Overview

The Rudd government promised to ‘fix up’ the public hospitals, but the review of hospitals by NHHRC doesn’t solve the tough problems: not enough attention was given to quality of care, safety, and innovation. These things are hard for bureaucrats to measure, but they matter a lot.

The NHHRC proposals would make the problems worse, disrupting the relationship between universities and their affiliated teaching hospitals, and reinforcing bureaucratic control of hospitals. Management matters, but hospitals are there to provide high quality medical care for sick people.

Australia needs a new structure that brings together what are currently planned to be separate silos of health care. These must couple health administration with clinical expertise, organised in Regional Clusters.

Public universities with Faculties of Medicine and Health Sciences are necessary partners in monitoring clinical quality, safety, innovation and training. Following comments received, a revised Plan is now presented.
A promise by the incoming Government

With problems hitting the media indicating loss of confidence in the public hospital system in 2007, Kevin Rudd made a commitment to conduct a review and delay for 12 months the planned ‘roll-over’ of the Healthcare Agreements with the States.

“If the States do not fix up the public hospitals in twelve months”, he said, “we will take them over and fix them.”....“If needs be we will have a referendum to safeguard Commonwealth control”.

Some initial funding relief has been provided by the Commonwealth, but the fundamental problems remain. It is not just money. It is how the hospitals work which matters.

We need a system through which the necessary roles of State and Australian Governments can partner with universities in delivering high quality health care for all.
Public hospitals over more than 30 years  (1)

Introduction of Medibank in 1975 was a huge step forward, securing free access for all to the medical services of Australia’s public hospitals. The system was then progressively modified under the Fraser government.

Election of the Hawke Government was followed by the introduction of Medicare in 1984. A national dispute between Government and the AMA erupted over proposed ministerial controls introduced with the legislation.

The need for partnership in public hospitals between the medical profession and governments was agreed by both sides, following six months of a national Committee of Inquiry, with widespread consultations.
Public hospitals over more than 30 years (2)

Since that time, with mounting bureaucratic regulation and control by State governments, the working partnership with the medical profession has been progressively eroded.

Hospitals are increasingly managed and judged on performance against budgets, DRG adjusted patient separation numbers, length of waiting lists and emergency room waiting times. Quality of care and innovation with fast evolving science and technologies no longer matter, because they are not measured or rewarded. Safety has become an after-thought.

Repeated crises keep occurring, e.g. in Bundaberg and Royal North Shore Hospital, and The Alfred Road Trauma Unit¹ - all performing well on the usual ‘bureaucratic’ criteria. Morale is low and staff are leaving the system.

¹ As reported by the Ombudsman to the Victorian Parliament October 28 2008.
A big opportunity wasted in important areas

The National Health and Hospitals Reform Commission (NHHRC) has reported after 15 months of deliberations. Like the curate’s egg, it is ‘good in parts’.

Initiatives to improve indigenous health are welcomed, as is additional support for preventive strategies, primary and mental health care, electronic health records and dental care. It is agreed there is a real need for health workforce reform. Even research is seen as worthy but there is no recognition that it matters within hospitals.

The ‘solutions’ represent a series of ‘silos’ rather than a cohesive model. Aged care is poorly done. Its proposals for health workforce reform are misguided. In all these areas there are big issues, critical for the future. (Appendices A, B & C).

The most striking omission is the lack of a realistic framework for hospital reform, the initial reason for establishing the Review. This is largely ignored, assuming external controls and telling hospitals how to treat their patients will solve everything.
What does NHHRC propose for hospitals?

The Final Report sees a progressive Commonwealth takeover of the hospital system with a yearly rise in the proportion of Commonwealth funding.

The longstanding partnership between universities and their affiliated teaching hospitals would be disrupted by the intrusion of Health Workforce Australia, which would control clinical education and its funding.

Hospitals would be told how to treat their patients by external agencies.

The principle of bureaucratic management and control would be unchanged, although regulation from Canberra would inevitably be yet more remote.

Professional pride in the quality of health outcomes for sick people and for innovation characteristic of teaching hospitals, with their university linked clinical research, would be in great jeopardy.

These are not an answer!
Are there real problems in hospitals?

Peter Garling SC reviewed NSW Public Hospitals in 2008.

“During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from serving in the public system.”

These problems are not confined to NSW.

