8 Malvina Place
Carlton Victoria 3053
Australia
+61 3 8344 3637
join@grattan.edu.au

Submission to Senate Standing Committee on Finance and Public Administration

Inquiry into COAG reforms relating to health and hospitals

David Penington
Senior Research Fellow
Grattan Institute

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Scope

The Committee's terms of reference encompass a wide variety of issues raised by the COAG Agreement on healthcare reform.

The following submission focuses on one of these issues: whether the COAG agreement will improve the *quality* of healthcare in Australia's public hospital system. The Australian community deserves access to high quality health care. The crucial change needed in public hospitals to deliver this is development of 'clinical governance' by doctors in every hospital to test and secure the quality and safety of services. Their interface with hospital management is a key issue.

I also make brief observations on the need for better coordination of aged care and resourcing of mental health services under the agreement.

1. *Quality issues in the public hospital system*

There is public perception that the public hospital system provides unpredictable quality, safety and 'right care'. According to a Commonwealth Fund (NY) survey comparing public perceptions of healthcare across a number of developed countries, Australians have low confidence in the quality of health care offered.[1]

This perception is understandable. Events at Bundaberg, Royal North Shore and Alfred Hospital Road Trauma Unit, widely reported in the media, show that it is possible for significant quality issues to remain unresolved in Australian public hospitals, even when evidence of the underlying problems is well-known in the medical community.[2]

2. *Critical features for maintaining quality*

Both Australian and overseas experience show that maintaining healthcare quality in public systems depends on several features:

- The management of individual hospitals should be a genuine partnership between medical practitioners and managers
- Clinical academic staff should be involved in the clinical governance of hospitals to ensure independent review and rapid implementation of the most recent international evidence of the best and most appropriate treatments

[1] The Commonwealth Fund: *Mirror, mirror on the wall: an international update on the comparative performance of American health care* New York 2007 cited by NHHRC Final Report (2009) Fig 1.4 p49

[2] Penington DG *Prime Minister Rudd's plan for reforming Australian public hospitals* MJA 192: 507-8 May 2010 – cites accounts of these issues.

These features recognise that high quality healthcare depends on local process and professional culture. Setting and enforcing prescribed 'standards' at a distance is not a substitute for this. Centrally set standards cannot deal with the many decisions involved day to day in management of individual patients. Only at a local level can medical peers effectively review case management and outcomes.

Many times every day medical practitioners make decisions, especially with patients suffering acute illness, which are not dictated by complete information at the time. Professional review (clinical governance) by colleagues is the most important measure to ensure that best practices are followed and that adequate safeguards are observed or developed. For this to function effectively, the role of medical staff must be respected within a hospital, contributing to management and planning.

Garling QC's 2008 Review of the NSW health system[3] recognised that a profound split between medical staff and hospital management was a major cause of miscarriages in health care and progressive loss of the best practitioners from the public sector. Following the Garling Review, NSW Health appointed clinical executive officers in public hospitals.[4] Similar appointments termed 'clinical CEOs' were made in three major teaching hospitals in Queensland following public concern over hospitals following the Bundaberg events.

Clinical governance entails groups of clinicians reviewing the quality of outcomes, identifying opportunities for improvement and reviewing errors and failures in care. Involvement of expert practitioners in clinical governance can be taken to another level by clinical academic staff, familiar with current literature, experienced in clinical research and evaluation of outcomes in the environment of university linked teaching hospitals.

This insight is consistent with overseas experience. Issues with healthcare quality in the UK in recent years led to major reforms, culminating in Lord Darzi's Report which confirmed that quality depends on a partnership between medical leaders and managers at every level in delivering medical services.[5] Staff from university medical faculties now play a major role in all of these processes in hospitals across the National Health Service. The reforms brought the British NHS in line with clinical academic leadership involved in national systems in Sweden, Finland, Netherlands, Belgium and Singapore, over the past 15 years of rapid change in medical science and technology, drawing on the long established experience of US university hospitals.

