

Fixing the problems that beset the Australian hospital system

John M Dwyer

Public hospitals need an injection of cash to help reduce demand for hospital services; networking and role delineation among hospitals would immediately increase safety and quality

While most patients in our public hospitals receive a very high standard of care, the incidence of misadventure and the inequities that currently exist¹ are unacceptable. These problems are a product of a workforce crisis, ever-increasing demand for hospital services from ever-sicker patients, and too many episodes where the clinical needs of a patient are not attended to by suitably skilled staff.

This last problem is a feature of a political climate in which warnings by hospital clinicians that a hospital cannot provide a quality service (such as an intensive care unit) are too often ignored for fear of community anger about that service not being available locally! Each evening, many hospitals have staff phoning medical agencies in frantic competition for doctors who might help them out during the coming night. It is a lottery in which the doctor you “win” may not have the experience needed for the tasks required.

Hospitals do not function optimally with occupancy rates that exceed 85%, yet many regularly exceed 100%. In very busy, inadequately staffed hospitals, communication breakdowns all too often compromise safety.²

Solutions

Role delineation for every hospital is essential. Too many are expected to provide a broad array of quality services. Each hospital should be an invaluable asset in a “networked” system, offering services based on its ability to guarantee quality and safety, and the overall needs of the network. We need to follow other countries and subclassify our emergency departments, redesignating some as acute care centres, with their capabilities and limitations clearly explained to the public.

Poor urban planning has seen the development of smaller hospitals in close proximity to each other. These should act as a single hospital on split sites, offering excellence at each site, but not duplication. Even some of our “principal referral hospitals” could benefit from such an approach. Instituting and, in some cases, improving interhospital transport will be an essential ingredient of such an integrated hospital system.

Commonsense changes like these do require political leadership and public understanding (as explored by Mooney in this series³). We would be promising our patients that, wherever they entered the public hospital system, we would ensure that they are given the highest quality care, even if that means moving them to a more appropriate facility.

Public hospital clinicians are feeling increasingly disenfranchised as budgetary control dominates the thinking and actions of hospital managers and promotes centralisation that removes clinicians from the frontline environment. This must change. Clinicians are extremely frustrated when their urgent concerns cannot be addressed by inhouse administrators with decision-making power. Decreasing budgetary pressures by instituting hospital funding

Key propositions

- **Funding** — an immediate injection of \$1 billion and agreement on equal state and federal funding of hospitals.
- **Institutional** — networking and role delineation for metropolitan hospitals, including subclassification of emergency departments to more accurately delineate their capacity; improved inter-hospital transport systems; and development of a mutually beneficial partnership between public and private hospitals.
- **Workforce and staffing** — accreditation of the skills of individual doctors who work as locums, restoration of constructive and timely interaction between clinicians and senior management, and a supportive environment to promote staff retention.
- **Demand management** — building up out-of-hospital services and preventive care.
- **Community engagement** — dialogue with the community to make sure they understand the rationale for the proposed changes. ♦

based on episodes of care rather than fixed historical budgets would see the re-emergence of all-important partnerships between clinicians and managers.⁴ Clinician governance (medical staff councils, clinical councils, etc) must be revitalised, with clinicians’ influence guaranteed in hospital by-laws. Up-front bonuses may attract some nurses to return to work, but flexible working conditions with support and mentoring replacing bullying and excessive workloads would be more effective.

Each state needs an institute for medical education and training, resourced to accredit the practical skills of Australian and overseas-trained doctors who plan to work as locums in our public hospitals. Senior doctors should be encouraged, and financially remunerated, to spend more time in their hospitals helping to improve the quality of decision making. Many inadequately staffed hospitals would benefit by training emergency response teams to provide quality urgent care at all times.

We need to develop a long-overdue, mutually beneficial partnership between public and private hospitals. With additional funding, public hospitals that do not have any additional capacity could purchase services for their patients from private hospitals.⁵

In the medium term, the reforms offered in these articles would provide more health care from current funding levels. However, the public hospital system, as constituted, needs a major and immediate injection of cash. Given the current federal budget surplus, the offer of \$2 billion over 4 years for our hospitals could surely be more generous, with at least \$1 billion more needed in the next year (\$500 million is on offer). The next Australian Health Care Agreements must represent both an instrument for these reforms and a return to the 50/50 funding split for the federal and state governments, as was mandated at the inception of the scheme.

Additionally, these reforms must be accompanied by major efforts to reduce demand for hospital services by focusing on

disease prevention, the maintenance of wellness, and earlier diagnosis and treatment of potentially chronic diseases.

Our health care system needs dollars, reform, public understanding of the rationale for changes needed and, most of all, political courage. These would provide our best chance in a very long time to create the sustainable, fair, quality hospital system we need and can afford.

Competing interests

None identified.

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References

- 1 Menadue J. What is the health service for? *Med J Aust* 2008; 189: 170-171.
- 2 Sprivulis PC, Da Silva JA, Jacobs G, Frazer AR. The association between hospital overcrowding and mortality among patients admitted via West Australian emergency departments. *Med J Aust* 2006; 184: 208-212.
- 3 Mooney GH. The people principle in Australian health care. *Med J Aust* 2008; 189: 171-172.
- 4 Duckett SJ. Casemix funding for acute hospital inpatient services in Australia. *Med J Aust* 1998; 169 (8 Suppl): S17-S21.
- 5 Rudd K, Roxon N. Federal Labor to tackle waiting lists for patients and demand tougher accountability on elective surgery. Media statement, 31 Oct 2007. Official website of the Australian Labor Party. <http://www.alp.org.au/media/1007/mshealoo310.php> (accessed Jul 2008). □