Does the National Health and Hospitals Reform Commission have a real answer for public hospitals?

David G Penington

Our public hospitals need medical leadership, and partnerships with medical schools can provide it

There have been huge changes in medical practice over the past 20 years, including advances in the fields of cardiovascular disease, orthopaedics and cancer. Many of these were introduced through major teaching hospitals, before going on to influence associated hospitals and private practice. Continuing advances in medical research and technology (including information technology) in coming years will offer yet further opportunities to improve patients' survival and quality of life.

Recurring events with mismanagement of patients have undermined confidence in public hospitals — well publicised incidents in Bundaberg and Royal North Shore Hospital are recent examples. Before the 2007 election, Kevin Rudd promised that public hospitals would be taken over by the federal government if they were not "fixed" by the state governments within 12 months. The community has a right to expect health care with a commitment to excellence and safety. Would transferring responsibility for public hospitals to the federal government, as is now foreshadowed by the National Health and Hospitals Reform Commission (NHHRC), solve anything?

The final report of the NHHRC,[1] with its 292 pages and 123 recommendations, warrants careful analysis, but the big issues are lost in the detail. I applaud its proposed initiatives to strengthen primary care, mental health care, dental care, preventive strategies and Indigenous health. The big gap is the lack of realistic proposals to "rescue" public hospitals.

Despite delivering constantly evolving services, our hospitals have been required to deliver more and more with their existing resources (except for some recent increase in federal funds), with their performance measured against metrics relating to diagnosis-related-group-adjusted "patient separations", waiting list numbers and emergency waiting times. Quality of care, in which professionals take pride, has become a low priority. Clinical academics and other medical leaders with a commitment to evaluation of quality, and to research and innovation, have been pushed to one side. Statements by the NHHRC that quality, safety, research and innovation should be encouraged have no meaning if management of hospitals continues in the current mode. Are the problems really understood?

Garling concluded in 2008 that the New South Wales health system is in a state of crisis — "It is the breakdown of good working relations between clinicians and management which is very detrimental to patients".[2] To varying degrees, the same applies in state after state, although Victoria's situation is better, with hospital boards overseeing chief executive officers who are expected to make decisions and work with professional teams, rather than detailed management responsibility resting with health bureaucrats and their delegates, as is the case in many other states.

In the 1970s and 1980s, Australia had some great university hospitals doing excellent work. The Austin Hospital in Victoria was, in 1966, the first to be established with academic leadership. From 1974, the Flinders Medical Centre in Adelaide was a model "joint" university hospital, but now functions largely as a community hospital. The fine Westmead complex in NSW, developed under guidance from the University of Sydney (from 1976) now suffers state bureaucratic interference. For all that, the medical schools of the University of Melbourne and the University of Sydney were rated among the world's top 300 medical schools for research in clinical medicine in 2009, being ranked 37th and 59th, respectively[3] — both higher than Cambridge University and the University of Manchester, two of the five medical schools in the United Kingdom recently recognised as leading academic health science centres overseeing large groups of hospitals. Four other Australian schools are in the top 200.

The interim report of the NHHRC dismissed the concept of "university hospitals"[4] as old-fashioned.[5] The National Health and Medical Research Council, in its Draft Strategic Plan for 2010–2012, ignores the strong recommendation of its own international strategic review (the Zerhouni Review) that the government should

> ensure that at least a few competitively selected hospitals have sufficient funds and a mission statement that also supports patient-based research rather than minimising current costs at the expense of long term transformation of health.[6,7]

This recommendation reflects the pattern so well developed in the United States, Sweden, Finland, the Netherlands, Belgium, Singapore and, more recently, the UK.

Despite generalities in the NHHRC final report about the importance of research, university medical schools are now to relate to their teaching hospitals through a new "competency-based" National Health Workforce Agency, and teaching hospitals are to respond to external advice from the National Institute of Clinical Studies (NICS) as to how to treat their patients.[1] Valuable though NICS is, its currency is "evidence-based medicine" derived from past clinical trials, usually performed by teaching hospitals, that reflects previous experience rather than advancing knowledge. "Competencies", the proposed basis for education, can also only be defined by looking at current patterns. Further, clinical governance, so central to the culture of clinical academics, is to be developed through "'Clinical Senates' at national, regional and local levels".[1] External control is seen as the answer! Surely we should by now have escaped the tyranny of distance and can learn from the experience of other countries tackling similar problems.

Britain's National Health Service (NHS) was, for years, centrally controlled by bureaucracies. Public disquiet grew as it became clear that the NHS was falling behind international standards of health care. Gordon Brown, as then Chancellor of the Exchequer, intervened over the Department of Health. The Cooksey review[8] called for major redevelopment of clinical research to safeguard and

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advance the quality of services. An outstanding academic surgeon, Lord Darzi, was then appointed a life peer, becoming the Parliamentary Under-Secretary of State for Health, to review the entire NHS. His reforms secured medical leadership of the system at every level, with groups of hospitals led by medical schools.[9] The changes have rapidly turned around the morale, culture and quality of services in British public hospitals. In 2009, only the fourth year of the reforms that began with the Cooksey review, an international panel recognised five large hospital groups led by medical schools — Imperial College London, University College London, King's College London, Cambridge and Manchester — as exemplary in their health care delivery, deployment and education of health professionals, and commitment to quality, clinical research and innovation. The key to reform has been medical partnership in managing services for patients at every level jointly with health service managers, all accountable to medical school leadership. Clinical research with constant evaluation of health care[10] is seen as the key to quality of services. Cost savings are now being realised with improved resource allocation, despite also meeting emerging challenges (E Byrne, formerly Vice Provost, University College London Medical School, personal communication, Aug 2009).

Australia's public hospitals should come under a new partnership between federal and state governments and the nation's medical schools, following British and other international patterns. Each group of hospitals would be led by an appropriate Executive Dean working jointly with a senior health administrator, with hospitals being grouped on current patterns of association for teaching and intern and registrar rotations. Some hospital groupings in the UK are large (including up to 60 hospitals), but clearly work well. Governance and management are devolved in the joint clinician–hospital administrator pattern, with accountability to university leadership, safeguarding appropriate medical involvement.

Kevin Rudd may choose to intervene over the "health establishment", as Gordon Brown did. We stand ready to work with him in rapidly turning around a system in disarray.

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