Implementation of the Garling recommendations can offer real hope for rescuing the New South Wales public hospital system

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ABSTRACT

- Public hospital clinicians across Australia will relate to the problems described in the Garling report and endorse most of the recommendations to bring the system "back from the brink".
- Implementation is feasible but requires substantial culture change, which must re-engage clinicians and stem the flow of desertion to the private sector. It must also address the fundamental causes of the current crisis.
- Key recommendations involve a substantial change in governance, with a transfer of many areas of the New South Wales Department of Health's responsibility into four board-governed statutory authorities, where equal partnership between clinicians and managers will exist.
- Of Garling's "four pillars of reform", the greatly expanded role for the current clinician-led Greater Metropolitan Clinical Taskforce is a strong indication of the seriousness with which the Commissioner viewed the clinician–manager divide (which he likened to the Great Schism of 1054).
- The major omission in implementation is a failure to adequately address the loss of local accountability in hospitals since the abolition of area health service boards.
- Major change can occur without additional funding, but without substantial new money from the Australian Government, the public hospital system will not be pulled back from the brink.
- A better opportunity for true partnership of such importance between state and federal governments may not come again before it is too late.

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For editorial comment, see page 51. See also page 78

The Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, led by Peter Garling SC, has delivered its recommendations to the New South Wales Government.[1] Consultation with hundreds of clinicians working on the "frontline" provided a remarkably consistent view of the reforms needed. Garling's review has national significance. Across Australia, public hospital clinicians will readily relate to the problems described and endorse most of the remedies offered.

With considered judgement, Garling concluded that the NSW public hospital system is "on the brink". The challenge now is to implement the recommendations that will pull it back. In planning this process, it is essential to measure each intervention against its potential to address the fundamental causes of the current crisis. In its submission to the Garling inquiry, the NSW Medical Staff Executive Council, the peak body representing the medical staff councils of each of the 200 public hospitals in NSW, provided a list of these root causes (Box). First on this list is inadequate federal funding; without correction of this deficiency, the ability to implement many of the Garling recommendations will be compromised, as will the ability of clinicians to find the extra energy and commitment needed to embrace and lead the process of change.

Many more "pennies from Kevin"

It is impossible to overstate the seriousness of the public hospital system's financial circumstances in recent times. With substantial deficits, replacement of most positions, both clinical and non-clinical, is frozen or delayed by deliberately excessive red tape. Most, if not all, area health services have a long list of unpaid bills. In one rural hospital in NSW, a pathologist personally paid for reagents to maintain availability of an essential test. Poverty of resources leads to clinician frustration and disengagement, and feeds bullying behaviour by managers with a personality so predisposed. This is not unique to NSW.

How did things get so bad? During the time of the Howard Government, the federal proportion of funding for public hospitals nationally fell substantially. To reverse this will require around $2 billion per year of new money — less than the $3 billion cost per year to the federal government of the tax rebate for private health insurance. Private hospitals have flourished while public hospitals declined.

Dear Kevin,

John took my money and gave it to you. Please give it back, best before I die.

Yours faithfully,
Public Hospitals of Australia

It is in this context that the level of funding enhancements announced by the Rudd Government at the Council of Australian Governments (COAG) meeting on 29 November 2008 must be assessed.[2] It is seriously inadequate. Of the $2 billion of new money needed per year, the NSW share on a population basis should be $650 million, but the outcome from COAG sets the NSW share of enhancement at only $197 million a year for 5 years. With the "efficiency" demands required of the $13.2 billion NSW Health budget in the recent state "Mini-Budget",[3] NSW Health can only spend about $160 million more per year on fixing its hospitals' problems. That figure will erode rapidly because of inadequate indexation for inflation.

COAG has made available to NSW $50 million per year over 5 years to help divert patients who are not thought to need urgent care away from emergency departments and toward general practice services. This money would do much more for emergency departments if it were used to open more beds and reduce access block, and help implement key recommendations from the Garling inquiry. Additional funding from COAG for NSW ($37 million per year over 5 years, to be matched by state funding) will help with training more health professionals, which should slowly relieve many of the workforce problems

Fundamental reasons why the New South Wales public hospital system is "on the brink" — solutions must address the root causes

All attempts to effect change have to be measured against their potential for impact on the entrenched causes of the current difficulties, including:

- Longstanding inadequate federal funding for hospitals and universities, with resultant reductions in numbers of beds, ageing equipment, unattractive work environments, and an inadequate supply of clinicians, with an excessive reliance on overseas-trained staff
- Wasteful and poorly coordinated dual jurisdiction between the federal and state governments
- Distorted funding framework: the public hospitals provide care at the severe end of the disease spectrum, with a state-determined budget that is capped; care outside the hospitals is in the less severe part of the spectrum, is supported by Australian Government funding and is essentially uncapped
- Highly centralised "control and command" governance at a state level
- Absence of local accountability of management in hospitals due to greatly reduced local clinical and community influence with the abolition of hospital and/or area health service boards, and failure to address this through alternative, safe governance structures
- Unmanageably large area health services following amalgamation
- Failure to delegate and increasing micromanagement by a remote bureaucracy resulting in poor and worsening alignment between responsibility and authority across the system
- The marginalisation of peer-selected senior clinicians in the decision-making process with an increasing disconnect between clinicians and management
- Fear of speaking out because it may lead to penalty, either personally or to one's department
- Dropping morale and goodwill of staff with increasing disengagement
- Longstanding underinvestment in clinical information management and technology
- Lack of trust between frontline clinicians and management, particularly the NSW Department of Health
- A decade of promotion of the interests of private over public hospitals providing clinical staff with increasing opportunities to desert to the private sector
- Diminished influence of universities, and the values they represent, in teaching hospitals
- Too close a nexus between government and senior public servants with inappropriate influence of the media
- A poor understanding by the community and the media of the complexity of the problems and their solutions, with excessive attention on symptoms that are easy to understand such as waiting times for surgery and in emergency departments ◆

noted by Garling; but those responsible for education are concerned at the inadequacy of new funding to support additional teachers.

