Health shake-up needed, not just cash

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By Tony Scott

In health care, one of the easiest things to do is to throw money at it. More money for doctors and nurses, more money for beds, more money for mental health are all on the table in this election campaign. More money is good if it is spent well and not wasted. In health care, the costs of inefficient spending are high in terms of loss of life, increased morbidity, and reduced productivity and economic growth. Inefficiency kills. One key source of inefficiency is the way the system is organised and financed. Increasing or reallocating spending ignores the fundamental structural problems in the Australian health care system. One of the hardest things to do in health care, and the one thing that most informed commentators agree should be done, is to alter the structure of the existing system to bring it into the 21st century.

The job for politicians is to strike a delicate balance between well thought through structural reform that might take a number of years, and the short term spending announcements that might swing an election.

The Gillard government's proposed reforms do attempt to blend structural reform with additional spending. The proposals seek to alter the architecture of the health care system and aim to make it more efficient and equitable, though these objectives have not been explicitly spelled out. The key attraction of the reforms is that they are comprehensive in covering both hospital care, primary care, aged care and prevention, and within each of these sectors there seems to be medium to long-term plan. Though some regard these reforms as no 'big bang' and they certainly have some holes, they do represent a cautious step in the direction of fundamental structural reform.

The idea of local hospital networks and primary care-based Medicare Locals will help to devolve decision making to lower regional levels. The government's intention to ensure that the geographical boundaries of these organisations match, sets up the possibility in the future that they could merge into regional health organisations, a policy advocated by many commentators. The UK NHS went through a similar experience 10 years ago, though it is difficult to tell whether such a model worked given the pace and breadth of other reforms in the NHS that occurred at the same time.

There are other aspects of the government's plans that are potentially important. The establishment of a National Performance Authority will begin to make health care organisations accountable for the tax revenues they use through the use of performance management frameworks. This needs to be matched by a 'bottom up' and clinically led focus on quality improvement. At the moment, there has been very little explicit performance management or incentives applied at the local level to hospital managers or GPs. Will these performance management structures have teeth? What incentives will there be for good performance and penalties for poor performance?

The announced incentive packages for schools and school principals should be replicated for hospital CEOs, general practices, and aged care providers. Simply generating lots of information on performance is unlikely to change behaviour unless there are consequences for good and bad performers. The MyHospital website and the public reporting of the performance of hospitals and GPs will provoke debate, but it will also generate better data on the system, which is urgently needed. To have a health care system that does not routinely measure patients' health improvements, is akin to having a business that does not measure profit. Failures (death rates) are measured very well, but success is not. Public reporting of performance may move this issue forward. One idea from the UK is patient-reported outcome measures (PROMs) where patients' health outcomes are measured before and after treatment.

Whether the public will be able to use this information to improve their health care is another issue. In the US the public reporting of performance information has made little difference to consumers' choice of health plans. However, in the UK the patient choice policy, where patients visiting a GP are given a number of choices about which hospital to be referred to, has produced some evidence of lower waiting times.

The Coalition's informed financial consent policy will be particularly important in the Australian health care system, where most of use do not have a clue how much health care will cost once we get referred. But let's also have an 'informed waiting times' policy, where the GP will tell you how long it takes to see a range of specialists, and the specialist tells you how long it will take to be admitted to a range of hospitals. The 'hidden' waiting time from GP referral to specialist is not routinely measured and can be substantial even for private specialists. For informed choice we need good data infrastructure which is slowly being developed in Australia but nevertheless continues to be a major barrier to better health care for all.

The health care system is complex, and reform was placed in the 'too hard' basket by the last Coalition government. The Gillard government has attempted to tackle it but the

outcomes are uncertain. What is lacking is good evidence about the most effective types of structural, organisational, and funding reforms to make the system work better.

Throwing money at the system doesn't always work, but getting smart about how the money is best used will produce results. More clinical research on new ways to fight cancer saves lives. More health services and health economics research on how to reduce inefficiency in the health care system is not quite as sexy but will also save lives. Many of the health policies on offer show promise, but unless they are evaluated, governments will still be muddling, patients will be no better off, and health care spending will continue to rise.

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