

Australian healthcare reform: ailments and cures

It's time to stop applying bandaids and get on with real change

DESPITE THEIR PROTESTS that it was a “hold-up” and that it “may tragically be the death warrant for some people”,¹ last month our state premiers capitulated and signed the 2003–2008 Australian Health Care Agreements (AHCAs). Since then, the healthcare crisis has all but disappeared from the front pages of newspapers and television screens, but, for the community, the crisis remains a daily reality. The desire for healthcare reform, so evident at the recent Australian Health Care Summit,² will continue, and the demand for the AHCA’s reform blueprint³ to be implemented will only increase in the face of the ongoing inertia of our health ministers. In short, there is now widespread expectation of less political rhetoric and more action.

However, sustainable reform requires a change in the political and professional landscape of Australian healthcare. In a keynote address at the Australian Health Care Summit, leading health reform expert John Menadue diagnosed the ailments of our healthcare system, and proffered some cures. His address, *Healthcare reform: possible ways forward*, appears in this issue of the Journal (page 367)⁴ as the first in a series of selected addresses to the Summit.

Menadue’s diagnostic skill comes from his role in promoting healthcare reform as chair of the New South Wales

Health Council,⁵ and, more recently, as chair of the South Australian Generational Health Review.⁶

It would seem that Australia’s healthcare system is not at all well. In the upper echelons of healthcare, Menadue has identified a multitude of ailments, including:

- endemic political buck-passing across jurisdictional divides;
- lack of public honesty by governments as to what the healthcare system can provide given its limited funding; and
- a preoccupation on the part of health ministers and their advisers with media management and health micromanagement, much to the detriment of more significant healthcare issues.

In essence, our health system is overpoliticised. Short electoral cycles, constant ministerial turnover and the body politic’s demand for instant solutions are not compatible with reforming a large and complex system.⁷

At a middle level the ailments include:

- isolated healthcare professionals who run insider debates with little involvement of the community;
- a system that is hospital-centred at the expense of primary care, population health and community-based care; and
- a pervading executive ethos of decision paralysis.

Healthcare reform in New South Wales

- **July 1999:** The NSW health minister initiated an extensive independent review of the NSW healthcare system which included establishing the NSW Health Council to examine the way the NSW healthcare system delivers care.
- **March 2000:** The NSW Health Council recommended developing a single, coherent, long-term, organised plan for metropolitan Sydney.⁵
- **May 2000:** The Greater Metropolitan Services Implementation Group (GMSIG) was convened by the health minister to examine hospital services.
- **June 2001:** GMSIG report, incorporating 162 recommendations related to a broad range of acute hospital services,⁸ was accepted as NSW government policy.
- **November 2001:** Health minister established the Greater Metropolitan Transition Taskforce (GMTT) to implement the GMSIG recommendations, specifically to examine hospital services in the greater metropolitan region, including Sydney, the Central Coast, Hunter and Illawarra.
- **July 2002:** \$64.5 million annual recurrent enhancement funding (\$30.9m to the 22 smaller "District" metropolitan hospitals) targeted to areas that clinicians considered the highest priority.⁹
- **December 2003:** GMTT to report on achievements in 15 clinical program areas identified by GMSIG and seven additional clinical programs reviewed at the request of clinicians. GMTT convened working groups across these 22 specialty areas, and held open meetings at hospitals across the greater metropolitan region. Over 2000 doctors, nurses, allied health professionals and consumers were involved in the working groups.

Selected outcomes to date

- Establishment of collegiate approach between doctors, nurses, allied healthcare professionals and consumers, and of clinical networks to coordinate services.
- Sustainable clinical governance with consumer involvement established in 24 hospital disciplines in the greater metropolitan region.
- 300 new clinical positions established in metropolitan hospitals; 19 stroke units with common treatment protocols established; three new cardiac units established on the periphery of the metropolitan area to provide cardiac angiography; five computed tomography scanners and staff provided; and interhospital transport upgraded.
- Statewide services coordinated in severe burns, spinal cord injury, brain injury rehabilitation and major trauma.

Menadue's diagnosis of Australian healthcare is that it is institutionalised, introverted, and wary of innovation and change — a system constantly crying out for "more money please".⁴

However, all is not doom and gloom. Menadue also offers possible cures. Most prominent among these is to have Commonwealth and state governments involve the community in setting priorities in healthcare spending. After all, it is about their health and their tax dollars!

Reform means change, and change is always difficult to achieve, but a real life example of healthcare reform and change management has been in train in NSW since 1999 (see Box). In that year, the then NSW Minister for Health, Craig Knowles, initiated a major review of the state's health system by two independent bodies comprising health and other experts, consumer representatives, and headed by

prominent individuals from outside the health system. After an extensive and consultative process, the overarching recommendations from one of these bodies, the NSW Health Council, were the need for metropolitan-wide planning of clinical services (including the role of district hospitals in clinical networks) and increased engagement of senior clinicians in planning and administering health services.⁵ The NSW government promptly accepted the major thrust of the report, and the health minister initiated a cascade of processes to improve healthcare delivery in the greater metropolitan region (see Box).⁸ The change process is driven by the Greater Metropolitan Transition Taskforce (GMTT), an independent external body established to monitor progress and facilitate progress (see Box).

The principles for achieving reform and managing change evident in this NSW experience include:

- a health minister with vision and political clout;
- use of respected outsiders to lead independent bodies in exploring frameworks for reform through extensive and inclusive consultation;
- timely acceptance of major recommendations by the government;
- delegating implementation of change and progress monitoring to an independent body, outside the bureaucratic stream, but with "buy in" of professional expertise; and, most importantly,
- giving "experts" the freedom and time to achieve the task.

Overriding all of this, however, is the need for a collective political will for meaningful reform.

The AHCA's have been signed and our health ministers have an interlude of no more than 4 years. Over a year ago, all our health ministers agreed on an agenda of reform and change.¹⁰ If there is no meaningful movement within the next year or so, patients, doctors, nurses and other health professionals have every right to say "a plague on both your houses".¹¹

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