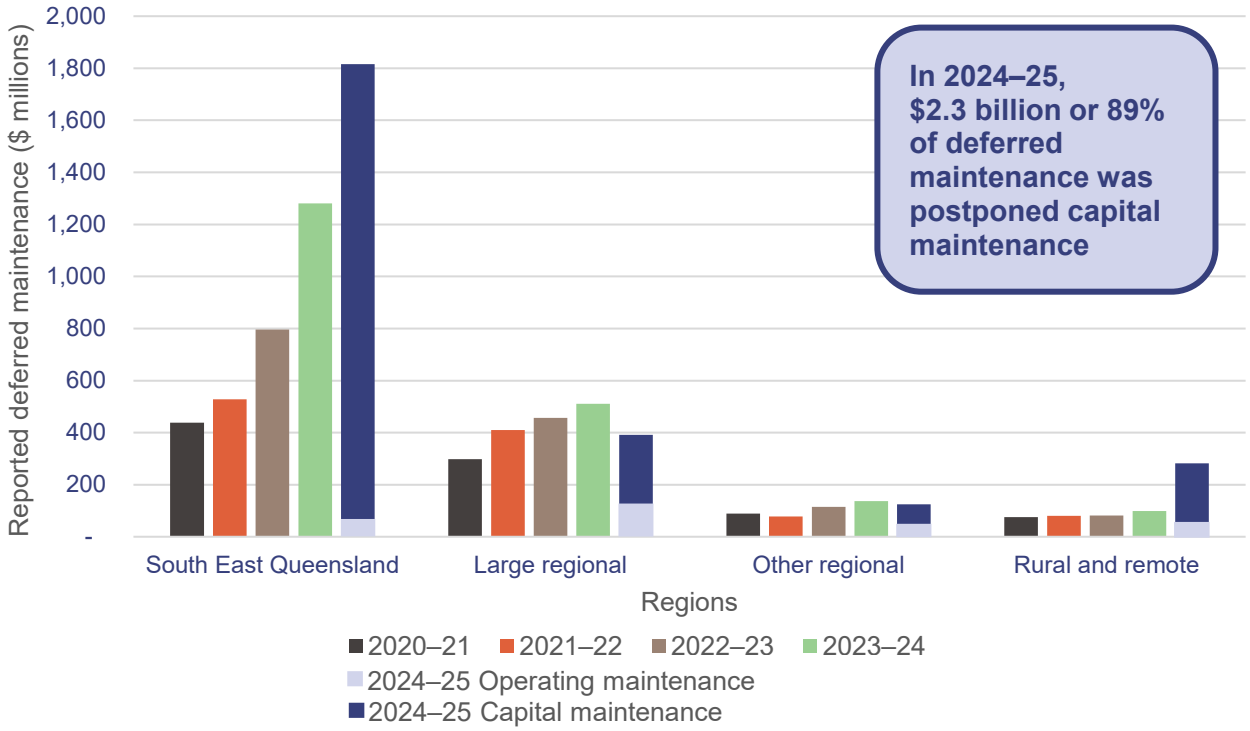
Maintenance needs are growing

As at 30 June 2025, the total cost of reported maintenance required across all HHSs was $2.6 billion – an increase of $587 million (29 per cent) from 2024. This increase has mainly been driven by a $495 million increase across 2 HHSs in the South East Queensland region.

For the first time, in 2024–25, HHSs have reported separate figures for deferred maintenance and postponed capital maintenance in their annual reports.

Figure 5C shows the growth in the amounts reported for maintenance needs over the last 5 financial years for each HHS region. As 2024–25 was the first year HHSs reported maintenance by the deferred maintenance and postponed capital maintenance categories, we can only provide these individual figures for last year, not the previous 4.

Figure 5C
Growth in reported maintenance requirements as at 30 June – by region



Source: Queensland Audit Office, from the hospital and health services' annual reports.

Capital maintenance has historically been underfunded. The annual base funding for capital maintenance was set in 2010 and remained largely unchanged despite a 284 per cent (to 2024) growth in the Queensland Health asset base. In the 2025–26 budget, $671.9 million has been allocated compared to $215 million last year, to help address these needs and balance the shortfall.

The level of deferred maintenance, which HHSs are responsible for managing and funding through their annual budgets, remains relatively small compared to the volume of postponed capital maintenance funded by the department. However, reducing deferred maintenance will continue to be challenging for HHSs over time, particularly given rising costs, the pressure to achieve a balanced budget, and the increasing number of HHSs that reported operating deficits in 2025.

The department has reviewed the required maintenance reported by HHSs and identified that the significant increase seen across the HHSs is due to 3 main factors:

- stricter evaluations of asset conditions, leading to the identification of additional maintenance needs that were already present
- increased cost of undertaking maintenance. Market conditions, including shortages of materials and labour, are placing significant pressure on costs, and causing difficulties in accurately forecasting costs
- inconsistency in the methodology employed by HHSs for asset condition assessments.

Queensland Health sets maintenance targets

HHSs have an annual expenditure target for maintaining their assets. Queensland Health has determined that this needs to be 2.81 per cent of the replacement value of those assets.

This maintenance expenditure target is made up of:

- a 1.56 per cent capital maintenance component, which is funded by the department following planning and applications by HHSs. This does not include building replacements or major refurbishments
- a 1.25 per cent operating repairs and maintenance component, which is funded by the HHSs.

Queensland Health is in the process of developing a methodology to measure the 1.25 per cent operating target of repairs and maintenance expenditure as a percentage of gross replacement costs for HHSs. The methodology includes not only repairs and maintenance expenses relating to buildings and land improvements, but also the costs incurred for trades and artisans, to reflect the true cost of maintaining buildings.

The department has engaged with the HHSs to ensure the methodology is complete and captures all repairs and maintenance costs associated with buildings. Through this process, it has identified that some HHSs are classifying certain building, engineering, and maintenance administration costs inconsistently. As a result, it is currently unable to accurately determine whether HHSs are meeting their asset maintenance targets.

The Department and HHSs should work together to finalise their methodology to accurately measure and report on whether HHSs are meeting their repairs and maintenance targets

Building, engineering, and maintenance administration costs should be classified consistently across the HHSs' financial systems, to make it easier to monitor and measure them.

Asset maintenance affects service delivery

Through our audits, and our engagement with various HHS stakeholders, we have identified several instances where assets have failed due to increasing delayed maintenance issues. We present these examples in Figure 5D to illustrate the consequences of not adequately addressing deferred maintenance. These examples do not indicate these issues are pervasive across the health system.

Figure 5D
Examples of hospital and health service assets that have failed due to delayed maintenance

Issue	Impact on health services
In September 2025, the boilers at a major South East Queensland hospital failed. This meant there was no steam for the sterilisation equipment, and the sterilisation process had to stop for 3 hours while it was rectified.	This resulted in operating theatres having to be temporarily shut down.

Issue	Impact on health services
Electrical equipment at a major South East Queensland hospital was flagged as being at very high risk of failing and needing to be replaced. Replacement parts could no longer be sourced, as parts were no longer being manufactured. The HHS had to source replacement parts from an electrician who was storing this old stock in his garage.	There was a serious risk of a power system failure if parts were not obtained.
Rust was found on large pendant lights throughout the intensive care unit of a major regional hospital.	Corrosion on electrical equipment and lighting could affect the safe delivery of patient services by increasing the likelihood of equipment failure or short circuits that may cause power outages.
The Queensland Tissue Bank was at risk of closing due to an imminent failure of critical facility infrastructure.	This could result in the service being unavailable locally and tissue having to be stored and distributed from other tissue bank locations. There is a risk that human tissue donated by Queenslanders for transplants may become unviable if the building is not adequately maintained.
Reverse osmosis (water purification) outages and plumbing issues at a hospital affected the ability to supply clean water to renal and pathology services.	This resulted in the hospital being unable to provide dialysis services, requiring patients to travel to other hospitals to receive care. This issue has been ongoing for 6 months and remains unresolved.

Source: Queensland Audit Office, from HHS risk registers, and review of audit and risk committee meeting minutes.

We note that action on recommendations relating to the maintenance needs of assets is likely to remain ongoing, as budgets and maintenance requirements will continue to change over time. This will continue to be an area that HHSs must actively monitor and manage to ensure assets are appropriately maintained.

All health entities should continue to address recommendations relating to maintenance needs including:

- Recommendation 5 from our *Health 2020* (Report 12: 2020–21) report, which was to prioritise high-risk maintenance (see Appendix E in this report)
- Recommendation 2 from our *Health 2023* (Report 6: 2023–24) report, which was to standardise the process for assessing deferred maintenance to ensure reliability in reporting and strategic asset management planning (see Appendix E in this report).

6. Demand for health services

Demand for health services in Queensland continues to increase, because of a growing and ageing population and a shortage of general practitioners.

This impacts on emergency departments and ambulances, even with the services provided by the satellite health centres built in recent years. It also contributes to delays in patients seeing specialists within the recommended times.

Chapter snapshot

Number of emergency department presentations is steady compared to 2023–24.

The 5-year trend shows demand is still increasing in some regions

50% of patients are not treated and discharged within the 4-hour target

2023–24: 52.1%

The target for Queensland Health is no lower than 80%

Ambulance ramping is decreasing slightly, but is still a challenge in metropolitan areas

41% of patients waited longer than 30 minutes to be transferred from paramedics' care to the emergency department

2023–24: 44%

Ambulance response times for Code 1 (emergency) incidents are better than in other jurisdictions, but still below Queensland's state target

Long waits for specialist outpatient services continues to increase

116,985 on long wait list as at 1 July 2025

77% of category 1 outpatients (most urgent) were seen within the clinically recommended time

The target for Queensland Health is no lower than 83%

Managing demand

Satellite health centres assisted 184,000 patients, more than last year as more centres opened, and most centres were in full operation in 2024–25.

Ambulance services assisted 47,000 patients through Virtual Emergency Care (▲ 24% compared to 2023–24)

Notes: For all items except the section on managing demand, the figures are reported for Queensland's top 26 reporting hospitals (see Appendix J). Ambulance ramping data includes priority codes 1 and 2 (emergency and urgent cases).

Long waits are when a patient has waited longer – by one day or more – than the clinically recommended time for a specialist appointment.

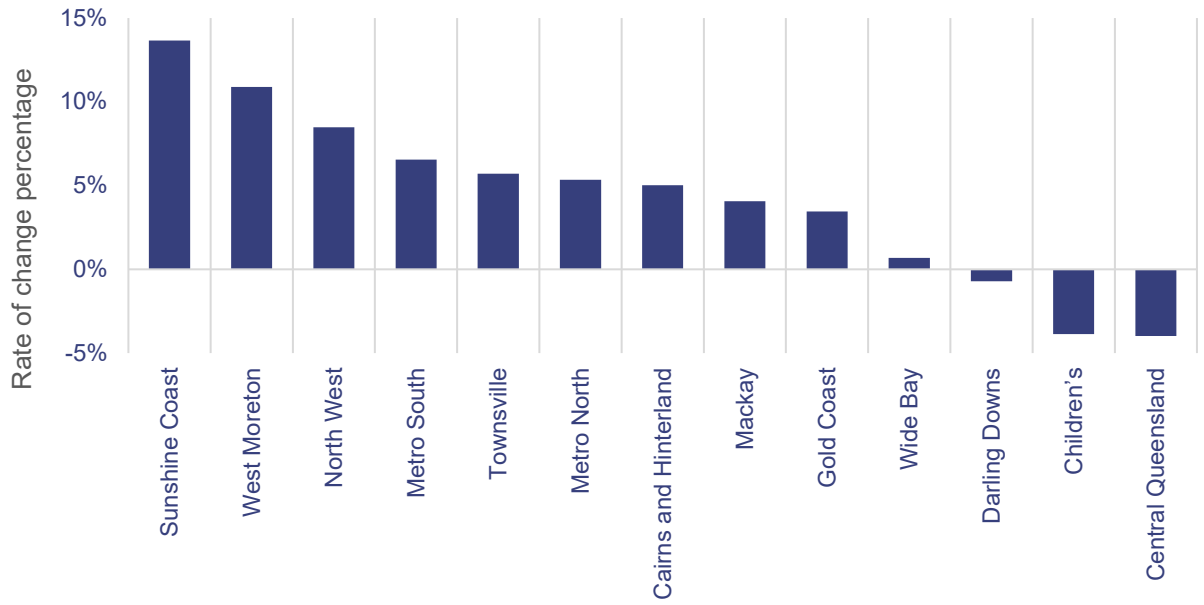
Virtual Emergency Care is where a patient called 000 and emergency medical dispatchers have assessed alternative pathways that do not require an ambulance vehicle dispatch.

