

GUEST EDITORIAL - Rhonda Griffiths

Professor Rhonda Griffiths, is the Director, South Western Sydney Centre for Applied Nursing Research, Liverpool Hospital, Sydney, Australia

'THEY' SAY IT'S THE BEST HEALTH SYSTEM IN THE WORLD.....

Readers of this Journal who were practicing prior to the late 1980's will remember when the effectiveness of health care was assessed against the processes of care delivery and patient/client satisfaction with services. That changed dramatically in the early 1990's, when funders of health services in Australia (government at State and Commonwealth level), began to assess the efficacy of services in terms of dollars spent. Health planners and administrators are now occupied by schemes designed to maximise health outcomes for users of services while containing the cost of care.

Value for money has become the issue, with variations in cost being closely monitored by administrators (Hindle and Newman 1996), reforms being linked to costs rather than clinical discovery (Bessler and Ellies 1995; Duckett 1996) and the corporatisation of health facilities (White and Collyer 1997).

The health needs, priorities and options of Australians are changing for a variety of reasons including:

- increasing prevalence of chronic disease particularly related to an aging society, that requires ongoing care across agencies
- continuing reduction in hospital length of stay and the expanding role of non-inpatient and ambulatory services
- pressures for improved productivity and efficiency in the delivery of health care
- increasing dependence on technology.

The Commonwealth Government has responded by taking a strategic approach to the design and funding of services. Six priority areas were identified (public hospitals; pharmaceutical; non-inpatient medical specialist and diagnostic services; primary health and community care; small rural communities and mental health) and an integrated approach to services was adopted (National Health Strategy 1991). An integrated health system was to be achieved through:

- incentives for best practice;
- incentives for productivity and efficiency;
- scope for sustainability and flexibility;
- service models which encourage continuity of care;
- selective use of market and competitive pressures;

- equity in distribution of health resources;
- devolution of administration and service delivery (National Health Strategy 1991).

This was to be the blue print for health reform in Australia and to support it, a new vocabulary emerged that included case management, best practice guidelines, funder/provider split, diagnosis related groups (DRGs) and more recently, access block.

Describing the model and enabling factors was a start, but the real conundrum is for the service administrators and clinicians who have the task of bringing together services, dealing with incentive programs, restructuring services and developing relationships between providers to achieve the goals for continuity of care.

How is the model working at the point of care? There have been some long overdue reforms and some frustrations.

Incentives for Best Practice

Accountability is fundamental to professional practice and peer review, quality management and clinical protocols have been introduced as the key to achieving best practice. That was a positive move. The quality initiatives have been supported by financial and organisational incentives, also considered to be best practice.

Incentives have produced positive and negative outcomes; the interpretation depends on priorities and agendas and is not regarded consistently throughout organisations. Funding patterns and priorities continue to be a stimulus to review practice and initiate 'innovation' and no individual associated with health, including users of the health system, are exempt from the consequences. The theory-practice gap widens as financial incentives overtake clinical imperatives. Consequently hospital wards are less effective for teaching purposes. Interestingly, some incentives don't generate best practice.

Within health there are markedly different financial incentives according to the care environment. For example, private medical practitioners receive incentives according to the number of patients they see. Over servicing is not unknown. However, in the public hospital system, the opposite is the case and in fact there are additional marginal costs associated with attracting patients. Demand on accident and emergency departments is an example, and hospitals have addressed the increasing

demands by encouraging non-emergency patients to see a general practitioner. The effect is to shift the cost of care.

Fundamental planks of best practice are still to be put in place. A major system weakness that discourages an integrated approach and best practice, is lack of funding across organisations and little scope for moving across episodes of care; the principles of managed care have some way to go before that model is adopted in Australia (Duckett 1996). The NSW Government has recently announced 3 year funding cycles which will enable Area Health Services to plan expenditure over that period (NSW Health Council, 2000). However funding for services continues to emphasise single organisations or specific service episodes.