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[3] Garling P Final Report of the Special Commission of Inquiry: *Acute Care Services in NSW Public Hospitals* Sydney NSW Government 27 Nov. 2008
[4] Tebbett The Hon Carmel (NSW) personal communication
[5] Lord Darzi of Denham. *High quality care for all* NHS Next Stage Review final report London Department of Health 2008
http://www.dh.gov.uk/en/publicationsandstatistics/Publications/Publicationsandstatistics/Publications/PublicationsPolicyand Guidance/DH_085825

The UK reforms led to rapid improvement in quality of services. The UK now has high public perceptions of service quality, safety etc, as shown in the 2007 Commonwealth Fund survey.[1] University medical faculties are now at the centre of every hospital trust grouping in the NHS. Five of the most outstanding have been recognised as national leaders in both research and development and high quality health services, titled Academic Health Science Centres, joining similar centres of excellence in the US, Scandinavia and Europe. They contribute and respond to the rapid evolution of medical science and technology, translating it into improved health services.

The International Strategic Review of our NHMRC in 2008, conducted by leaders from the US, the UK and Singapore, was *'concerned at the apparent lack of modern Academic Health Science Centres delivering research, healthcare and education'* in Australia. It strongly recommended that *'adequate government funds (state and Commonwealth) are made available to support patient-based research in hospitals with the goal of creating at least a few Australian centres of world class excellence in modern translational and clinical research'*. Under ministerial direction, no such development was undertaken at a time when the political mindset in both States and Commonwealth was one of external bureaucratic control of all hospital functions.[6]

3. *Concern over the outcomes of some COAG decisions.*

Whilst I welcome the achievement of funding arrangements which can secure meeting inevitable future growth in the cost of necessary health services, there remain real problems.

Despite the clear need to improve clinical governance, the COAG agreement will do little to improve quality of healthcare in Australia's public hospitals.

- The COAG agreement imposes a centralised process for reporting on quality that will be expensive and largely ineffective.
- The increased role for evidence based protocols, while worthwhile, over-emphasises the value of such protocols, and down-plays the importance of university medical and health science faculties in ensuring that patients receive treatment informed by the forefront of medical research.
- The COAG agreement does not mandate structures involving medical practitioners and university medical school and health science faculties in hospital clinical governance shown to be necessary by international experience.

[6] Penington DG *New NHMRC plan: a missed opportunity* Australian R&D Review July 2009 p9

3.1 *Centralised reporting*

Even though it will now be the dominant funder of the public health system, the Commonwealth's function in promoting quality healthcare under the COAG agreement will be largely restricted to setting national standards against which quarterly reports will be required from every public and private hospital, every Primary Health Care Organisation in Australia (now termed Medibank Locals) together with 'healthy community' reports. These will be considered by a new National Performance Authority, by the Australian Commission for Safety and Quality in Health Care (ACSQHC) and by the COAG Reform Council. These reports will be based on existing performance indicators associated with the Australian Healthcare Agreement of 2008 and by newly modified sets of performance indicators approved by COAG on the advice of these bodies.

This massive commitment to central reporting is, in my view, likely to have little effect on the way services are actually delivered to people in hospitals or in the community.

Under similar sets of indicators, the Bundaberg Hospital in Queensland, the Alfred Hospital in Victoria, and some NSW hospitals were adequate performers on the usual budgetary or other numerical performance indicators, despite manifest issues with quality that emerged.

Even if ACSQHC could make useful judgments, it is unclear how these will translate into changes in individual hospitals. The COAG Agreement refers to ACSQHC making assessments on their data *'prior to reward payments being made'*.[7] There is, however, no clear provision for such reward payments elsewhere in the documents or in the systems governing funding transfers to institutional service providers.

