

Healthcare reform: possible ways forward*

John Menadue

THERE IS LITTLE DISAGREEMENT about the directions public health reform should take — greater emphasis on primary and preventive care, workforce reform, community participation, improved governance and better application of information technology. It is clear that there are gaps and duplication in clinical services that reflect outdated population patterns and jealously guarded clinical territories. There is concern about the health disadvantage of certain groups, and particularly Aboriginal and Torres Strait Islander people. In quality of life measured by life expectancy, Australia ranks number two in the world, but in healthcare equality we rank number 17.¹ If all Australians had the same health experience as Aborigines, we would rank number 140 in the world, alongside Bangladesh.

These issues are common to many advanced healthcare systems. This is confirmed by almost any healthcare enquiry or commission. One doesn't have to be a rocket scientist to know where we need to head.

But there is considerable disappointment and disillusionment about the ability of the leaders of our health systems to lead and manage the change. And the public is right about the failure of health leadership — political, clinical and managerial. In the two inquiries I headed in New South Wales² and South Australia,³ the cynicism I encountered was abundant and depressing. I was continually told that “your inquiry may be well and good, but nothing will really happen”.

I understand their cynicism. It is part of a larger issue of alienation, which the community feels towards all our major institutions — parliament, political parties, the media, trade unions, companies, and churches.⁴ We so often feel that they are not honest and open with us, and that they try to manage and manipulate information to protect their own interests. Major institutions have lost touch with their natural constituencies. It is true in healthcare.

I would like to identify briefly some of the major underlying problems and then suggest some possible ways forward. My comments are very much influenced by observing, at

close hand, the NSW and South Australian health systems and the way they relate and react to Commonwealth health funding.

- There is clearly a failure of the Commonwealth and states to cooperate in the funding and delivery of healthcare services, with resulting inefficiencies, buck-passing, cost-shifting and poor integration. It was made clear to me in NSW and SA that the public wants change here, but doesn't see any leadership through the impasse.

- There is a lack of honesty by governments as to what the healthcare system, with limited funds, can reasonably provide. As a result the public has unrealistic expectations and the health workforce is under great pressure. In this situation, political mischief by Oppositions is easy. Unless governments face this issue of limited funds and rationing, and are honest with the public, they will always be under pressure and in crisis, with numerous band-aids applied, but no system change.

- The healthcare system is remarkably inward looking. The debate is between insiders. The community is not enfranchised or involved. If I have been able to contribute anything to the health debate, I believe it is because I am an outsider.

- There is clearly waste in the present system, with a \$2.5 billion private health subsidy that produces few obvious health dividends. There is widespread overhospitalisation, overservicing in some areas, duplication of clinical services and large central health bureaucracies.

- We have a very institutionalised, medicalised and hospital-centric system, rather than a health system. The debate and resources are pre-empted by hospital interests at the expense of, for example, primary care, prevention, clinical support in the home, more appropriate facilities for the aged, and hospital avoidance programs. Hospitals should be the last resort, but, in the current system, they are often the first.

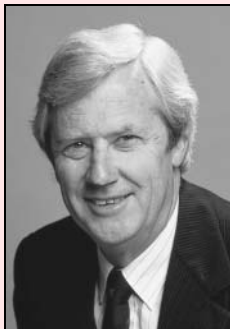
- There is the problem of the quality of healthcare, and avoidable adverse events as a result of spreading our skilled clinical services too thinly.

In attempting to tackle these issues, the plea invariably is “more money please”. More money is clearly necessary in key areas, but more investment in doing the same things the same way will only delay reform. It encourages just the attitude that is at the centre of our problems — that resources are unlimited and that choices do not have to be made. It will be the same old treadmill. Governments and taxpayers rightly insist on value for money. Reform will not be successful unless we can persuade treasuries that the money will be better spent in the future. In achieving that, I believe some or all of the following elements need to be in place.