Emergency department presentations

Demand for emergency department services since 2020–21 has increased by 4.5 per cent. Figure 6A shows the change in emergency presentations by hospital and health service (HHS).

The areas that have experienced the largest increase in demand since 2020–21 are Sunshine Coast HHS (13.65 per cent), followed by West Moreton HHS (10.9 per cent) and North West HHS (8.48 per cent).

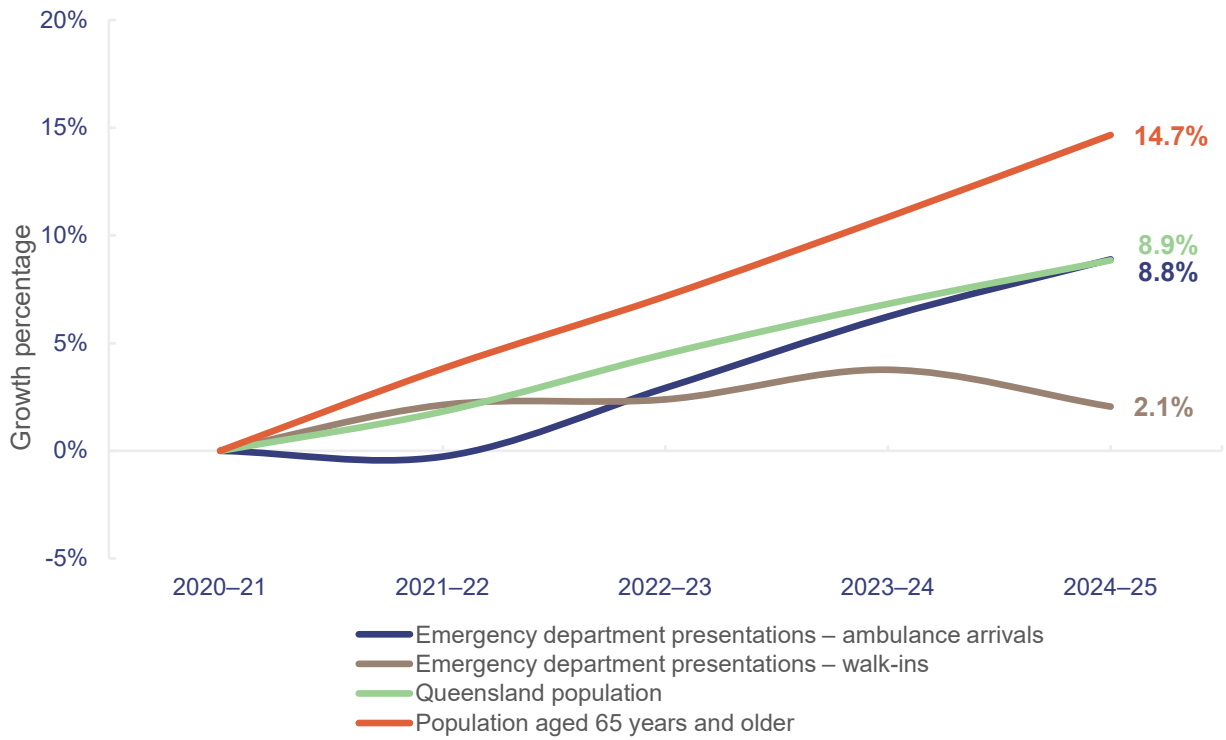
Figure 6A
Change in emergency department presentations by hospital and health service from 2020–21 to 2024–25



Source: Emergency department presentations: Queensland Audit Office, from Queensland Health – System Performance Branch – for the top 26 reporting hospitals.

Figure 6B shows the cumulative growth in emergency department presentations by mode of arrival (ambulance and walk-ins) since 2020–21. It also shows Queensland's population growth and ageing population over the same period.

Figure 6B
Cumulative growth in emergency department presentations compared to Queensland's population growth and growth in population aged 65 years and older from 2020–21 to 2024–25



Source: Emergency department presentations: Queensland Audit Office, from Queensland Health – System Performance Branch – for the top 26 reporting hospitals. Queensland population: quarterly Australian Bureau of Statistics population data (latest available data as of March 2025). Ageing population: Queensland Audit Office, based on data from Queensland Government Statistician's Office and Report of the Health Officer Queensland, March 2025.

Overall, patients arriving at emergency departments by ambulance are increasing on par with Queensland's population growth and increasing at a faster rate than walk-in arrivals. Demand for emergency services is driven by the increase in population – especially the increase in people aged 65 years and over, which has increased by 14.7 per cent since 2020–21.

According to the 2021 census, around 32 per cent of Queenslanders, and around 63 per cent of Queenslanders aged 65 years and over, have one or more long-term health conditions. This contributes to an increase in more complex cases requiring emergency and ambulance services.

Emergency department presentations have steadied in the last year

Overall demand for emergency department services in 2024–25 remained steady. In 2024–25, the number of presentations at emergency departments was 1,767,000, a decrease of 0.2 per cent. Walk-in arrivals decreased by 1.6 per cent and ambulance arrivals increased by 2.5 per cent.

Some of the contributing factors to the steady number of presentations at emergency departments are:

- the completion of the satellite health centre program, which commenced in 2023
- the expansion of virtual care services such as the first state Virtual Emergency Care Service, which started in July 2024.

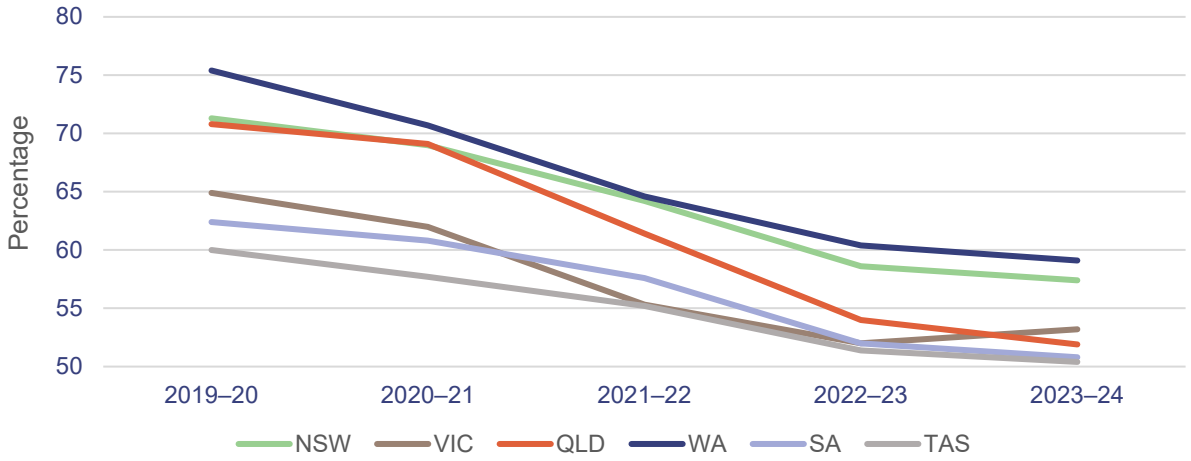
These initiatives aim to reduce the pressure associated with emergencies by offering alternative care pathways to patients who may not require assessment or admission at an emergency department.

50 per cent of patients are not treated and discharged within the 4-hour target

In 2024–25, the top 26 reporting hospitals in Queensland treated and discharged 882,000 patients at their emergency departments within 4 hours or less. The target is 80 per cent of presentations within 4 hours or less. Queensland achieved 49.9 per cent this year, which is 2 percentage points worse than last year. Queensland's performance is similar to that of other states.

In most Australian states, more patients are staying longer in emergency departments and fewer emergency department visits are completed in 4 hours or less. In 2023–24, Queensland ranked sixth across all states and territories in Australia and fourth across all states in Australia. At 51.9 per cent, it was behind Western Australia (59.1 per cent), New South Wales (57.4 per cent), and Victoria (53.2 per cent), as shown in Figure 6C.

Figure 6C
Percentage of presentations to emergency departments with a length of stay of 4 hours or less, by state



Notes: The target for emergency length of stay of 4 hours or less ranges between 75 to 90 per cent across the states. The target for Queensland is 80 per cent.
TAS – Tasmania; VIC – Victoria; SA – South Australia; QLD – Queensland; NSW – New South Wales; WA – Western Australia.
Data is for all hospitals across the states. The latest available information is up to the 2023–24 financial year.

Source: Queensland Audit Office, from Australian Institute of Health and Welfare, My Hospitals data.

Satellite health centres are having an impact

In February 2025, Queensland Health renamed the satellite hospitals to 'satellite health centres' to reduce public confusion about the facilities' purpose. This change reflects feedback from frontline clinicians and primary care providers, to better represent the services these facilities offer – urgent care for illnesses and injuries not expected to be life-threatening in nature. This aims to reduce category 4 and 5 presentations at emergency departments in major hospitals. However, due to unmet demand at general practitioners and community-based health services, satellite health centres may not always drive a direct reduction of patients at nearby hospitals.

EMERGENCY DEPARTMENT TRIAGE CATEGORIES

When patients present to an emergency department, they are assessed and triaged according to the following categories of urgency:

Category 1 – immediately life-threatening – for example, a patient requires resuscitation, heart attack.

Category 2 – imminently life-threating – for example, chest pain; difficulty breathing; potential stroke.

Category 3 – potentially life-threating – for example, severe illness; wounds.

Category 4 – potentially serious – for example, sprains; fractures; broken bones.

Category 5 – less urgent – for example, minor illnesses – coughs; colds; rashes.

Source: Australasian Triage Scale.

Queensland Health opened 7 satellite health centres in the last 2 years. Figure 6D shows the opening dates and the nearby hospitals.

There were 183,505 presentations at satellite health centres in 2024–25 compared to 90,740 in 2023–24. The increase is mainly due to an increase in capacity over time, as shown in Figures 6D and 6E.

Figure 6D
Opening dates of satellite health centres and nearby public hospitals

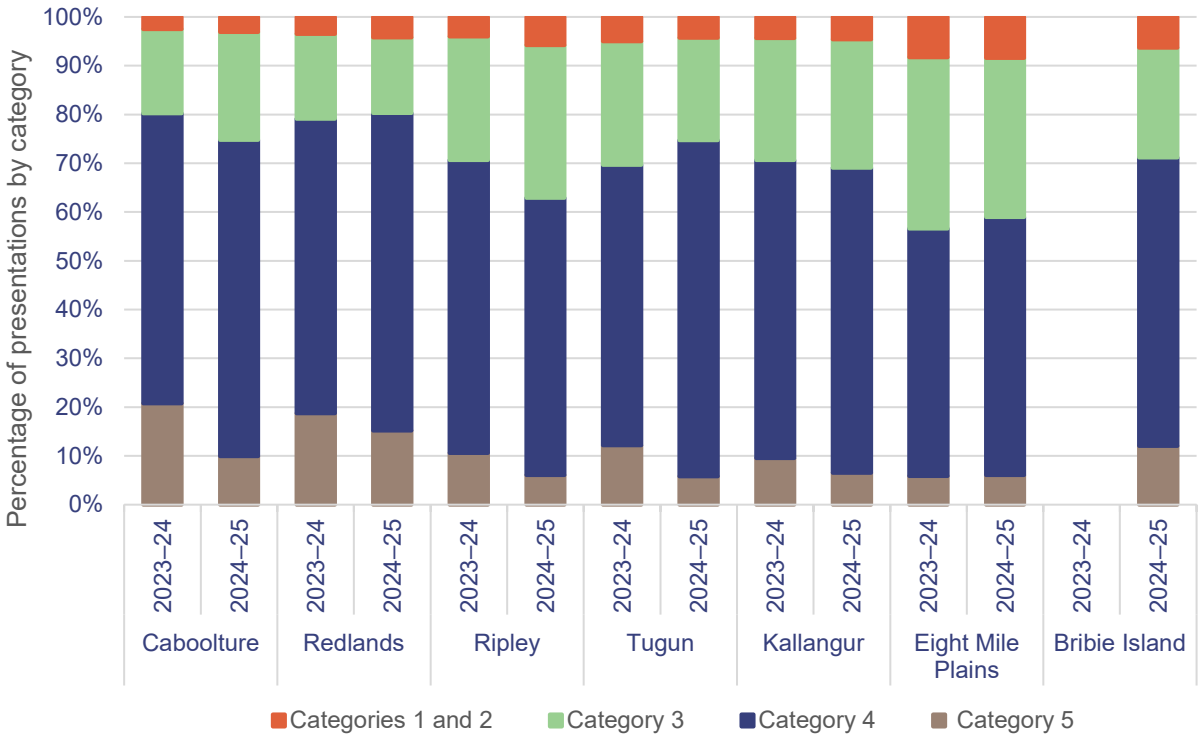
Satellite health centre	Opening date	Nearby hospitals*
Caboolture	3 August 2023	Caboolture Hospital
Redlands	28 August 2023	Redland Hospital
Ripley	30 August 2023	Ipswich Hospital
Tugun	15 November 2023	Robina Hospital
Kallangur	11 December 2023	Redcliffe and The Prince Charles hospitals
Eight Mile Plains	27 May 2024	Logan and Princess Alexandra hospitals
Bribie Island	17 July 2024	Caboolture Hospital

Note: *Only Queensland public hospitals are listed.