Changing structures so as to achieve a major cultural change, with doctors and other health professionals taking pride in the quality of the health care they deliver to sick people, is the key to improvement.
Where do we go?
Don’t be trapped by the Tyranny of Distance

We should learn from the recent UK experience – Gordon Brown intervened to reform an NHS ‘strangled’ by bureaucratic control and falling behind in quality of care. Other countries had already moved the same way – e.g. Sweden, Finland, Netherlands, Belgium, Singapore.

The U.K.’s NHS has now dismantled its ‘bureaucratic process driven model’. An academic surgeon, Lord Darzi\(^2\), led the reforms.

They saw a close working relationship between practising clinicians (for them clinical academics) and hospital management as essential, with leadership from university Faculties of Medicine across the country.

The key initiative was to reinvigorate the involvement of clinicians, interfacing with every level of management of health care delivery. There has been a rapid turn-around in staff morale (not just medical) and the quality of services in just several years.

Far from being more costly, the new system is now making savings with more sensible allocation of resources.

Teaching hospitals and medical schools

All agree that the primary role of hospitals is the delivery of medical services to sick people which is of high quality, safe and uses up-to-date knowledge. Active clinical research in teaching hospitals has always been the key to this.

Good medical education and post-graduate training are essential to the future quality of the system and should also be in a context where the quality of care is constantly tested as medical science and technology advance.

Medical schools have long been key partners with their teaching hospitals in all these functions and in recent years have become far more widely involved with public health, primary care and in rural and regional hospitals.

University Departments of General Practice and Schools of Public or Population Health and Rural Medicine have much to contribute in monitoring and developing health care for the community, including vital preventive strategies. Medicine and Health Science Faculties now include Nursing, Physiotherapy and other disciplines.
A telling International Review noted by NHHRC

### Figure 1.4: Six nation summary scores on health system performance

<table>
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<th>Overall ranking</th>
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<th>GER</th>
<th>NZ</th>
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<td>5</td>
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<tr>
<td>Overall ranking – 2007 edition</td>
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<td>5</td>
<td>2</td>
<td>3.5</td>
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<td></td>
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<tr>
<td>Healthy Lives</td>
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<td>$3,005</td>
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Note: 1=highest ranking; 6=lowest ranking

*Health expenditures per capita figures are for 2004 except for Australia and Germany (2003) and are adjusted for differences in cost of living.

We recommend the creation of ‘Clusters’ of public hospitals with delegation, but oversight of governance and quality of health care, education and training in regions across Australia, working jointly with State governments, the new Health Workforce Australia and other national bodies. Primary care, preventive strategies and community level interventions all need to be linked.

The Clusters should be developed around the public universities’ Faculties of Medicine & Health Science in every State, in association with their teaching hospitals and general practice, adapting for Australian conditions, the recent British experience.

Practising clinicians should interface with management at every level. This is the most critical change to safeguard quality and safety. Every hospital needs to recognise a clinical Principal Medical Officer to work with its CEO.

Such a change, with clinical involvement in all management, is not foreign to Australia. After the problems in Bundaberg, the Beattie Government introduced ‘clinical CEOs’, now in three major teaching hospitals, following recognition that central bureaucratic control and administration of the hospitals was in serious disarray.

The new system would represent a three-way partnership between the Commonwealth, the States and the universities.
The new national structure - Regional Clusters.

The pattern builds on strengths, using existing resources:

- NSW: Five clusters.
- Queensland: Three clusters.
- Victoria: Three clusters.
- South Australia: Two clusters.
- Tasmania and ACT: each one cluster.
- W.A. to have one southern Cluster, but a second for central and northern WA.
- Northern Territory: One cluster.

Three clusters would have a key role in remote and indigenous health, emphasising primary care and prevention. NT would be led academically by the Menzies Institute from Darwin. That for central and northern WA would be supported by Fiona Stanley’s Institute; that for Northern Queensland by James Cook University’s faculty.
Regional Clusters – the first 3 years (1)

COAG would lead a process for States to appoint a Board overseeing each Cluster, representing the new tripartite relationship between Australian and State governments and faculties of Medicine and Health Sciences.

Each Board to appoint a CEO and recognise an Executive Clinical Dean to work in partnership with the CEO.