- A Commonwealth/state health commission should be established in any state that agrees to cooperate with the federal government in the joint funding and operations of public healthcare services in that state. Which state will

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break the impasse and be the first to put its hand up? Will the Commonwealth respond? We need to move beyond Commonwealth/state pilots and demonstration projects to real system change.

I am sure that a joint service would deliver better quality and efficiency of care, even if no additional funds were provided. So let us put that joint Commonwealth/state health commission on the agenda, put the case as compellingly as we can, and hopefully within 3 to 5 years we would have started to break the wasteful impasse and buck-passing of the present divided jurisdictional system.

■ The roles of ministers, health executives, boards and health institutions, particularly in the states and territories, must be clearly defined and accountabilities established. The micromanagement of healthcare systems by ministers and their private offices must be stopped. I have heard and seen at first hand endless cases of private ministerial staff members who suppose that, as the minister's alter egos, they can hector quite senior clinical and non-clinical staff. Some members of ministerial staff even think it is appropriate to try to micromanage external and independent committees of review. This is not a new problem, nor is it restricted to one government. It is a very serious problem. Certainly, ministers and their offices need to manage short-term crises and they need to get on top of some of the detail, and there is a lot of detail in healthcare, but so often they allow themselves to be submerged by the detail, lose their way and allow the nightly TV news to set the agenda. So, ministers spend disproportionate amounts of time putting out brush fires. Media management and micromanagement by ministers and their offices go hand in glove.

This preoccupation with daily crises and micromanagement has many unfortunate consequences — long-term issues, such as the reform agenda we are discussing at this summit, are put on the back-burner. Senior executive officers are confused and reluctant to make decisions. They become gun-shy. They manage upwards to the minister. The minister becomes the client, and not the public. Disproportionate resources and energy are spent serving the minister, and particularly his or her staff. The central department also becomes too close to the political agenda of the minister, with the emphasis on news management. In my experience, private staff of ministers are petrified at the prospect of robust discussion and debate.

This issue must be addressed, or confusion and frustration at senior levels will continue to paralyse the system. Only ministers can lead this change and forgo their micromanagement. It is not only in the interests of a well functioning system for them to do this, but it would seem clearly in their own interests to break out of the daily political cycle of calls for more beds and complaints about ambulance bypasses. The healthcare system would greatly benefit if they would use their political credit and influence to win the debate and change the system — to achieve, for example, better primary care, improved mental healthcare and putting us on track to remedying the most disastrous problem of all, poor Aboriginal health.

In speaking of micromanagement, I know I am treading on toes, but if I could paraphrase the words of Confucius

when asked “how to serve the minister”, the sage replied “tell him the truth, even if it offends him”.

■ Not only must there be clearer definition of roles, and clear accountabilities, there must also be close linkages between corporate, clinical and community governance. Each role must be clearly defined within an overarching governance structure. Clinical governance in the end must be subject to corporate governance. Managers must recognise the professional responsibility and skills of clinicians. Clinicians must understand the financial and political constraints under which the system operates. It is they who admit patients to hospitals — not patients themselves or even hospital managers. Nothing is ideal, but improvement is possible.

Great care is also necessary in choosing boards of governance, for getting the governance structure right will not be sufficient if ministers appoint political or personal extensions of themselves. Similarly, board members must carefully and determinedly assert their duties to ensure good governance, and not knuckle under to short-term pressures. Governance boards are not the same as advisory committees. They must be structured and appointed with full regard to the overarching responsibilities which governance boards have — financial, ethical and legal probity, adherence to occupational health and safety standards, high standards of professional conduct and competence and efficiency.

■ The health agenda must be changed and the community is the key to doing that. I believe that in SA, we have recently made significant progress in presenting a compelling case to the public for change — the main change being a public understanding that we can't have everything in healthcare. However, the status of the new agenda may be precarious, and could easily revert to the daily political cycle of media headlines about hospital beds and new high-tech equipment.