Source: Queensland Audit Office, from Queensland Health – System Performance Branch.

As shown in Figure 6E, satellite health centres mainly treated category 3 and 4 triage categories in 2023–24 and 2024–25.

Figure 6E
Percentage of presentations by satellite health centres and category, in 2023–24 and 2024–25



Source: Queensland Audit Office, from Queensland Health – System Performance Branch

As the announcement of the change in name came into effect in February 2025, it is expected that the number of patients in categories 1 and 2 will decrease in 2025–26 and onwards.

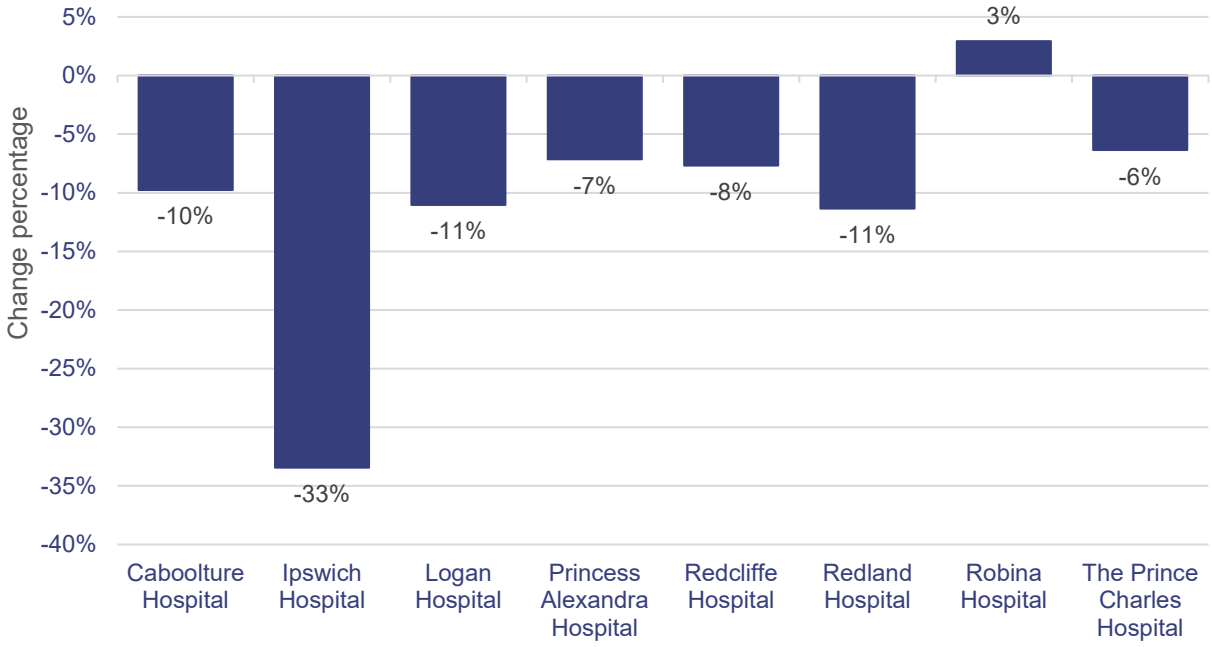
Figure 6F shows how non-urgent presentations at emergency departments close to satellite hospitals have changed since 2022–23. The Ipswich Hospital emergency department has seen the greatest reduction (33 per cent) in non-urgent (category 4 and 5) presentations, followed by Logan Hospital and Redland Hospital at 11 per cent. Robina Hospital emergency department has shown a 3 per cent increase in non-urgent (category 4 and 5) presentations.

A range of factors influence the number of presentations at satellite health centres and whether this is reducing the number of presentations at hospital emergency departments. Some of these factors include:

- overall demand growth in a region
- whether there was previously unmet demand that is now being met by a satellite health centre
- demand for services after hours
- transport and accessibility options
- services available in an area
- patient awareness and behaviour.

Health Infrastructure Queensland is conducting an evaluation to determine the impact of satellite health centres on hospital demand.

Figure 6F
Changes in category 4 and 5 presentations at nearby emergency departments from 2022–23 to 2024–25



Source: Queensland Audit Office, from Queensland Health – System Performance Branch.

Ambulance services

Delays in hospitals have a flow-on effect on ambulances. In this section, we provide an updated analysis of the demand for ambulance services, and on Queensland Health's and Queensland Ambulance Service's performance against:

- ambulance ramping, which measures the percentage of patients transferred to the care of an emergency department beyond 30 minutes
- response times (the time from when a call to 000 is answered to when an ambulance arrives at the scene of an emergency).

Demand for ambulance services keeps increasing

The overall demand for ambulances (excluding virtual models of care) has increased by 3.2 per cent since last year and 10.5 per cent since 2020–21.

Since 2020–21:

- Code 1 incidents (emergency) have increased by 48.4 per cent.
- Code 2 incidents (urgent) have decreased by 22.4 per cent.

The number of ambulance incidents (codes 1 and 2) reported under the mental health category has also increased by 40 per cent over the last 5 years, from about 58,000 incidents in 2020–21 to about 82,000 in 2024–25.

A contributing factor to the decrease in code 2 incidents is the use of the Virtual Emergency Care Service, with 47,007 patients assessed and treated in 2024–25.

Comparison with other states

Queensland continues to be the Australian state with the highest number of ambulance incidents per 1,000 population.

A likely reason for this is that the Queensland Ambulance Service is publicly funded. New South Wales has adopted a user-pays model, while Victoria, South Australia, and Western Australia use subscriber models.

Figure 6G shows the number of ambulance incidents by state from 2019–20 to 2023–24.

Figure 6G
Ambulance service demand, by state, per 1,000 population

Notes: Data is for all hospitals across the states. The latest available information is up to the 2023–24 financial year. Population rates are derived using the 31 December estimated resident population for the relevant financial year.

Source: Queensland Audit Office, from Productivity Commission, Report on Government Services 2025, Part E Section 11 Ambulance services.

Ambulance ramping continues to be an ongoing challenge

The Queensland Government's goal is to reduce ambulance ramping to below 30 per cent by 2028. In 2025–26, Queensland Health introduced specific ambulance ramping targets in its service agreements with HHSs. Each top 26 reporting hospital is expected to contribute to a collective statewide ramping reduction of 3 percentage points by the end of 2025–26.

In 2024–25, 41 per cent of patients were ramped for longer than the recommended time frame in the top 26 reporting hospitals. Overall, ambulance ramping has shown an improvement of 3 percentage points compared to last year. However, ramping continues to be an ongoing challenge in some areas, as demand for emergency services continues to increase.

DEFINITION

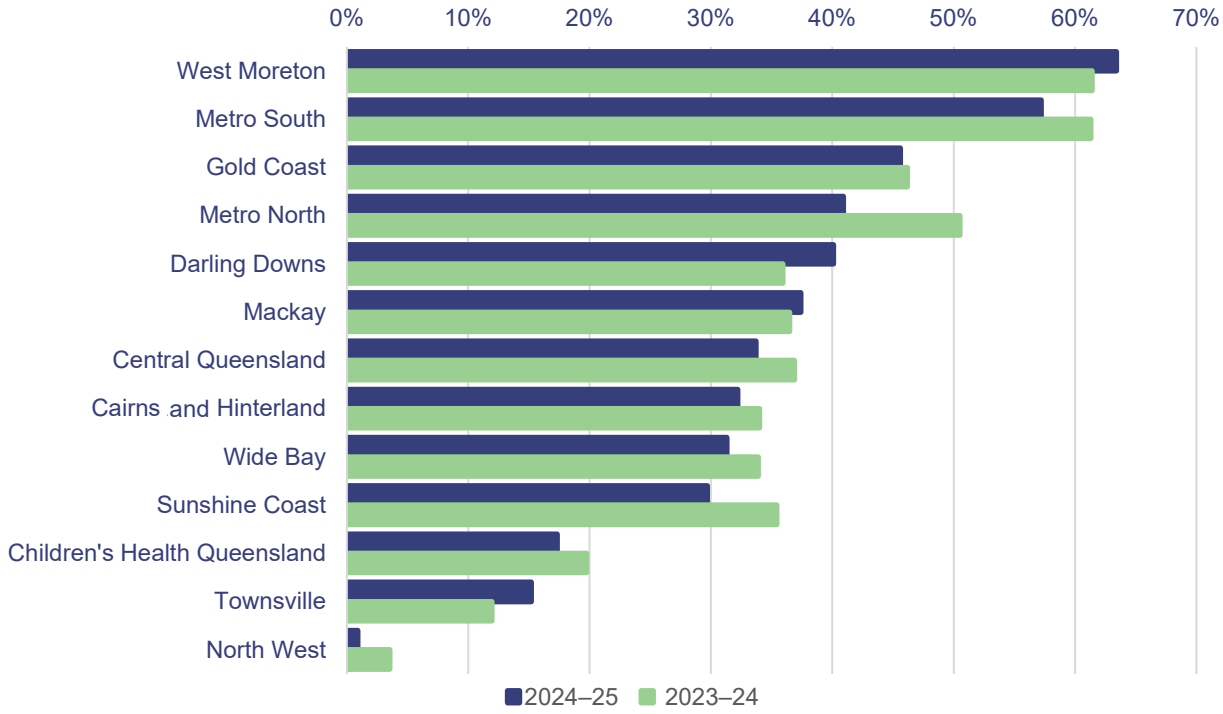
Ramping: When an emergency department is at capacity, ambulance paramedics are unable to transfer patients to emergency department nurses and clinicians in a timely manner. This delay is referred to as ambulance ramping or patient off-stretcher time delay.

For Queensland public hospitals, ramping is measured when patient off-stretcher time is not within 30 minutes of an ambulance arriving at the hospital.

Patient-off stretcher time (POST): This is the time between presentation of a patient by ambulance services to an emergency department triage point and the transfer of the patient to an emergency department bed.

Figure 6H shows the ramping rates per HHS in 2023–24 and 2024–25. The HHSs with the biggest ambulance ramping in 2024–25 were West Moreton, Metro South, Gold Coast, and Metro North. West Moreton experienced a 2 percentage point increase in ramping from 2023–24 to 2024–25, while the others experienced a slight improvement in ambulance ramping.

Figure 6H
Ambulance ramping in hospital and health services in 2023–24 and 2024–25



Source: Queensland Audit Office, from Queensland Health – System Performance Branch for the top 26 reporting hospitals.

Ramping means that paramedics are unable to respond to subsequent ambulance callouts while they wait for patients' care to be formally transferred to emergency departments. Faster off-stretcher times ensure ambulances are available to respond to those patients waiting in the community.

Ambulance ramping is linked to the:

- number and complexity of patients presenting for treatment (both walk-ins and ambulance presentations)
- limited availability of specialists to attend patients in emergency departments
- availability of ward beds to receive patients transferred from emergency departments
- inefficiency of hospital discharge processes in freeing up hospital beds, and the increase of patients who remain in hospital beds despite being clinically ready for discharge.

The average length of stay of patients admitted to hospital at the top 26 reporting hospitals increased by 4 per cent in 2024–25 compared to 2023–24, going from 2.6 days to 2.7 days. Mackay HHS and West Moreton HHS showed the largest increases, with 26 per cent and 12 per cent respectively.