3.2 *Evidence based protocols*

The NHHRC Interim Report asserted that evidence based protocols from the National Institute for Clinical Studies (NICS) would become the basis of management of patients throughout.[8] Evidence-based protocols of this kind represent accepted and respected treatment protocols derived from previous publications. They inevitably relate to past research, generally some ten or more years old before being tested in clinical trials, published and gaining broad respect. Although they have value, they need to be coupled with access to more active medical research. Medical science and technology continues to advance rapidly. Most clinical research comes through university medical and health science faculties. In a specialist hospital active in clinical research, the needs of every sick person are tested against

[7] COAG, National Health and Hospitals Network Agreement (2010) http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/NHHN_Agreement.pdf at p.42

8 National Health and Hospitals Reform Commission, *A healthier future for all Australians: Interim Report* (December 2008) p349

advancing knowledge. The application of such knowledge is a feature of major teaching hospitals, which are leaders in clinical practice and professional training, with their culture of testing treatment outcomes by research and willingness to submit to peer-review. In hospitals that have come to be managed primarily against transactional numbers through bureaucratic and administrative processes geared to containing expenditure and meeting minimum institutional standards of performance, the commitment to excellence and innovation is in danger of being lost.

3.3 *Involvement of medical practitioners*

Unfortunately the COAG agreement does not mandate involvement of medical practitioners in hospital clinical governance. Such involvement was supported in the Prime Minister's proposals of March 2010,[9] following many visits to hospitals. These would have seen clinicians *'closely linked to decision making processes to contribute knowledge, advice and leadership guidance on clinical issues and service planning'* (p60). They were a potential basis for developing realistic clinical governance monitoring the quality and safety of medical services delivered. Consistent with this approach, the Commonwealth proposed that Local Health Network boards would include clinicians, thus influencing management (p63).

It is not clear how the COAG agreement will ensure an appropriate role for medical professionals in hospital clinical governance. These responsibilities now rest with the States in management of the Local Hospital Network system. Under the agreement, the Commonwealth's role is largely restricted to collection of information based on existing or improved performance indicators.

4. *A better agreement for all*

As well as involving individual clinicians in hospital boards and hospital management, clinical governance could also be improved by building on the proposed COAG agreement, and involving Australia's university medical and health science faculties in supporting development of hospital clinical governance.

All Australian public and private medical schools, through their clinical academics, can play a significant role in supporting the development of clinical governance in their own principal teaching hospitals and also reach out to the associated metropolitan hospitals and regional and rural hospitals to which their students go for clinical experience. Teaching hospital interns, residents and registrars 'rotate' to many of these and their consultant staff commonly provide visiting professional services. All medical schools could be partners in this sense with ACSQHC in ensuring the mission of clinical governance extends throughout the system.

[9] Australian Government (DoHA), *A National Health and Hospitals Network for Australia's Future* (March 2010)

A number of Australian medical schools are assessed as amongst the top 300 in the world, and many would join two in the top 100 if the clinical research from their "satellite" institutions were included.[10] If recognised as serving a special role, they could give effective leadership in our system. The NHMRC could readily identify the principal faculties responsible for the great bulk of Australian clinical research as appropriate for recognition as Australian Health Science Centres with their associated teaching hospitals, as proposed in the NHMRC Strategic Review.[11]

Consistent with the UK approach, five or six such Centres could be recognised as providing national leadership in health service development, research and clinical practise. They could assist in developing the models of clinical governance and performance assessment in their own, and in associated hospitals, in the quality of delivery of training, in integration of services between hospitals, primary care, aged care and mental health, as in general applied in the UK for their five such centres within the NHS. These would assist greatly in ACSQHC's daunting task, with its quarterly oversight of reports from more than 1000 deliverers of health services across Australia.