Special responsibilities of the Clinical Dean would include:
- Development of teaching, intern and post-graduate training.
- Mobilising the resources of the Faculty’s Schools and Departments to interface with the Cluster, liaising with other universities as needed including other relevant Schools of Nursing and Physiotherapy.
- In partnership with the CEO, monitoring governance, particularly clinical governance, which safeguards quality and safety across the Cluster.
- Developing the lead role of major teaching hospitals, supporting international recognition of some as Academic Health-Science Centres of Excellence.
- Liaison with hospital CEOs and their associated Principal Medical Officers.
Regional Clusters – the first 3 years  (2)

Authority for reporting by CEOs and Boards of hospitals, and if necessary authority for intervention, rests in State legislation. This authority should be exercised by the Regional Clusters on behalf of the State, with necessary safeguards.

Changes in hospital governance are to be progressed during this period, establishing or adapting to purpose, hospital Boards to oversee CEOs and receive reports on quality and safety of services, in addition to financial management and related data.

Support staff to be seconded to Clusters by State Health Departments in the first instance. Financial oversight of hospital budgets and related activity based data collection would remain with State Health Departments through these three years, in consultation with the Regional Clusters.

Ongoing roles of the States in financing hospitals, provision of buildings, shared State-wide programs such as mental health and cancer and the evolution of e-health are to be worked out in consultation. State Treasuries would remain ‘bankers’ for the system.

Schools of Nursing, Physiotherapy, Public Health and Rural Medicine would all play important roles in outreach through each Cluster. Departments of General Practice would be linked with recast Divisions of General Practice and with other regional health services in supporting primary care with a greatly expanded training role. Such arrangements will need appropriate consultative mechanisms.
Regional Clusters – the first 3 years  (3)

There will be a flood of new interns in regional hospitals and general practices from recently established medical schools and also fresh post-graduates to be trained in many fields. They will need appropriate supervision and training which only educational institutions have the systems to support. The functions of 21 national Providers for GP training should be rationalized between the Clusters.

All post-graduate training will require collaboration with Health Workforce Australia, the Australian Medical Council, the Clinical Colleges and other professional bodies. Where a Faculty does not include an academic discipline, support from adjacent Clusters would be provided.

Medical Research Institutes (MRIs) are affiliated with universities in which their PhD students are enrolled. They are a valuable resource in basic medical science, but nearly all the clinical research, on which quality of health care depends, comes through the universities’ clinical outreach. Governance arrangements are needed to bring these groupings effectively together creating outstanding Academic Health Science Centres of Excellence on the European and North American pattern.
Regional Clusters - The Longer Term

By the second three year term, all recurrent funding for public health services and activity based data collection should be transferred to the Clusters, including that related to Sub-acute and Aged Care.

Clusters should have the authority to purchase services from public or private providers based on judgement relating to both quality and price. State Treasuries should continue to be Bankers to the Clusters.

Recurrent funding of clusters (both State and Commonwealth) should be determined on a population basis with forward 3-year projections from the Bureau of Statistics, and agreed adjustments to funding taking account of age-mix and special groups such as indigenous populations receiving additional support from programs specifically designed to narrow the gap in infant mortality and life expectancy.

Base recurrent funding per 100,000 should be adjusted year on year by an inflator taking account of the annual increment beyond GDP growth in a basket of comparable OECD countries (not including outliers such as the US)\(^3\). Surpluses should be able to be carried forward as reserves to handle epidemics and other contingencies.

The move to standard national population-based funding may require a phase-in period over three years.

\(^3\) NHHRC Final Report 2009 Fig. 8 p59.
What comes now? A Summary

Kevin Rudd will report to COAG, in early December 2009, his judgement on implementation of health care reforms following the NHHRC Report.

This proposal would bring together the various silos of development in health services. After an transitional 3 year phase, recurrent hospital funding and its oversight would have been transferred to the Clusters. Aged care would be added once initial national funding problems are resolved.

The Clusters would report to AHMAC through State Health Departments and State Health Ministers would speak for them to COAG and its agencies.

The entire package could be developed and implemented over six months, if there is good will. Major benefits would follow in delivery of high quality health care both through hospitals and in the community, drawing on real strengths which exist.

Minimal new costs would be involved, but there would be a substantial reduction in the bureaucratic workforce in States and Commonwealth, and in the General Practice Divisions, which would become regionally based.

Following constructive negotiation with the States the new Clusters could be in place by July 2010.
Appendix A: Hospitals for patients

Health services are failing to match the needs of the Australian community.

Current health policies assume that driving the system ever harder with existing resources will handle constantly growing demands due to population growth and ageing. This is fundamentally flawed.

Assuming KPIs on waiting lists and emergency room waiting times will deliver ever-expanded services reflects a lack of understanding of the system being governed.