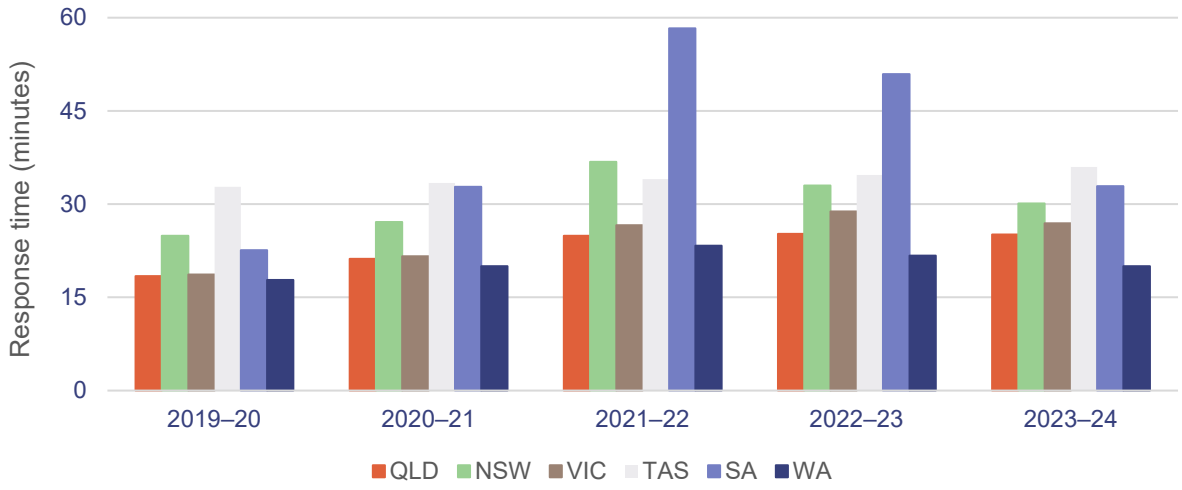
In terms of the average length of stay for patients over 65 years old, West Moreton HHS and Darling Downs HHS showed the largest increases, with 17 per cent and 13 per cent respectively. This puts pressure on ambulance ramping when it takes longer to discharge patients from the hospital to free up hospital beds. This can occur, for example, when a patient cannot be discharged due to unavailable beds in an aged care facility.

The Queensland Ambulance Service achieves some of the best response times in the country, but does not meet all its performance targets

Comparison with other states

As noted earlier, the Queensland Ambulance Service continues to achieve better response times for emergency cases (code 1) than most other jurisdictions, as shown in Figure 6I. This is despite having the highest number of responses in Australia in proportion to population, and a 48.4 per cent growth in code 1 incidents over the last 5 years.

Figure 6I
Ambulance service response times (minutes) for code 1, by state, 90th percentile*



Notes: The latest available data is up to the 2023–24 financial year. *The 90th percentile refers to the time in which 90 per cent of emergency incidents are responded to.

Source: Queensland Audit Office, from Productivity Commission, Report on Government Services 2025, Part E Section 11 Ambulance services.

Ambulance response times measure how long it takes from when a 000 call is answered to when an ambulance arrives at the scene.

Performance targets for response times are measured in minutes for code 1 emergencies, for the:

- 50th percentile – the Queensland Ambulance Service expects that 50 per cent of ambulances respond to emergency incidents (code 1) in less than 8.2 minutes
- 90th percentile – the Queensland Ambulance Service expects that 90 per cent of ambulances respond to emergency incidents (code 1) in less than 16.5 minutes.

Code 1 response times

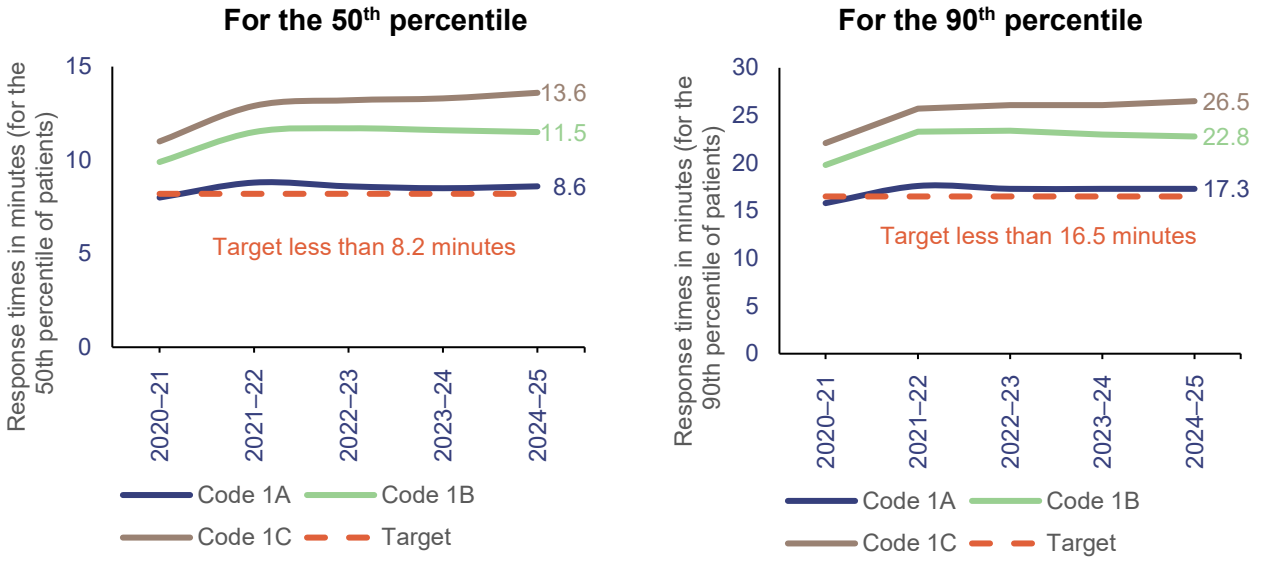
Code 1 incidents are potentially life-threatening events that require the use of ambulance lights and sirens. Code 1A is ‘actual time critical’, code 1B is ‘emergent time critical’, and code 1C is ‘potential time critical’.

There were 628,276 code 1 incidents in 2024–25 (62.44 per cent of total code 1 and 2 incidents).

The Queensland Ambulance Service has not met its response time targets for priority code 1A since 2020–21 and has not met its response time targets for code 1B and 1C incidents since at least 2017–18, when we started tracking this measure.

Figure 6J shows ambulance response times for code 1 from 2020–21 to 2024–25.

Figure 6J
Queensland ambulance response times from 2020–21 to 2024–25 for code 1 incidents



Source: Queensland Audit Office, from data received from the Queensland Ambulance Service reporting system.

Code 2 response times

Code 2 incidents may require a fast response, but do not require lights and sirens. Code 2A incidents require an urgent response but are not critical.

There were 377,931 code 2 incidents in 2024–25 (37.6 per cent of total code 1 and 2 incidents). Response times for code 2A incidents (28 per cent of total code 1 and 2 incidents) slightly increased from 61.1 minutes in 2023–24 to 61.7 minutes in 2024–25 – for the 90th percentile.

The Queensland Ambulance Service has not set performance targets for code 2 incidents. This is because its focus is on ensuring it is responding to the most urgent cases.

Specialist outpatient services

We audited specialist outpatient services in *Improving access to specialist outpatient services* (Report 8: 2021–22). In this section, we update key graphs from that report, and from *Health 2024* (Report 8: 2024–25), using data provided by the Department of Health.

Outpatients are not seeing specialists within the target time measures

DEFINITION

Seen-within time measures whether patients attend their first appointment within clinically recommended times.

A **long wait** is when a patient has waited longer – by one day or more – than the clinically recommended time for a specialist appointment.

Figure 6K shows the 3 urgency categories for specialist outpatient services and the clinically recommended times within which patients should be seen. It also shows the target for the percentage of patients seen-within time, as per Queensland Health's service delivery statement and service level agreements.

Since 2020–21, service delivery statements have only had a target for category 1 specialist outpatients' seen-within time. However, the department's service agreements with the HHSs include targets for all 3 categories.

Figure 6K
Urgency category definitions and targets for 2024–25

Urgency category	Appointment required within	Target seen-within time (service delivery statement)	Target seen-within time (service agreements)
Category 1	30 calendar days	83%	90%
Category 2	90 calendar days	-	85%
Category 3	365 calendar days	-	85%

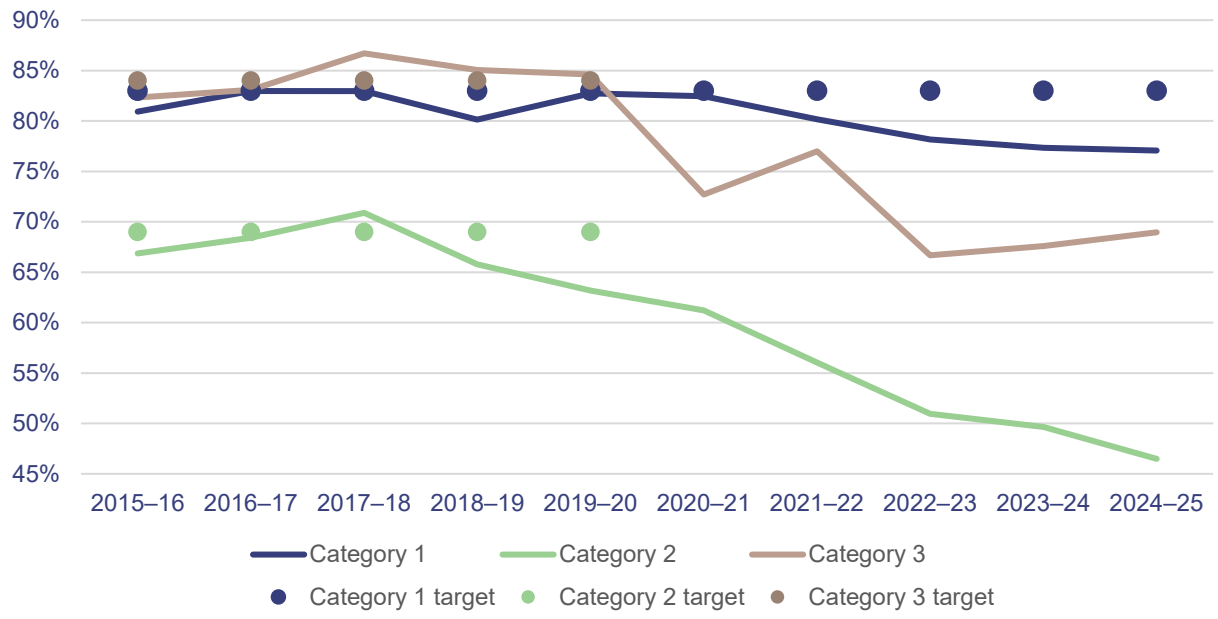
Source: Queensland Audit Office, from Specialist Outpatient Services Implementation Standard and Queensland Health service delivery statements and service level agreements.

Figure 6L shows the percentage of outpatients seen by a specialist within clinically recommended times for each category. For patients in category 1, Queensland Health has not met the targets from 2021–22 to 2024–25. However, the percentage of patients seen-within time remained steady from 2023–24 to 2024–25.

For patients in category 2, 2024–25 shows the lowest percentage of patients seen in time in the last 9 years, from 50 per cent in 2023–24 to 46 per cent in 2024–25.

There was a slight improvement in category 3, from 68 per cent in 2023–24 to 69 per cent in 2024–25.

Figure 6L
Percentage of outpatients seen within time targets

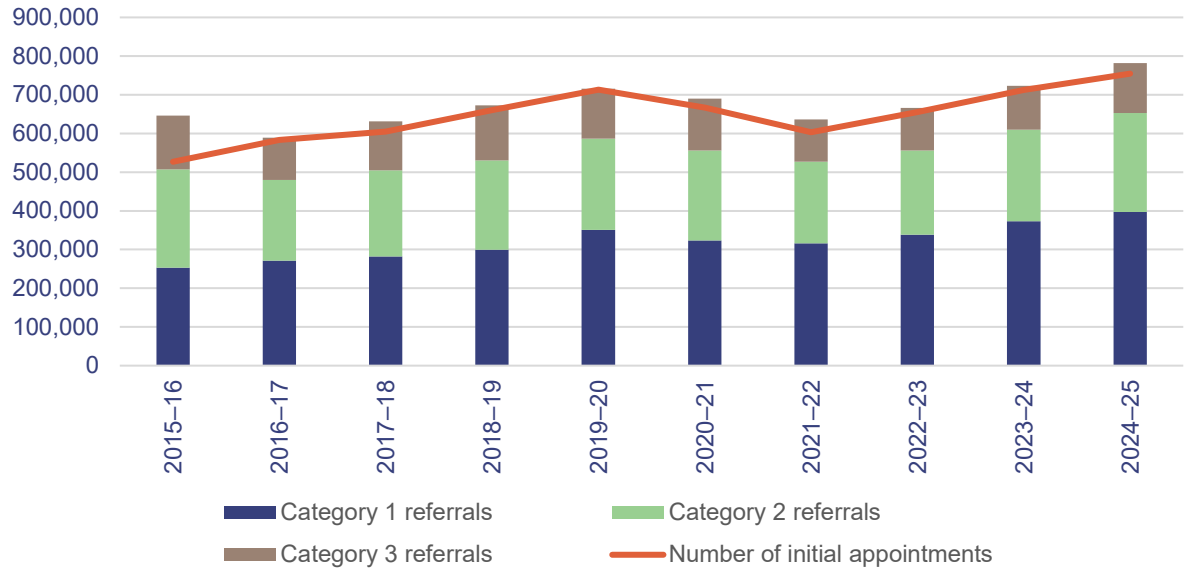


Notes: The target is per service delivery statements. Data is for Queensland's top 26 reporting hospitals at each reporting year and the specialist outpatient services within reporting scope applicable to each year. Caloundra Hospital was a reporting hospital until 2016–17 and is included in this graph until 2017–18.