The Centres could be funded, with agreement of the States, on receiving the planned Commonwealth support for 60% of recurrent expenditure on research and training undertaken in public hospitals. The clinical research is virtually all associated with the medical schools. The research, itself, is already largely funded by NHMRC and other continuing sources. The new funding stream, envisaged in the COAG agreement, could provide the necessary modest infrastructure to bring the teaching hospitals into partnership with the university faculties and associated research Institutes, and support interaction with associated hospitals. Processes to determine the precise quantum of this grant remain to be finalised, but this is planned to occur during 2011. The agreement separately identifies this research component, and makes clear that this money is to be dealt with outside of the Funding Authority's recurrent and capital funding to individual Local Health Networks. Renewal of such designation as Centres of excellence after an initial five years could depend on the Centre demonstrating, to ACSQHC and NHMRC, effective leadership in development of clinical governance, methods of monitoring performance and contributions both to innovation and quality in addition to continuing performance in clinical research. Such a development would access the powerful force of professional pride in excellence and quality of service to support the original intent of the reforms at virtually no additional cost.

10 Higher Education Evaluation and Accreditation Council of Taiwan 2009 *Performance ranking of scientific papers for world universities. Clinical medicine*. http://ranking,heeact.edu.tw/en-us/2009%20by%20Fields/Domain/MED (accessed May 2010). Note that these published rankings do not include the work of university-associated independent research institutes that are a distinctive feature of the Australian health landscape, driven by funding arrangements.

11 Penington DG *New NHMRC plan: a missed opportunity* Australian R&D Review July 2009 p9

The mindset of State governments is inevitably one of controlling costs in hospitals which inevitably continue to rise at a rate greater than inflation, as is the case across the OECD. In reality, academic endeavour in hospitals does not necessarily imply greater cost. Better clinical judgement and testing of outcomes can actually save money. A notable article compared the cost of health care in El Paso, Texas, close to the Mexican border, with that in the vicinity of the Mayo Clinic in upstate New York[12] (with a medical school ranked no 12 in the world on its clinical research). It showed cost per patient in the latter was a mere fraction of that at El Paso although the Mayo is a private institution which provides the highest quality care available in the US. The new Academic Health Science Centres in the UK are also making savings despite their heavy involvement in clinical research.

4. Aged care

With the Commonwealth assuming responsibility for aged care, it is alarming to note there is no explicit plan for this program. It is noted that discussions will take place in COAG in 2011. With an ageing population and the prospect of large numbers of aged people in need of skilled assistance to sustain independent lives for as long as possible, constructive and innovative planning should be underway.

The Academy of Technological Science and Engineering and associated researchers have already attracted international interest in their collection of information and programs to greatly facilitate independent living for elderly people using telemedicine, simple IT devices to facilitate communication with families and friends and many other strategies and technologies to improve their capacity to remain at home. Fresh thinking and innovation are important rather than simply shifting 'deck chairs' for what will be one of the fastest growing areas of demand for appropriate health services in coming years as illustrated by a recent international assessment in the journal Lancet[13].

Aged care should look after elderly people in their own homes, with community nurse practitioners and rehabilitation services. It should aim to use 'sub-acute hospitals' to serve elderly people with rehabilitation services where appropriate. These are far cheaper to build and operate than acute public hospitals, but appear to fall, under COAG arrangements, within the funding channels for Local Hospital Networks. Such hospitals are run very efficiently by the private sector in providing rehabilitation services. They need to be part of an integrated service which not only serves the needs of transition from acute hospitals, but other vital functions, now under Commonwealth management, including aged care, primary care and mental health. These issues need resolution to avoid 'cost shifting' and inefficiencies.

12 Gawande, Atul *Getting there from here. How should Obama reform health care?* The New Yorker http://www.newyorker.co./reporting/2009/01/26/090126fa_fact_gawende

13 Christensen K, Doblhammer G, Vaupel JW Ageing populations: the challenge ahead Lancet 2009: 1196-1206

5. Mental Health

The funding provided for mental health services falls far below that recommended by the Senate Committee of 2006.[14] Its recommendations should be revisited.

[14] *A national approach to mental health – from crisis to community*. Senate Committee of Inquiry 2006