There must be major and successful communication campaigns to establish what are the clear priorities in healthcare spending. Expenditure on healthcare in Australia has increased from about 6% to 9% of GDP (gross domestic product) over the last 40 years. While healthcare demands are almost unlimited, resources are finite. The health budgets of Commonwealth and state governments are clearly not sustainable into the future.

I have seen numerous surveys of community priorities in health. They all tell very largely the same story. Whilst the community appreciates the important role of hospitals, they see mental health as today's top priority, followed by the health of children (particularly children subject to violence), and Aboriginal health. The community speaks very clearly and consistently on these issues, but they do not shape the priorities in spending. Insiders make the decisions.

Ministers give lip service to community participation, but many quite seriously believe that they represent the community, so do not see the need for another level of community participation. Unless the Commonwealth and state governments involve the community in setting priorities in health spending, we will not make real progress in systemic reform. We called our South Australian report “Better choices,

better health".³ Choices cannot be avoided. Unless the community is locked in through appropriate structures and processes, health reform will not happen. The public must be connected.

■ Health leaders must acquire and demonstrate proven capabilities in managing change in large organisations. For large-scale change is necessary, and, if I was a minister, I wouldn't be confident that I had the senior executives who were capable of leading the process. In my experience, the public sector has superior analytical and policy development skills compared with the private sector. But there is a big difference when it comes to being prepared to take risks. Change management is now a significant feature of leadership in major companies in Australia and around the world. It is desperately needed in healthcare systems. While change in healthcare systems must be driven from within, it requires major help from outside experts.

■ The healthcare workforce is composed largely of people of great professional commitment and skill, but they know little else but health. So change is hard to visualise if healthcare is the sum total of one's work life. Nowhere is the healthcare system in greater need of external expertise than in human resources and industrial relations. These are essential if we are to see a restructuring and rejuvenation of the healthcare workforce, which is, frankly, more appropriate to the needs of the 19th than the 21st century. Training and work are in separate compartments, and work demarcations abound. Restrictive work practices and denial of career prospects, large central offices and shortages in critical areas are rife. There is little linkage between workforce plans (if they exist at all) and budgets, infrastructure planning and delivery of services. The labour market is supply-driven, with little effective linkage between the supply through training and educational institutions and the demands of a changing healthcare system.

We are rightly proud in Australia of the workforce renewal that has helped transform the Australian economy. But that workforce renewal has not really touched the professions, and particularly the healthcare sector, where jobs need substantial redesigning and work processes must be significantly re-engineered. Over a period, this could deliver major productivity gains and enhanced job satisfaction, particularly for nurses. New people with resolution, new ideas and new attitudes are essential if workforce renewal is to occur.

■ The solutions to many "health" problems will not be found only within a highly medicalised healthcare system. The greatest cause of poor health is poverty. This is abundantly clear with Aboriginal people. Their poverty and associated bad health are compounded by a lack of hope. I recall in SA an Aboriginal elder telling me that young Aboriginal people say to her "with our grim prospects, what is the point of being healthy". So a response must be holistic. It requires whole-of-government action, with targets set across a range of portfolios — employment, education, water supply, police and health. And this can only be driven by the Cabinet. Interdepartmental committees will not do the job. Aboriginal health is a national emergency that requires ministerial leadership by every Cabinet minister in Australia, not just health ministers.

■ Because the health system is so inward-looking, an independent and external monitoring body to report publicly on implementation of a change program is essential. Change will be hard, and every day there will be those with vested interests who will want to beat back the change. Not surprisingly, the leaders within the system are likely to lose heart. That is why an independent and strong external group is essential in checking progress and helping to chart the way forward. In this work, that monitoring body needs to focus on a few simple and clear measures of progress. Healthcare produces reams of reports and statistics, but these are not used to measure and drive reform. The Canadians have something to teach us, as in so many healthcare areas, about what are the really important measures of success in health systems.⁵

Finally, I guess all this comes down to leadership — political, clinical and managerial. My recent experience in SA is that the public wants to be engaged, and responds very positively to a well argued case for change. That case requires leaders prepared to take risks.

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