We need more doctors in the house

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Health professionals must be given a larger role to guarantee real reform, writes ***David Penington.***

The airwaves are busy with federal government advertisements trumpeting its program of health reforms, but questions mount as we watch them. After the Council of Australian Governments meeting in April that sealed the deal, states still control hospitals, so what will change?

Real reform requires securing quality and safety of care, and effective links between services. Clinical governance is needed in every hospital, a real challenge for governments, hospitals and the medical profession.

Huge advances in medical care in the past 30 years have been led by university hospitals in the US, Sweden, Britain, Finland, Belgium and The Netherlands, although the key advance for sufferers of peptic ulcer worldwide came through Nobel prize-winning clinical research at the Royal Perth Hospital.

Leading groups overseas are recognised as academic health science centres, with vigorous clinical research testing quality, with clinical governance a given, together with linkage of services. Australia rejected this model, despite it being the main recommendation of the 2008 international review of our National Health and Medical Research Council.

Expenditure on health care increases in every Organisation of Economic Co-operation and Development country by about 4 per cent to 7 per cent more than the GDP rate of growth, partly due to ageing populations, but our heavily regulated and splintered system has difficulty in responding.

States are preoccupied with curtailing costs. In several, central bureaucratic approval is required for even minor expenditure within hospitals.

Hospitals are managed against metrics of budget, patient throughput, waiting lists and emergency room waiting times. They report numbers to state health departments. They are there to deliver medical services, but the role of doctors in overseeing quality of care is minimal. Realistic yardsticks of quality have not been developed.

Medical mishaps that occurred in Bundaberg and Sydney's Royal North Shore Hospital were in facilities performing well on the usual metrics.

Peter Garling SC, who led an inquiry into NSW health services after the preventable death of a young woman in a state hospital in 2008, saw the rift between doctors and administration as the key.

The National Health and Hospitals Reform Commission, however, headed by Christine Bennett, saw quality and safety secured by externally set standards, overlooking the key role of health professionals in clinical governance.

In the local hospital network plan of March 3, management was to be by local boards with chief executives, which were required to achieve medical involvement in governance, planning and management. The commonwealth was to provide policy direction and funding, but management was to be local, responding to community needs.

John Howard had reduced the commonwealth's hospital funding from 2004, expecting states to meet the shortfall from GST revenue. When COAG considered the Rudd plan in April, funding was secured for the short term with substantial new commonwealth money, and in the long term by transfer of 30 per cent of GST revenue (excepting Western Australia). Premiers, as a condition of the clawback,

required that they retain control of hospitals. Safety and quality were seen as matters for national agencies.

The COAG document requires doctors appointed to LHN boards be from outside the network in question, as in Victoria. Clinical governance arrangements are up to each LHN, despite having little understanding of what it entails.

The commonwealth will be a member of each independent state funding authority, which will have no policy or operational role. It will not intervene in matters concerning governance of LHNs or the negotiation or implementation of the LHN service agreement. A key aspect of the LHN plan has been derailed.

Apart from securing long-term funding and new hospital boards in NSW and Queensland, what will change?

The one positive commitment in the COAG package is paying 60 per cent of the states' annual cost of research and training within hospitals. The bulk of clinical research in Australia is through six faculties of medicine and health sciences, in their associated hospitals. These clusters of university-linked hospitals and research institutes are of international standing and should be recognised as AHSCs.

COAG must now require all states to develop clinical governance across their hospitals to safeguard safety and quality, a challenge for the new Prime Minister.

AHSCs, supported with these funds, would lead clinical governance, quality improvement and innovation through research, influencing the whole system through their links with other hospitals and services.

We must develop realistic tools to measure the quality of services that are credible and respected by doctors for relevance and accuracy. These would provide a means of comparing quality between hospitals and other providers, a big driver for improvement of a kind the community has every right to expect.

For aged care, we also need a realistic framework for support of the elderly in their homes. The same applies to woefully under-resourced mental health.

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