DIAGNOSING THE CAUSE OF HEALTH REFORM FEVER

BY PROF STEPHEN LEEDER

Prime Minister Kevin Rudd's announcement that the Federal Government would fund 60% of public hospital costs and 100% of community care and general practice costs attracted major headlines as serious health reform.

It is hardly surprising. For many Australians, the issue of who runs our hospitals is front of mind and the prism through which they view our complex health system.

For these people the proposed local hospital networks and the proposal for activity funding, where hospitals get paid for what they do, probably also struck a chord.

But, as health professionals probe deeper and look into areas such as prevention, mental health, dental health, general practice and primary care, there is much need for reform and detail that remains unanswered. If the Prime Minister does not address these concerns, he risks an increasingly hot reaction to his plans and the allegation that he is merely concocting headlines without addressing the real issues.

Finding the cause of fever in an older person with arthritis, the best metaphor I can offer for the health system, is notoriously tricky. You need to look in many odd sites, including bones. If Mr Rudd's proposals for health reform start to run a fever, he might attend to five places in his plan to track down the cause.

First, the proposed hospital networks resemble Mr Howard's fabled white picket fence; as described, they are romantic historical relics. And, although Mr Rudd has since elaborated on local hospital networks, describing how they differ from local hospital boards, they are probably still too small. The evaluation data about running health services for Australian communities are scant, but areas of half a million or more people allow for services to be developed that are largely adequate for a population that size.

Anything much smaller, and the critical mass of surgical and medical skills cannot be maintained. Public health and preventive services crumble and become idiosyncratic and ineffectual. Management economies in purchasing and maintenance wobble. Anything much bigger, and the supply lines and personal connectivity are lost and clinicians lose spirit and commitment. Assigning control of smaller networks to boards would be a reversion to patterns of management attuned to the 1950s.

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Second, the suggestion that hospital activity be rewarded, possibly on the basis of diagnosis-related groups, suggests that a hospital's chief end is to produce sausages, and the more it produces the richer it will be. Since when has encouraging more hospital activity been a goal of our over-stretched hospitals? And what about quality? Two dozen poor-quality sausages earn twice as much as one dozen top-grade bangers. And, for small country hospitals serving multiple non-sausage producing purposes in the life of their communities, including de facto nursing home care, this makes no sense. Hospitals are not sausage factories. Beside clinical care, they provide social support, do research and support teaching. A fever may be due to a problem with the sausages.

Third, Mr Rudd knows full well from the Intergenerational Report what the future holds for health services, and it will include a big increase in chronic illness care, already chewing up 70% of our health budget. Yet Mr Rudd's hospitals do not coordinate care for chronic patients but rather provide episodes of care. This is expressly what coordinated care is designed to avoid.

Fourth, managers who recognise that the health service budget is largely consumed by wages wonder what will happen to economical efficient services such as State-based payroll and group purchasing. Will it be managed idiosyncratically by networks ("my neighbour has developed a beaut payroll package," says a board member) or centralised in Canberra? If pay is messed up, employees' temperatures rise.

Fifth, despite the emphasis placed on putting the patient as the major portrait on the health care canvas in most of the 83 reviews, 17 committees, commissions or boards, 12 inquiries, 11 working groups, 11 discussion papers, seven summits, consultations and audits that we counted that had been established by Mr Rudd up till mid 2008 - and of course there have been more since - these individuals are nowhere to be seen in the hospital painting for the future. Consumer groups are not happy.

To be fair, Mr Rudd made it quite clear that his initial announcement was only about the financing and management of hospitals. Most people applaud moving to single payer for health care and most like the idea of devolving more authority for the arrangement of health care as far towards the edge of the health care universe as possible. But at present you can draw any number of straight lines, leading to success or sliding into chaos, if you have only one point. There are serious danger signs that things are hotting up.

Mr Rudd must move quickly to describe more of his vision for an integrated, responsive, community-orientated health system for the future or risk losing the initiative.