Source: Queensland Audit Office, from Queensland Health specialist outpatient data collection.

There has been a 5.9 per cent increase in the number of initial outpatient specialist appointments delivered and an 8.1 per cent increase in the number of specialist outpatient referrals, which may be impacting HHSs' ability to meet their targets (see Figure 6M).

Figure 6M
Specialist outpatient referrals and initial appointments delivered



Note: Data is for Queensland's top 26 reporting hospitals at each reporting year and the specialist outpatient services within reporting scope applicable to each year. Caloundra Hospital was a reporting hospital until 2016–17 and is included in this graph until 2017–18.

Source: Queensland Audit Office, from Queensland Health specialist outpatient data collection.

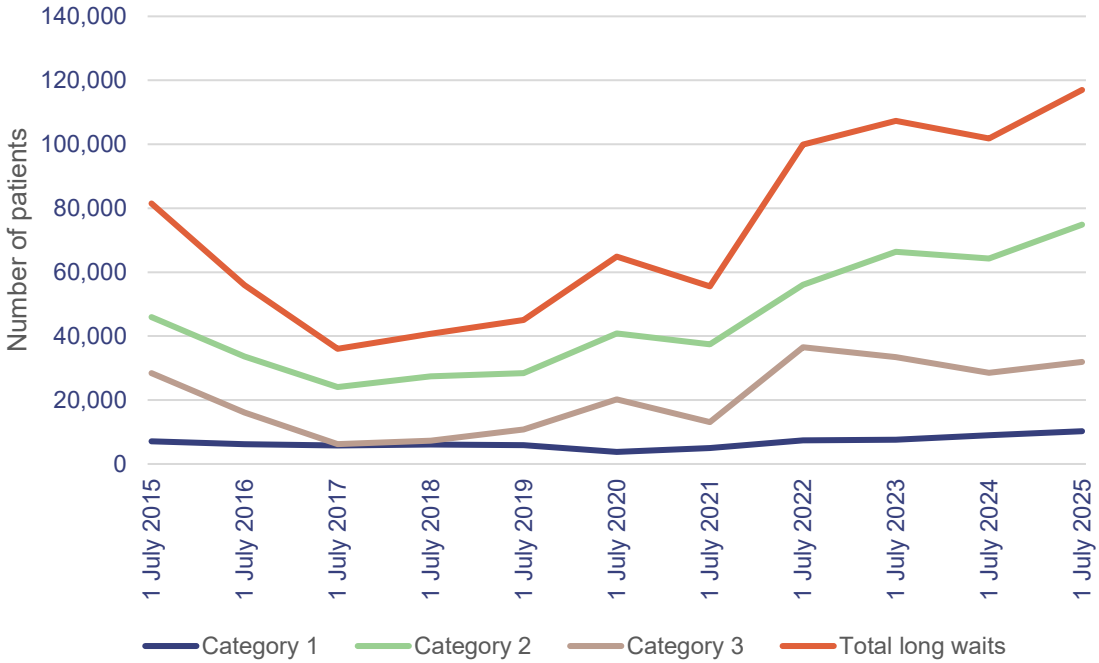
More people are waiting longer than clinically recommended for specialist care

Figure 6N shows that the total number of long waits who are ready for care (available to attend an appointment) halved in the first 3 years of Queensland Health's *Specialist Outpatient Strategy,* which began in July 2015. But the total number of long waits as of 1 July 2025 is 44 per cent higher than it was on 1 July 2015.

In 2024–25, outpatient long waits who are ready for care reached their overall peak, with 116,985 patients ready for care waiting (as at 1 July 2025). This represents an increase of 15 per cent, or 15,217 patients, compared to 2023–24.

While the HHSs are working through the backlog of patients, new patients are being placed on waitlists. This means managing the specialist outpatient waitlist requires the HHSs to balance the overall growth in demand by prioritising seeing the longest waiting patients and patients with the most urgent clinical needs.

Figure 6N
Number of outpatient long waits – ready for care



Notes: In 2021–22, the total number of long waits increased by 80 per cent due to the impacts of COVID-19 on system capacity. Data is for Queensland's top 26 reporting hospitals at each reporting year and the specialist outpatient services within reporting scope applicable to each year. Caloundra Hospital was a reporting hospital until 2016–17 and is included in this graph until 2017–18.

Source: Queensland Audit Office, from Queensland Health specialist outpatient data collection.

Appendices

A. Full responses from entities

As mandated in Section 64 of the *Auditor-General Act 2009*, the Queensland Audit Office gave a copy of this report with a request for comments to the Department of Health.

We also provided a copy of the report to the following entities and gave them the option of providing a response:

- Minister for Health and Ambulance Services
- board chairs of the 16 hospital and health services
- chief executive officers of the 16 hospital and health services.

We provided a copy of this report to the Premier and the Director-General, Department of the Premier and Cabinet, for their information.

This appendix contains the responses we received.

The heads of these entities are responsible for the accuracy, fairness, and balance of their comments.

Comments received from Director-General, Queensland Health

Queensland Government

Queensland Health

Enquiries to:

Telephone:
Our ref: C-ECTF-25/25125
Your ref: PRJ04660

Ms Rachel Vagg
Auditor-General
Queensland Audit Office
Level 14, 53 Albert Street
BRISBANE QLD 4000

Email: qao@qao.qld.gov.au

Dear Ms Vagg

Thank you for your email dated 5 December 2025, regarding the Queensland Audit Office's (QAO's) proposed report to Parliament titled 'Health 2025' (the report).

I acknowledge receipt of the report and the contents proposed to be included in this report. I am responding on behalf of the Department of Health and 16 Hospital and Health Services (HHSs) to provide a single health system response. I would also like to advise that the report has been received by the Honourable Tim Nicholls MP, Minister for Health and Ambulance Services, and acknowledge with gratitude your offer to personally provide a briefing if required on the report.

It is pleasing to note the Department and all 16 HHSs received unmodified opinions on their annual financial statements for the 2024-25 financial year. It is also positive to note your recognition of the improved and timely tabling of all Health Sector Annual Reports by the legislative deadline.

Noted below are Queensland Health's responses to matters and topics covered in the report.

Recommendation 1: HHSs should each develop a plan for managing conflicts of interest for board members who are employed as clinicians at the HHS
The Department intends to support the HHSs and the clinician board members, in consultation with the Queensland Integrity Commissioner, to support conflict of interest management plan development as follows:

- the Department is proposing to introduce a standardised baseline for all Hospital and Health Board (HHB) clinician members' conflict of interest management plans in preparation for the 2026 HHB appointments;
- establishing baseline management and reporting strategies for clinician members will ensure that conflicts of interest are identified and managed appropriately and consistently across all HHBs; and
- the Department will consult with the Queensland Integrity Commissioner to standardise the core content for these plans.

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Website health.qld.gov.au
Email
ABN 66 329 169 412

The key themes intended within the standardised content will be as follows:

- employment and clinical involvement;
- relationship with the Health Service Chief Executive;
- Board deliberations affecting employment or professional role; and
- personal relationships.

Financial performance and sustainability
The report comments again on health entities' ongoing financial sustainability. The report notes that the HHSs have a combined operating deficit of $271.5 million in 2024-25 (2023-24: $8.8 million operating surplus). HHSs exceeded their expense budgets by $1.72 billion or 7.8 per cent (2023-24: $1.95 billion or 9.8 per cent).

Queensland Health continuously monitors health services provided and notes the increase demands driven by an increasing and ageing Queensland population. The increase of 11.7 per cent in demand for health services is reflected in the increased expenditure, with some of the primary drivers of the increased expenditure being the higher volume of services delivered in the year, increased employee costs, and the impact of inflation on the costs of goods and services. Queensland Health recognises the challenges for financial sustainability which remains a key focus of all leadership teams and their staff. The challenges of increased health services demand, increased health service provider numbers and associated costs, and managing procurement to counter inflationary pressure are key focus areas for Queensland Health.

Workforce pressures and employee expenses
Aligned with the matter above, the report notes the significant impact and continued workforce pressures, emphasising future requirements and recruitment challenges in the sector. It highlights expected HHSs activity growth over seven years due to population growth, ageing, and complexity of health conditions, noting that from 2026, approximately 36,000 additional employees will need to be onboarded to meet this target based on the number of full-time equivalents reported in the 2024-25 financial statements.

It is pleasing to note that the QAO recognises the work Queensland Health is undertaking to address these workforce challenges in the *Health Workforce Strategy for Queensland to 2032*, focusing on three key areas which are supporting and retaining the current workforce, building and attracting new pipelines of talent and adapting and innovating new ways to deliver health services. The QAO notes the early indicated success of these strategies with the number of full-time equivalent employees working at HHSs increasing by approximately 5.9 per cent during 2024-25.

In 2024-25, Queensland Health recorded a 3.6 per cent decrease in expenditure for frontline contractor staff (for example, nurses and other clinical contractors), a decrease of $15.6 million. Queensland Health continues to face recruitment challenges for remote areas and is constantly addressing recruitment strategies to broaden the potential pool for candidates and attract staff to these areas.

The impact of population growth and ageing on the need for hospitals and other assets
The report comments on the continuing increase in Queensland population and the related demand that this places on future demand and capital requirements. Approximately 39.9 per cent ($10.3 billion) of buildings currently owned by the Department and the 16 HHSs are due to be replaced within the next 10 years based on their recorded remaining useful lives. The Department anticipates that buildings will last longer than recorded due to planned refurbishments, redevelopments, and various capital maintenance projects that will prolong their useful lives.

Queensland Health recognises the formidable challenges arising from these demands and the requirement to develop and maintain infrastructure to continue providing health services that meets demand is a key focus. As noted in the report, Queensland Health spent $2.55 billion on infrastructure development in 2024-25, with the continued delivery of major capital programs across the State, with that investment into infrastructure only continuing over the coming years.

The report notes that current market conditions are placing significant pressure on costs, while shortages of materials and labour are causing delays in the anticipated schedule for the projects. Over the next eight years, this pressure will intensify, as a substantial number of capital projects are implemented throughout Queensland, such as the Olympic and Paralympic Games, as well as transport, energy, and water initiatives. Queensland Health is aware of these challenges and is continually developing and reviewing strategies to contain costs across the delivery of the portfolio.

Maintenance needs of assets and prioritising high-risk maintenance
The QAO notes that HHSs reported a 29 per cent increase in the maintenance needs of their assets, which indicates that they continue to face significant challenges in funding the maintenance of their assets. The reported maintenance needs to include operational maintenance that has been deferred, capital maintenance that has been deferred and, in some cases, forecast future asset renewals, replacements and refurbishments.

Queensland Health agrees with the report statement that the growing maintenance requirements across the sector suggests there is a need for additional funding in this space. This is to ensure the entities can maintain these assets and continue to deliver services effectively and efficiently. Queensland Health continues to identify and prioritise high risk maintenance as recommended in the report. I welcome that the report recognises that buildings will likely remain functioning longer than their recorded remaining useful lives indicate due to planned refurbishments, redevelopments, and various capital maintenance projects that will prolong their useful lives.

Increased demand for health services and the impacts on emergency departments and ambulances even with the services provided by new satellite hospitals
The report discusses the impacts of increasing health service demands on emergency departments and ambulances in line with Queensland's population growth. I am pleased that through the completion of the Satellite Health Centre Program and expansion of Virtual Care Services, that the overall demand for emergency department services has steadied in 2024-25.

Queensland Health recognises the ongoing challenges to service access across the public health system, both within Queensland and more broadly across the nation. Timely access to hospital care remains a priority and I welcome the QAO in recognising that current performance is impacted by the constantly increasing demand for services provided by the health system. The Department considers increasing demand on the emergency department as a whole-of-hospital issue, requiring equal focus on inpatient bed management, discharge practices and hospital substitution. As such, initiatives will be progressed to improve healthcare performance. Initiatives include, optimising patient transit hubs, implementing surgical rapid assessment units, reviewing general medicine best practice models of care, and increasing transparency of the performance of emergency departments through the publication of real time data.

It is pleasing that the report comments on the fact that despite having the highest number of responses in Australia proportionate to population, Queensland Health continues to achieve better response times for emergency incidents than most other jurisdictions. As noted in the report, delays in hospitals have a flow-on effect on ambulances. The reduction in ambulance delays will be significantly dependent on infrastructure development and increased staffing to meet the increasing demand for health services.