Between 1995 and 2006 the total number of beds per 1,000 population in Australia fell by 11% - due almost entirely to an 18% reduction in public beds. Medicare offers free hospital services to all Australians. It is no wonder people are held in ambulances, on trolleys or on waiting lists.

Building new hospitals is a slow answer. Elderly people in very expensive acute hospital beds with no easy ‘placement’ are part of the problem. Greater public use of private facilities is needed.

Creating new, small community based sub-acute hospitals, built quickly and operated by the private and not-for profit sector would give rapid relief. They are much cheaper to build and operate. If sensible economic conditions apply in reimbursement for public services, capital would rapidly be found, relieving a stressed Commonwealth budget.

Given DoHA’s failure to create an economically viable nursing home sector since the Hogan Report of 2004, rapid action is needed to set workable conditions. Good nursing home organisations, many surviving with subsidy from religious communities, might be the first cabs off the rank for sub-acute hospital services with appropriate reimbursement conditions.

4 AIHW 2008 Health Expenditure Series No 35 Cat No HWE42 p346
Appendix B: Aged Care

The Commonwealth intends to assume total responsibility for Aged Care, adding to its current obligation for Nursing Homes. Greater flexibility proposed by NHHRC for people choosing care options is good in principle, but negotiating bureaucratic complexity with government officers is hardly the answer for most elderly people.

DoHA’s record with nursing homes is poor. Since the Hogan Report of 2004, it still has to resolve proposed funding arrangements (supported by NHHRC) for high care homes. Increments to funding have been 1.5 - 1.9% p.a. – well below CPI and award salary increases. The number of nurses per home has steadily dwindled; providers have withdrawn. The system is in crisis. Is control by DoHA the answer?

Most aged citizens want to stay in their own homes as long as possible. They need local support of high quality. Agencies such as the Royal District Nursing Service and associates or counterparts in many States, have given huge support in poor communities for many years.

Major expansion of Community Nursing, with a well supported career structure and capacity to work with local government, could bring personal health advice including options for care, fittings for homes, social support for isolated people and families caring for the disabled or the demented. Nurse practitioner authority from GPs to renew prescriptions or tests within patient management plans from GPs would go far to assist the elderly and reduce the GP’s burdens.
Appendix C1: Clinical Education

As noted by the Productivity Commission in 2005, there is a great need for expansion and reform of the health workforce in Australia. This is agreed. But how?

In 2005 the Productivity Commission received submissions from Stephen Duckett (Dean at La Trobe) and Peter Carver (DHS Vic.) recommending medical education be taken away from universities and transferred to Health. After university protests, this proposal was dropped.5

The Productivity Commission recommended COAG develop a brief for a Health Workforce Agency, and the task for its planning was given to Peter Carver from Victoria.

Legislation has established the HWA. NHHRC proposed it should require that clinical medical undergraduate education be ‘competencies based education and training’ (CBT), with universities to contract for access to placements in their teaching hospitals, in conjunction with HWA.

The proposal to use CBT revives the attempts of Dawkins and Carmichael in 1991-93 to impose CBT on all university education. This would have regulated movement between the unskilled, the trades and even professions, based on observable skills.

After two years of vigorous controversy, Minister Baldwin commissioned the Marginson review and resolved that CBT would not apply to universities, but would be confined to the TAFE sector.

Appendix C2: Clinical Education

Undergraduate medical education is more than acquiring particular skills. A medical practitioner of the future must learn to understand the human body and mind, the nature and manifestations of disease, as well as principles of diagnosis and treatment which continue to change with evolving medical science and technology.

Solving clinical problems as they see them in teaching hospitals is part of this process with a commitment to ongoing learning at every stage. Seeing multidisciplinary teams, characteristic of every modern major hospital, is an important part of this, as is the environment of questioning outcomes to achieve the best result for patients, which derives from the culture of clinical research.

Once graduated, the intern and year thereafter is very much more about gaining the practical skills of patient care under supervision, followed by embarking on training to gain yet further skills to practise in one of many special roles, including general practice. The language of skill acquisition is used internationally in this context.

A hierarchy of skill and knowledge acquisition may be constructed for each specialty, building on and expanding the educational base. But to recognise only observable skills, using the language of competencies-based education appropriate to TAFE, without recognising the education on which skills are built, is very dangerous.

HWA must work through medical schools, not control them. Teaching hospitals are vital to both education and the ongoing quality of health care.