It is time for the Rudd Government to live up to its pre-election rhetoric and work with the states in urgently restoring adequate funding to the public hospital system. We need fewer reviews, and more action. Coupled with the implementation of the Garling recommendations, remarkable outcomes could be achieved in NSW. The lessons learned will have national relevance. Without far greater Australian Government help, substantial improvements can still be achieved, but our public hospital system will not be pulled back from the brink.

Cultural change: fixing the divide between clinicians and managers

Many of the most important reforms sought by Garling involve restructuring and culture changes that are cost-neutral and should be actioned immediately.

Clinicians across Australia should be heartened by Garling's recognition and lucid description of the breakdown in good working relations between clinicians and management, which, as he reports, "is alienating the most skilled in the medical workforce from service in the public system". He adds:

> If it continues, NSW will risk losing one of the crown jewels of its public hospital system: the engagement of the best and brightest from the professions who are able to provide world-class care in public hospitals free of charge to the patient.

This conclusion was supported by extensive survey data submitted to the Garling inquiry by the Workplace Research Centre at the University of Sydney, which showed that only 17% of doctors and 33% of nurses in public hospitals trusted their managers, compared with a national workplace average of 70%. Further, 69% of visiting medical officers and 64% of staff specialists had "seriously considered leaving the public hospital system in the past year". Without dramatic change for the better, we believe — and fear — that many will turn this into action in the next 2 years.

How does Garling propose to bridge this divide, and are his remedies likely to be enacted by the government and, if so, to be effective? He notes that, "So serious is this problem that I have approached it at each level of the public hospital system" — statewide, at the area level, and within hospitals.

At the state level, Garling endorses a marked expansion of the responsibility and authority of the current clinician-led Greater Metropolitan Clinical Taskforce — to be renamed the Clinical Innovation and Enhancement Agency — as a board-governed statutory authority and one of the four "pillars" of the Commission's reform agenda (discussed by Skinner and colleagues in this issue of the Journal;[4] *page 78*). All four bodies forming these pillars will feature major input from hospital clinicians and consumer representatives. The hospital workforce will enthusiastically support these changes. The Clinical Innovation and Enhancement Agency will take over significant areas that are currently the responsibility of the Department of Health. Many of the talented bureaucrats at NSW Health may well enjoy moving into a structure where they are more intimately involved with clinicians in planning, monitoring and implementation of health services. Further, Garling proposes that:

> Each of the chief executives of the public health organisations is to report every six months to the Clinical Innovation and Enhancement Agency and the Director-General of NSW Health on the progress of implementation of all endorsed innovation and enhancement programs, and if any program has not been implemented the explanation for such failure.

History warns that major changes in bureaucratic structure often meet with much resistance, and strong leadership from within the

Department and the government will be needed to provide a firm foundation for these pillars, particularly the Clinical Innovation and Enhancement Agency.

At the area level, Garling proposes to close the divide through the appointment of an Executive Clinical Director who should be "a recognised clinical leader able to speak on behalf of doctors and other clinicians and who is to be consulted by the area chief executive on all matters affecting clinical procedure". This is a worthy recommendation, but is likely to be of limited benefit. In terms of implementation, Garling avoids essential detail on the selection process (which must be independent of management) and terms of reference. Clinician advice to the Health Minister on these points will be essential and is already in preparation.

At the individual hospital level, Garling recommends devolution of power to local managers. This critical reform is long overdue and will be applauded from the frontline, but, with unmanageably large area health services and the current financial crisis, it will not occur. This highlights the nexus between the Garling report and the need for increased funding from the Australian Government.

Reinstating local accountability

For us, the most disappointing aspect of the Garling report is its failure to recommend structural changes that would address the loss of local accountability within hospitals and areas since area health service boards were abolished in 2005. This loss has been a major cause of the current mistrust of hospital and area administrators and plummeting clinician morale. The several indirect solutions included in the Garling report will not be regarded as adequate, and the state government will need to do more work on this problem between now and March, when implementation plans are to be finalised. Area medical staff executive councils can play a significant role in this regard.

Plus ça change, plus c'est la même chose?

Other contributors in this issue of the Journal note that there is nothing new about reviews of the NSW public hospital system (*page 78* and *page 51*).[4,5] What *would* be new would be implementation of the suggested reforms.

The Garling blueprint provides the plans for a major restructure that would markedly improve access to better quality and safer services — the imperative that triggered the inquiry. It addresses many of the root causes that have brought us to "the brink". However, political history teaches us that implementation requires each of the shareholders in the NSW public hospital system to maintain very public expectations that the government will not allow this report to meet the fate of others now gathering dust on some archival shelf.

Desperately seeking cooperative federalism

The Garling recommendations provide an opportunity for focused partnership between state and federal governments, with new money to be invested in a system with vastly improved governance. It is part of a broader challenge that must be urgently dealt with. Major restructuring of Australia's health system is being considered by at least four federal government committees, with reports due by the middle of 2009. A major emphasis is being placed on ways in which better community services (primary care) might reduce the demand on pressured hospitals by implementing far more effective prevention and early intervention strategies. In this context, looking at a huge hospital system in isolation from other parts of the health care system is a somewhat artificial exercise. This is not to argue for any delay in implementing Garling's recommendations, but rather to urge that "cooperative federalism" facilitates the necessary integration of all the accepted reform agendas — and that it does so with an urgency that recognises the current crisis in the NSW public hospital system.

Competing interests

None identified.

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