Payroll overpayments
The QAO has commented on the continuing increase in payroll overpayments occurring across the health entities and the need for this to be addressed. The rollout of the Integrated Workforce Management (IWFM) system aims to address this by automating rostering and payroll processes.

In 2024-25, the Department finalised the rollout of its electronic rostering system, IWFM, across all HHSs for nursing and midwifery staff (representing approximately 40 per cent of the HHS workforce and 38 per cent of the total cost of employee expenses). The Department will be implementing IWFM in a staged approach across the HHSs for other occupational groups, including doctors/medical officers, starting in 2025-26.

The implementation of IWFM is a key strategy being implemented to reduce the incidence of salary overpayments. The IWFM system will remove the need for forms to be completed manually and will make roster-to-pay processes simpler. Health entities will continue to be vigilant in ensuring strong compensating controls over roster and paper-based variation forms during the continuing transition of other cohorts.

The Department undertook work during 2024-25, in accordance with prior year recommendations by the QAO, to review and update the Human Resource Policy C13 - Payment of salaries and wages and Human Resource Policy C60 - Overtime resulting in greater clarity and strengthened controls over rostering and overtime practices and further assisting in limiting overpayments upfront.

Information systems and cyber security
The QAO discusses the ongoing need for a focus on information system controls and cyber security, with a number of prior year recommendations and deficiencies being recorded across the health system remaining unresolved.

Queensland Health is committed to regularly reviewing and updating security controls to maintain a strong security posture, addressing emerging threats, and ensuring alignment with industry best practices and regulatory requirements. This proactive approach helps safeguard assets, mitigate risks, and support continuous improvement in security and compliance across Queensland Health. As part of this commitment, the Department is focused on uplifting Essential Eight Security Controls, which includes multifactor to combat emerging threats to health system user accounts and compromise of information systems.

Each year the Department performs an independent assurance and attestation activity, with the results demonstrating continual improvement using a risk-based approach in accordance with the Queensland Government Information Security Policy (IS18) and the Queensland Health Information Security Management System framework.

Recent work has been undertaken to review and identify root causal factors contributing to deficiencies in information system security controls that has resulted in remedial activities to address and mitigate recurrence. Activities include strengthening policy and governance processes, raising awareness, reviewing operational workflows, and implementing sustainable technical controls in line with industry best practice.

The Department has established forums that proactively promote a positive cyber awareness culture and build cyber capacity across the health system. People, process, and technical controls are in place and continued to be strengthened to support account security and least privileged access across information systems while a continued focus on maturing contemporary best practice controls is actively reducing vulnerabilities and risk of compromise to critical enterprise systems.

An internal deep dive was performed on the findings from the QAO general IT controls audit that assessed foundational IT systems that provides user account management, authentication, access control and management of passwords to access key financial and other systems. The deep dive identified underlying factors that contributed to the findings resulting in significant cleanup activities, improved automation and workflows, deprovisioning of legacy systems, increased management oversight and alerting. A maturity uplift and focus on utilising modern authentication for 0365 is currently underway transitioning users from legacy SMS to more secure methods such as Authenticator Application.

Should you or any officers of your department require further information, the Department of Health's contact is

Yours sincerely

Dr David Rosengren
Director-General
5 January 2026

5

B. How we prepared this report

Queensland Audit Office reports to parliament

The Queensland Audit Office (QAO) is Queensland's independent auditor of public sector entities and local governments.

QAO's independent public reporting is an important part of our mandate. It brings transparency and accountability to public sector performance and forms a vital part of the overall integrity of the system of government.

QAO provides valued assurance, insights, and advice, and recommendations for improvement via the reports it tables in the Legislative Assembly, as mandated by the *Auditor-General Act 2009*. These reports may be on the results of our financial audits, on the results of our performance audits, or on our insights. Our insights reports may provide key facts or a topic overview, the insights we have gleaned from across our audit work, the outcomes of an investigation we conducted following a request for audit, or an update on the status of Auditor-General recommendations.

We share our planned reports to parliament in our 3-year forward work plan, which we update annually: www.qao.qld.gov.au/audit-program.

A fact sheet on how we prepare, consult on, and table our reports to parliament is available on our website: www.qao.qld.gov.au/reports-resources/fact-sheets.

About this report

QAO prepares its reports on the results of financial audits under the *Auditor-General Act 2009*, specifically:

- section 60, which outlines the Auditor-General must prepare a report to the Legislative Assembly on each audit conducted of a public sector entity
- section 62, which outlines the Auditor-General may combine reports on any 2 or more audits
- section 63, which outlines the discretion the Auditor-General has for reporting to parliament.

This report summarises the audit results of Queensland Health entities, which include the Department of Health and the 16 hospital and health services. It also summarises the audit results for 13 hospital foundations, 5 other statutory bodies, and 3 entities controlled by other health entities.

What we cover

Through our financial audit program, we form opinions about the reliability of entity financial statements. QAO completes these audits under the related Auditing and Assurance Standards Board standards. Each respective entity publishes our audit opinions in its annual report.

Our financial audit reports to parliament provide the results of our audits and assess the quality and effectiveness of internal controls. They also consider public sector-specific risks. These include the probity of matters associated with entity stewardship; propriety of administrative decisions; acts or omissions that give rise to a waste of public resources; and compliance with relevant Acts, regulations, and policies.

This report highlights key insights and information from across our work.

We provide information and insights from our annual financial audits of the entities included in this report and from follow-up inquiries of some of our previous performance audits in the health sector.

Entities included in this report

- Department of Health
- 16 hospital and health services
- 13 hospital foundations
- 5 statutory health entities
- 3 controlled entities.

Refer to Appendix F for the names of the above entities.

Our approach

Data and information

This report has been prepared in accordance with the *Auditor-General Auditing Standards*.

We have used the following data sets in preparing our report:

- We extracted leave, overtime, and expenditure data from the Department of Health and hospital and health service payroll systems, which we audit as part of our financial statement audit processes. We used this to update graphs and support our commentary in Chapter 4.
- We used data in the Department of Health and hospital and health service finance system, which we audit as part of our financial statement audit processes. We have also used annual reports and media statements, which are publicly available information. We used this to update graphs and support our commentary in Chapter 5.
- To update or create graphs and support our commentary in Chapter 6, we used
  - emergency department presentations and key performance indicator data for the top 26 reporting hospitals – from the Department of Health
  - ambulance incident responses and key performance indicator data for the top 26 reporting hospitals – from the Queensland Ambulance Service
  - specialist outpatient services key performance indicator data for the top 26 reporting hospitals – from the Department of Health
  - statewide average length of stay for admitted patients – from the Department of Health
  - publicly available information relating to emergency department data by jurisdiction in Australia
  - publicly available information relating to ambulance service data by jurisdiction in Australia – available at the Australian Government Productivity Commission website.

There has been no change in the way we compiled the graphs compared to last year, except for specialist outpatient graphs in Chapter 6. This year we reported outpatient specialist data for the top 26 reporting hospitals and for the services in scope for performance reporting applicable to each reporting year.

We have not audited these data sets for completeness and accuracy.

Presentation

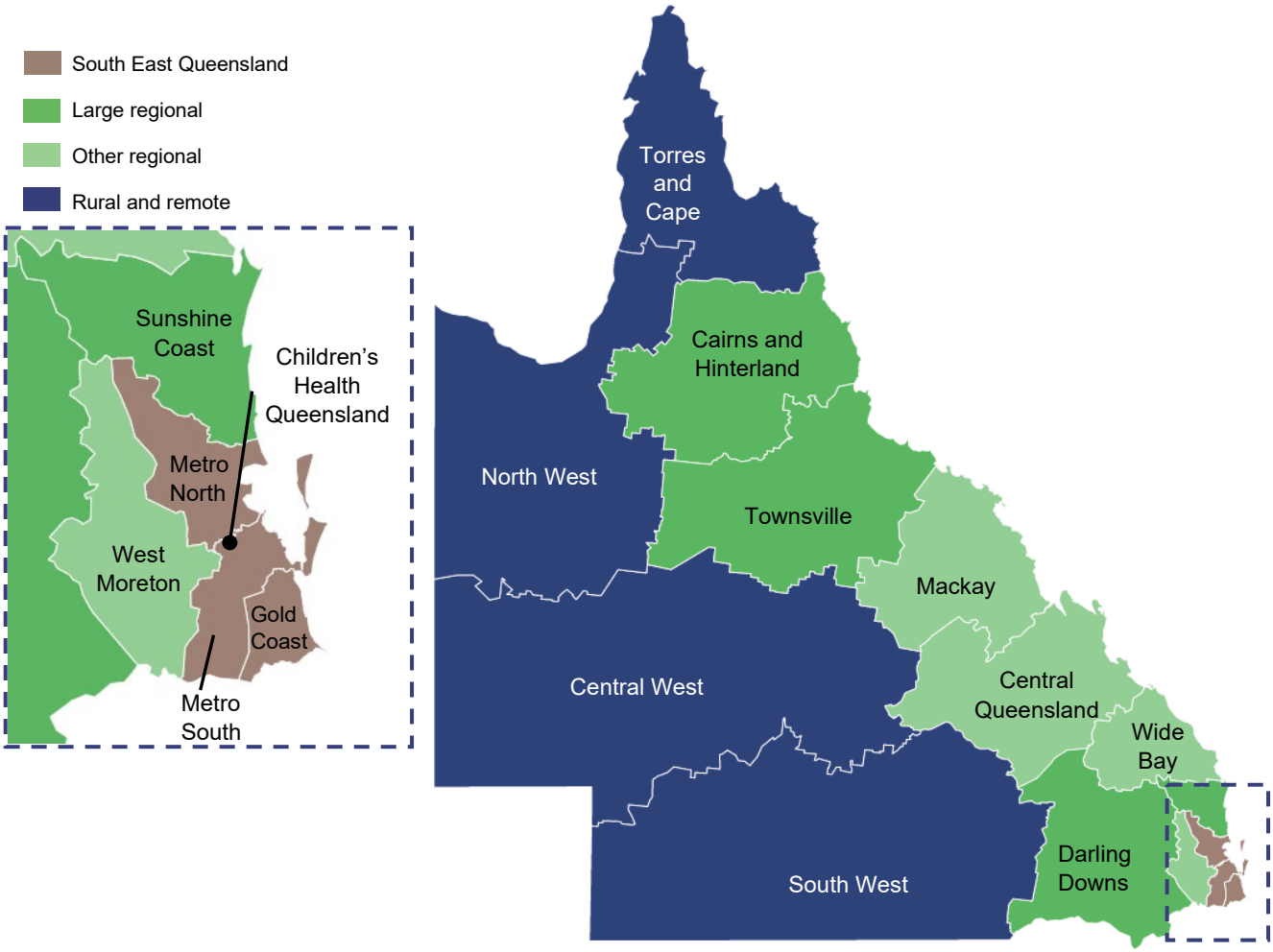
Where useful, we present our graphs with comparative data going back to either 2020, 2021, or 2022 (3 to 5 years) to show the relevant movements where appropriate. For graphs related to specialist outpatient services, we present data back to 2014–15 (1 July 2015 for waitlist – outpatients ready for care) to align with the release of the Department of Health's *Specialist Outpatient Strategy*.

C. Queensland hospital and health service regions

Hospital and health services (HHSs) provide health services across metropolitan, regional, and rural areas of Queensland. They are grouped into 4 regions, as shown in Figure C1.

Figure C1
Queensland hospital and health service regions

South East Queensland	Large regional	Other regional	Rural and remote
Children's Health Queensland HHS	Cairns and Hinterland HHS	Central Queensland HHS	Central West HHS
Gold Coast HHS	Darling Downs HHS	Mackay HHS	North West HHS
Metro North HHS	Sunshine Coast HHS	West Moreton HHS	South West HHS
Metro South HHS	Townsville HHS	Wide Bay HHS	Torres and Cape HHS



Source: Queensland Audit Office, from Queensland Health.

D. Legislative context

Frameworks

Health entities prepare their financial statements in accordance with the following legislative frameworks and reporting deadlines.

Figure D1
Legislative frameworks for the health sector

Entity type	Entities	Legislative framework	Legislated deadline for financial statements
Departments	• Department of Health	• *Financial Accountability Act 2009* • Financial and Performance Management Standard 2019	31 August 2025
Statutory bodies	• 16 hospital and health service boards • 13 hospital/health foundations • The Council of the Queensland Institute for Medical Research (QIMR) • Health and Wellbeing Queensland • Office of the Health Ombudsman • Queensland Mental Health Commission • Queensland Pharmacy Business Ownership Council	• *Financial Accountability Act 2009* • Financial and Performance Management Standard 2019 • *Statutory Bodies Financial Arrangements Act 1982* • *Hospital and Health Boards Act 2011* • *Hospital Foundations Act 2018* • *Queensland Institute of Medical Research Act 1945* • *Health and Wellbeing Queensland Act 2019* • *Health Ombudsman Act 2013* • *Queensland Mental Health Commission Act 2013* • *Pharmacy Business Ownership Act 2024* • *Australian Charities and Not-for-profits Commission Act 2012**	31 August 2025
Controlled entities that are companies	• Endpoint Pty Ltd • Tropical Australian Academic Health Centre Limited	• *Corporations Act 2001* • Corporations Regulations 2001 • *Australian Charities and Not-for-profits Commission Act 2012*	31 October 2025^ 31 December 2025
Other	• Sunshine Coast Health Institute	• Joint Venture Agreement	30 April 2025

Notes: Controlled entity – an entity owned by one or more public sector entities.

* The *Australian Charities and Not-for-profits Commission Act 2012* is applicable to the 13 hospital/health foundations that are registered charities.

^ The *Corporations Act 2001* does not require all small proprietary companies to prepare financial statements. Where financial statements are required, they must be completed within 4 months after the end of the financial year.

Source: Queensland Audit Office.

Accountability requirements

The *Financial Accountability Act 2009* applicable to health sector entities requires these entities to:

- achieve reasonable value for money by ensuring the operations of the entity are carried out efficiently, effectively, and economically
- establish and maintain appropriate systems of internal control and risk management
- establish and keep funds and accounts that comply with the relevant legislation, including Australian accounting standards.

Queensland state government financial statements

Each year, Queensland state public sector entities must table their audited financial statements in parliament.

These financial statements are used by a broad range of parties including parliamentarians, taxpayers, employees, and users of government services. For these statements to be useful, the information reported must be relevant and accurate.

The Auditor-General's audit opinion on these entities' financial statements assures users that the statements are accurate and in accordance with relevant legislative requirements.

We express an *unmodified opinion* when the financial statements are prepared in accordance with the relevant legislative requirements and Australian accounting standards. We *modify* our audit opinion when financial statements do not comply with the relevant legislative requirements and Australian accounting standards and are not accurate and reliable.

There are 3 types of modified opinions:

- qualified opinion – the financial statements as a whole comply with relevant accounting standards and legislative requirements, with the exceptions noted in the opinion
- adverse opinion – the financial statements as a whole do not comply with relevant accounting standards and legislative requirements
- disclaimer of opinion – the auditor is unable to express an opinion as to whether the financial statements comply with relevant accounting standards and legislative requirements.

Sometimes we include an *emphasis of matter* in our audit reports to highlight an issue that will help users better understand the financial statements. It does not change the audit opinion.

E. Status of prior recommendations

In our report, *Health 2024* (Report 8: 2024–25), we identified 2 recommendations for health sector entities. The Department of Health has fully implemented the first recommendation. Hospital and health services (HHSs) have taken appropriate action on the second recommendation. We continue to identify deficiencies we have made recommendations about in previous years. In particular, we continue to find control weaknesses in the security of information systems.

Figure E1
Status of recommendations from Health 2024 (Report 8: 2024–25)

Managing assets to ensure maintenance is performed when required		**Fully implemented**
2024 – REC 1	We recommend that the Department of Health updates its 'Asset Management Key Terms paper' to clearly define key asset maintenance terms	The department, as reported in Chapter 5 – Asset management in health entities – has fully resolved this recommendation.
Managing assets to ensure maintenance is performed when required		**Appropriate action has been taken**
2024 – REC 2	We recommend that the Department of Health and HHSs report the values against each of [the following] terms in their annual reports • deferred maintenance • postponed capital maintenance • forecast life cycle replacement, renewals, and refurbishments (if applicable).	HHSs have, for the most part, taken on the guidance from the department on how to report on the different asset maintenance terms. The department and 15 of the 16 HHSs reported details of deferred maintenance and postponed capital maintenance in their 2024–25 annual reports. One HHS continued to only report deferred maintenance. Of 16 HHSs, 12 referred to 'deferred maintenance' (up from 9 in 2024), while 4 used the term 'anticipated maintenance' (down from 7 in 2024) when they were describing deferred maintenance.

Source: Queensland Audit Office.

In *Health 2024* (Report 8: 2024–25) we identified that the following recommendations from our *Health 2023* (Report 6: 2023–24)*, Health 2022* (Report 10: 2022–23)*, Health 2021* (Report 12: 2021–22), and *Health 2020* (Report 12: 2020–21) reports remained outstanding. We have included an update on the status of these issues.

Figure E2
Status of recommendations from Health 2023 (Report 6: 2023–24), Health 2022 (Report 10: 2022–23), Health 2021 (Report 12: 2021–22), and Health 2020 (Report 12: 2020–21) reports

Improve controls over rostering and overtime		Further action needs to be taken
2023 – REC 1	The department and 16 HHSs should: • develop a sector-wide policy for the timely submission of pay variation forms • reassess more effective and efficient ways to – control the approval of and recording of overtime approvals – monitor unplanned and planned overtime • develop a policy that defines the appropriate level of detail required by an employee to justify overtime hours worked and document the reasons for overtime worked • finalise the rollout of an electronic rostering system for nursing and midwifery staff as soon as practicable and establish a plan and timetable to roll it out for other medical staff.	The parts of this recommendation that require further action relate to approving overtime and extending the scope of the electronic rostering system. We reported deficiencies in the controls relating to overtime approvals at 4 HHSs, and a significant control deficiency at one HHS. The department and HHSs completed the rollout of the electronic rostering system (the Integrated Workforce Management – IWFM system) for nursing and midwifery staff during 2024–25. The department and HHSs are taking steps to extend the electronic rostering system for other cohorts to address this control deficiency. Eight HHSs and the department are expected to begin IWFM implementation for medical officers before 30 June 2026, with 3 of these and the department expected to go live by that date.
Address inconsistencies in calculating deferred maintenance of assets		**Further action needs to be taken**
2023 – REC 2	The department and 16 HHSs should: • standardise the process for assessing deferred maintenance of assets to ensure reliability in reporting and strategic asset management planning across the department and HHSs • ensure asset data, including data on the condition of assets, is up to date.	The department has made progress in addressing this recommendation. It introduced an 'Asset Management Key Terms paper' to clearly define key asset maintenance terms and provide guidance to HHSs. This was to achieve consistency on processes for assessing deferred maintenance. Although the department is seeing improvements in the quality of condition assessments performed at HHSs, some HHSs are still adopting inconsistent approaches in calculating their maintenance needs. Maintenance needs increased by $587 million during 2024–25.

Strengthening of information system and cyber security controls		Further action needs to be taken
2022 – REC 1	The 16 HHSs should: • review the dashboard of active users regularly to ensure access to the department's network is limited to authorised users only and promptly notify the department of any changes required. The Department of Health should: • progress the Identity and Access Management Maturity and Service Uplift Project • update insecure settings in relation to passwords and default accounts.	We continue to identify significant control weaknesses in the security of information systems, as noted in Chapter 3. The Identity and Access Management Maturity and Service Uplift Project was (scoping stage) completed in June 2025 after we completed our audit testing. This remains a recommendation.
Procurement and contracting controls need to be strengthened		**Further action needs to be taken**
2021 – REC 1	The Department of Health and 16 HHSs should: • ensure they have appropriate contract management and procurement systems in place • provide training in procurement processes and procedures • maintain complete and up-to-date contract registers • ensure all documents relating to contracts are kept in a central location.	No significant deficiencies were identified in procurement practices. However, we did identify non-compliance at 3 health entities with the requirement to publish information on awarded contracts on open data. This remains a recommendation.
Resolve outstanding audit issues		**Further action needs to be taken**
2020 – REC 2	Queensland Health entities and their audit committees should continue to regularly review the status of outstanding audit issues and ensure they are resolved in a timely manner.	As noted in Chapter 3, internal controls are generally effective. However, 25 issues raised in prior years (2020–24) are yet to be resolved. Therefore, this remains a recommendation.

Strengthen the security of information systems		Further action needs to be taken
2020 – REC 3	We recommend all entities strengthen the security of their information systems. They rely heavily on technology, and increasingly, they have to be prepared for cyber attacks. Any unauthorised access could result in fraud or error, and significant reputational damage. Their workplace culture, through their people and processes, must emphasise strong security practices to provide a foundation for the security of information systems. Entities should: • provide security training for employees so they understand the importance of maintaining strong information systems, and their roles in keeping them secure • assign employees only the minimum access required to perform their job, and ensure important stages of each process are not performed by the same person • regularly review user access to ensure it remains appropriate • monitor activities performed by employees with privileged access (allowing them to access sensitive data and create and configure within the system) to ensure they are appropriately approved • implement strong password practices and multifactor authentication (for example, a username and password, plus a code sent to a mobile), particularly for systems that record sensitive information • encrypt sensitive information to protect it • patch vulnerabilities in systems in a timely manner, as upgrades and solutions are made available by software providers to address known security weaknesses that could be exploited by external parties. Entities should also self-assess against all of the recommendations in *Managing cyber security risks* (Report 3: 2019–20) to ensure their systems are appropriately secured.	The deficiencies that we identify in Chapter 3 show that the department needs to do more to strengthen controls over system access. This remains a recommendation.
Address backlog of asset maintenance		**Further action needs to be taken**
2020 – REC 5	Queensland Health entities should continue to prioritise high-risk maintenance. The hospital and health services should work with the department to find ways to mitigate the operational, clinical, and financial risks associated with deferred maintenance.	HHSs reported a $587 million increase in deferred and postponed capital maintenance this year. Further action is required to ensure that deferred maintenance, including high and very high-risk maintenance, is correctly identified, reported, and appropriately managed.

Source: Queensland Audit Office.

Where a recommendation is specific to an entity, we have reported on the action that entity has taken and whether the issue is considered to be *fully implemented*, *partially implemented, not implemented* or *no longer applicable*.

Status	Definition	
Fully implemented	Recommendation has been implemented, or alternative action has been taken that addresses the underlying issues and no further action is required. Any further actions are business as usual.	
Partially implemented	Significant progress has been made in implementing the recommendation or taking alternative action, but further work is required before it can be considered business as usual. This also includes where the action taken was less extensive than recommended, as it only addressed some of the underlying issues that led to the recommendation.	
Not implemented	**Recommendation accepted**	No or minimal actions have been taken to implement the recommendation, or the action taken does not address the underlying issues that led to the recommendation.
	Recommendation not accepted	The government or the agency did not accept the recommendation.
No longer applicable	Circumstances have fundamentally changed, making the recommendation no longer applicable. For example, a change in government policy or program has meant the recommendation is no longer relevant.	

Where a general recommendation has been made for all entities to consider, we have assessed action on issues reported to specific entities in the prior year, as well as any further issues identified in the current year. On this basis, we have concluded whether *appropriate action has been taken* across the sector, or if *further action needs to be taken* to address the risk identified.

Status	Definition
Appropriate action has been taken	Recommendations made to individual entities have been implemented, or alternative action has been taken that addresses the underlying issues, and no further action is required. No new issues have been identified across the sector that indicate an ongoing underlying risk to the sector that requires reporting to parliament.
Further action needs to be taken	Recommendations made to individual entities have not been fully implemented, and/or new recommendations have been made to individual entities, indicating further action is required by entities in the sector to address the underlying risk.

F. Audit opinions for entities preparing financial reports

The following table details the types of audit opinions issued, in accordance with Australian auditing standards, for the 2024–25 financial year.

We express an *unmodified opinion* when the financial statements are prepared in accordance with the relevant legislative requirements and Australian accounting standards.

Sometimes we include an *emphasis of matter* (EOM) in our audit reports to highlight an issue that will help users better understand the financial statements. It does not change the audit opinion.

Figure F1
Audit opinions issued

Entity type	Entity	Date audit opinion issued	Type of audit opinion issued
Department	Department of Health	26.08.2025	Unmodified
Statutory bodies – hospital and health services (HHSs)	Cairns and Hinterland	28.08.2025	Unmodified
	Central Queensland	29.08.2025	Unmodified
	Central West	29.08.2025	Unmodified
	Children's Health Queensland	27.08.2025	Unmodified
	Darling Downs	28.08.2025	Unmodified
	Gold Coast	22.08.2025	Unmodified
	Mackay	27.08.2025	Unmodified
	Metro North	28.08.2025	Unmodified
	Metro South	20.08.2025	Unmodified
	North West	29.08.2025	Unmodified
	South West	27.08.2025	Unmodified
	Sunshine Coast	29.08.2025	Unmodified
	Torres and Cape	27.08.2025	Unmodified
	Townsville	19.08.2025	Unmodified
	West Moreton	25.08.2025	Unmodified
	Wide Bay	29.08.2025	Unmodified
Statutory bodies – hospital foundations	Bundaberg Health Services Foundation	29.08.2025	Unmodified
	Central Queensland Hospital Foundation	28.08.2025	Unmodified
	Children's Hospital Foundation Queensland	27.08.2025	Unmodified
	Far North Queensland Hospital Foundation	28.08.2025	Unmodified
	Gold Coast Hospital Foundation	29.08.2025	Unmodified
	Mackay Hospital Foundation	04.09.2025	Unmodified
	PA Research Foundation	29.08.2025	Unmodified
	Royal Brisbane and Women's Hospital Foundation	28.08.2025	Unmodified
	Sunshine Coast Health Foundation	29.08.2025	Unmodified

Entity type	Entity	Date audit opinion issued	Type of audit opinion issued
	The Prince Charles Hospital Foundation	28.08.2025	Unmodified
	Toowoomba Hospital Foundation	28.08.2025	Unmodified
	Townsville Hospital Foundation	29.08.2025	Unmodified
	West Moreton Health Foundation^	27.08.2025	Unmodified
Other statutory bodies	Health and Wellbeing Queensland	28.08.2025	Unmodified
	Office of the Health Ombudsman	26.08.2025	Unmodified
	Queensland Mental Health Commission	10.09.2025	Unmodified
	Queensland Pharmacy Business Ownership Council	28.08.2025	Unmodified
	The Council of The Queensland Institute of Medical Research (QIMR)	22.08.2025	Unmodified
Controlled entities	Endpoint IQ Pty Ltd^^ (controlled entity of QIMR)	21.08.2025	Unmodified – EOM
	Sunshine Coast Health Institute (SCHI)^^^	25.03.2025	Unmodified – EOM
	Tropical Australian Academic Health Centre Limited	19.11.2025	Unmodified

Notes:

^ Effective 3 May 2025, the legal name of the foundation was changed from Ipswich Hospital Foundation to West Moreton Health Foundation.

^^ The audit report for Endpoint IQ Pty Ltd included an emphasis of matter to alert users that special purpose financial statements had been prepared. The audit report also included a paragraph on 'material uncertainty related to going concern' due to the company's net current liability position.

^^^ SCHI is a joint venture collaborative partnership between the Sunshine Coast HHS, University of the Sunshine Coast, TAFE Queensland, and Griffith University. The financial year of SCHI was 1 January 2024 to 31 December 2024. We included an emphasis of matter in our audit report to highlight to users of the statements that special purpose financial statements had been prepared. The audit opinion for the financial year ended 31 December 2025 has not yet been issued.

Source: Queensland Audit Office.

G. Other audit and assurance opinions

We issued the following opinions for other audit and assurance engagements performed in the Queensland public health sector. To provide assurance, an auditor must confirm whether specific information is correct, so users of the information can confidently make decisions based on it.

Figure G1
Other audit and assurance opinions issued

Type of engagement	Subject	Date opinion issued	Type of opinion issued*
	Department of Health		
Audit of a special purpose financial report	National Health Funding Pool Queensland State Pool Account – the cash receipts from the Australian and Queensland governments to fund Queensland public health services	28.08.2025	Unmodified – EOM
Compliance audit	Annual Prudential Compliance Statement for Queensland Health's aged care facilities that collect refundable deposits and accommodation bonds	03.11. 2025	Qualified
Assurance audit	ASAE 3402 Assurance Report for the period 1 July 2024 to 31 March 2025 (Type 2) – covering the design, implementation, and effectiveness of key financial controls	04.06.2025	Unmodified
Assurance audit	ASAE 3402 Assurance Report as of 30 June 2025 (Type 1) – covering the design and implementation of key financial controls	29.07.2025	Unmodified

Note: * We express an *unmodified opinion* when the financial statements are prepared in accordance with the relevant legislative requirements and Australian accounting standards.

Sometimes we include an *emphasis of matter* (EOM) in our audit reports to highlight an issue that will help users better understand the financial statements. It does not change the audit opinion.

Source: Queensland Audit Office.

H. Entities not preparing financial reports

For each state public sector company, other than government owned corporations, the board of directors considers the requirements of the *Corporations Act 2001* or the company's constitution to determine whether financial statements need to be prepared. The board must revisit the assessment every 3 years or whenever a significant change occurs.

When entities are part of a larger group and are secured by a guarantee with other entities in that group (that they will cover their debts), the Australian Securities and Investments Commission allows them to not prepare a financial report.

In addition, dormant or small companies that meet specific criteria under the *Corporations Act 2001* are not required to prepare financial statements. If entities form part of a larger group that reports to the Australian Charities and Not-for-profits Commission, the commissioner may allow the group to jointly report under subsection 60–95(1) of the *Australian Charities and Not-for-profits Commission Act 2012*.

Accordingly, the Auditor-General will not issue audit opinions for the following controlled public sector entities for 2025, as they were not required to produce financial statements.

Figure H1
Health sector entities not preparing financial reports in 2024–25

Public sector entity	Reason for not preparing financial statements
Controlled entities of The Council of The Queensland Institute of Medical Research (QIMR)	
Vaccine Solutions Pty Ltd	Dormant
genomiQa Pty Ltd	Non-reporting
Q-Gen Pty Ltd	Dormant
Fovero Therapeutics Pty Ltd	Non-reporting
Cyteph Pty Ltd	Non-reporting

Source: Queensland Audit Office.

I. Financial results

Figure I1
Department of Health and hospital and health services – for the year ending 30 June 2025

Amounts in $'000						
Health entity	**Total assets**	**Total liabilities**	**Total income**	**Total expenses**	**Operating result**	**Accumulated operating result**
Department of Health	7,742,487	3,308,079	41,060,933	41,750,042	(689,109)	672,279
Cairns and Hinterland HHS	1,476,544	118,892	1,539,599	1,566,049	(26,450)	(104,447)
Central Queensland HHS	659,157	81,265	948,668	985,687	(37,019)	(76,253)
Central West HHS	150,395	13,435	122,943	121,051	1,892	5,183
Children's Health Queensland HHS	1,375,123	110,692	1,141,331	1,141,202	129	46,646
Darling Downs HHS	846,465	129,965	1,322,292	1,358,181	(35,889)	38,524
Gold Coast HHS	2,268,596	239,278	2,579,446	2,577,913	1,533	63,273
Mackay HHS	567,186	71,482	731,062	758,367	(27,305)	(16,681)
Metro North HHS	3,144,089	828,334	4,676,971	4,700,646	(23,675)	167,006
Metro South HHS	1,948,864	316,688	3,934,612	3,951,922	(17,310)	(7,979)
North West HHS	189,916	30,961	301,588	304,653	(3,065)	(12,331)
South West HHS	358,966	21,409	242,643	242,052	591	37,926
Sunshine Coast HHS	2,707,228	684,020	1,924,176	1,961,781	(37,605)	(103,821)
Torres and Cape HHS	352,198	58,273	382,698	382,588	110	8,934
Townsville HHS	1,089,435	147,592	1,572,109	1,571,501	608	78,798
West Moreton HHS	542,041	105,132	1,135,349	1,166,973	(31,624)	(40,439)
Wide Bay HHS	474,416	97,973	1,000,286	1,036,666	(36,380)	(61,325)
Total	**25,893,106**	**6,363,470**	**64,616,706**	**65,577,274**	**(960,568)**	**695,293**

Source: Queensland Audit Office, from Queensland health entities' 2024–25 financial statements.

J. Queensland's top 26 reporting hospitals

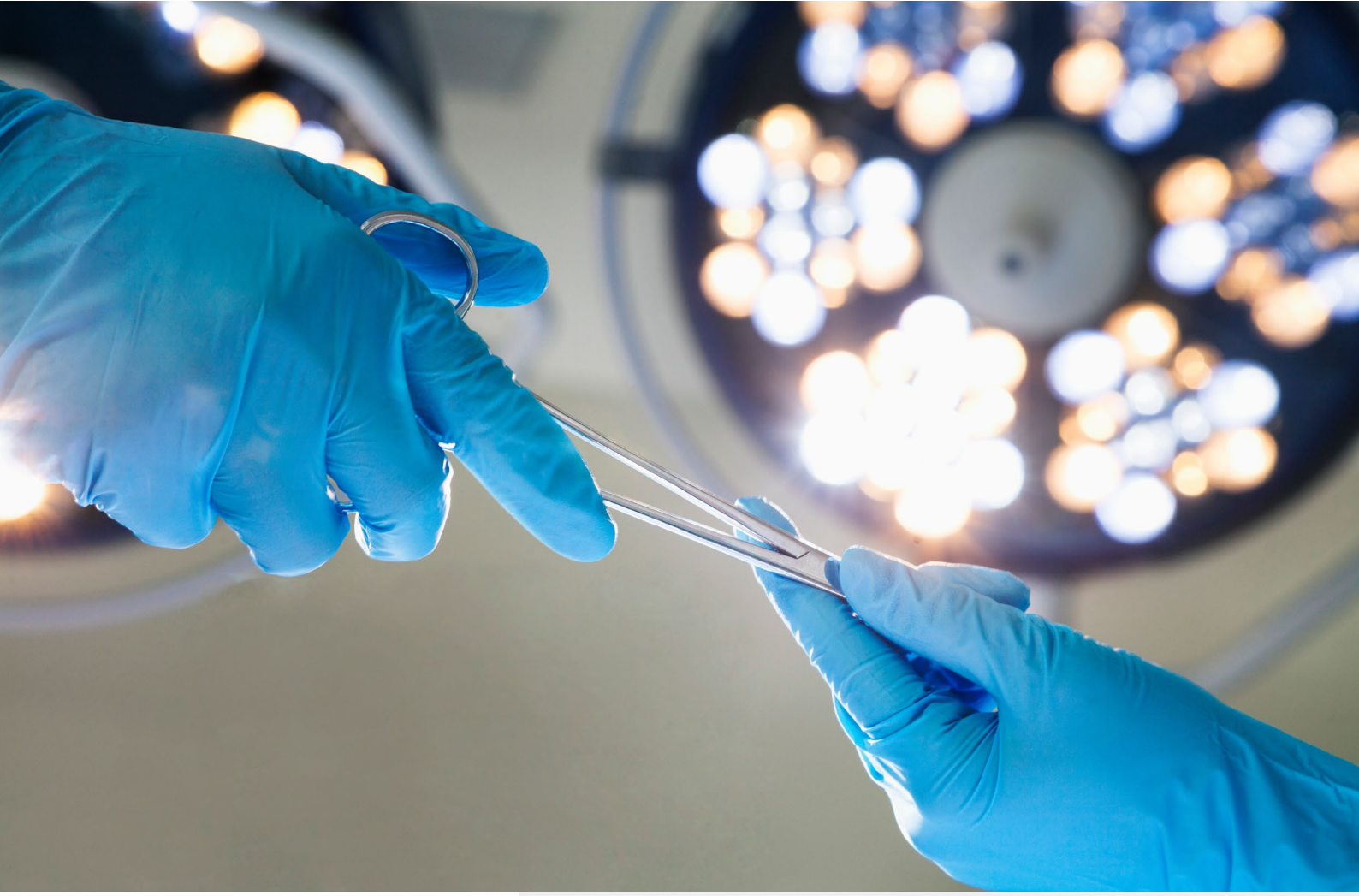
The figures and data presented in Chapter 6 are for the top 26 reporting public hospitals in Queensland, unless otherwise specified. These hospitals treated approximately 74.7 per cent of people who presented at emergency departments for treatment in 2024–25.

Figure J1 lists the top 26 reporting hospitals, grouped by hospital and health service.

Figure J1
Top 26 reporting hospitals

Hospital and health service (HHS)	Hospital
Cairns and Hinterland HHS	Cairns Hospital
Central Queensland HHS	Gladstone Hospital Rockhampton Hospital
Children's Health Queensland HHS	Queensland Children's Hospital
Darling Downs HHS	Toowoomba Hospital
Gold Coast HHS	Gold Coast University Hospital Robina Hospital
Mackay HHS	Mackay Base Hospital
Mater Health Services	Mater Hospital Brisbane Public Hospital
Metro North HHS	Caboolture Hospital Redcliffe Hospital Royal Brisbane and Women's Hospital The Prince Charles Hospital
Metro South HHS	Logan Hospital Princess Alexandra Hospital QEII Jubilee Hospital Redland Hospital
North West HHS	Mount Isa Hospital
Sunshine Coast HHS	Gympie Hospital Nambour Hospital Sunshine Coast University Hospital
Townsville HHS	Townsville University Hospital
West Moreton HHS	Ipswich Hospital
Wide Bay HHS	Bundaberg Base Hospital Hervey Bay Hospital Maryborough Hospital

Source: Queensland Audit Office report – Measuring emergency department patient wait time (Report 2: 2021–22).



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