Incentives for productivity and efficiency

Demand for health services is increasing and in the majority of cases, growth in demand is met through efficiency and productivity savings within existing services. Clinical review mechanisms have been developed to enhance and emphasise evaluation of effectiveness of different types of interventions. The emphasis is on providing lower cost substitutes for higher cost services. That is not always bad if managed intelligently, for example early obstetric discharge programs.

Service models to encourage continuity of care

Clinicians confirm that the goal of continuity of care has not been realised, partly due to the funding procedures. There are numerous separate Commonwealth and State programs delivering primary and community care, often to the same target groups. Rural communities also have expressed concern about lack of access to services and inability to develop services that reflect their needs and resources where economies of scale are required to demonstrate viable and sustainable services (Trickett Titulaer and Bhatia 1997).

The idea of integrated services is very sensible, the irony is that neither Medicare nor other funding arrangements encourage integration. In fact methods of payment actually encourage a highly specialised and segmented health service (National Health Strategy).

Selective use of market and competitive pressure

Market mechanisms are widely regarded as important for improving consumer responsiveness and efficiency. However in health, consumer choice is restricted and consumers have limited ability to review data describing the effectiveness and consequences of particular services. Universal health insurance and bulk billing means that the cost of services has little impact upon consumer choice.

Equity in distribution of health resources

Area Health Services in NSW receive funding according to a Resource Distribution Formula based on geographic and demographic variables, in addition to functions such as research and teaching. Equity in health does not imply all

Australians will have access to all services in their local area. The purchaser-provider split was introduced in New Zealand as one strategy to ensure all residents would have affordable access to a range of core health services (Ashton 1997). That model could positively influence equity by separating the demand side (funder) from the supply side (provider), however in New Zealand it is not seen as a long term strategy, rather a precursor to managed care (Ashton 1997).

CONCLUSION

Health is a complex system; one in which hardly anything is as it seems.

Area Health Services purchase services from local sources to meet their requirements based on type and quantity of service and location. Purchasers reorganise services based on their priorities, frequently with the view of introducing an element of rationing, or substituting a costly service for a less costly alternative.

Nurses are the public face of the health system and in that position take much of the criticism that should more accurately be aimed at Government and Area Health Services. We continue to be excluded from priority setting, particularly at the local level and therefore continue to react to directives, which at times are in conflict with our professional philosophy and personal priorities for job satisfaction and fulfilment.

Is it any wonder that an experienced registered nurse is becoming a rare find in wards? Health Departments and nurse registering authorities have expressed concern at the declining number of students enrolling in nursing programs and the increasing number of experienced nurses leaving the profession. The reasons are multifactorial, however I believe a review of the impact of current policy on nursing services would be worthwhile.

REFERENCES

- Ashton, T. 1995. The purchaser-provider split in New Zealand: The story so far. *Australian Health Review*. 18(1):43-60.
- Bessler J.S, Ellies M. 1995. Values and value-avision for the Australian health care system. *Australian Health Review*. 18(3):6-17.
- Cromwell, D. and Mays, L. 1998. Waiting list statistics as performance indicators; Observations on their use in hospital management. *Australian Health Review*. 21(4):15-26.
- Duckett, S. 1996. The new market in health care: Prospects for managed care in Australia. *Australian Health Review*. 19(2):7-22.
- Hindle, D. and Newman J. 1996. Hospital input price indices in Australia: Are they worth the effort? *Australian Health Review*. 19(3):28-39.
- National Health Strategy. 1991. *The Australian Health Jigsaw*. Integration of Health Care Delivery. Issues Paper No. 1. Treble Press: Sydney.
- NSW Health Council. 2000. *A Better Health System for NSW*. Better health Centre-Publications Watehouse: Sydney.
- Trickett, P., Titulaer, I. and Bhatia, K. 1997. Rural, remote and metropolitan area health differentials: A summary of preliminary findings. *Australian Health Review*. 20(4):128-137.
- White, K. and Collyer, F. 1997. To market. To market: Corporatisation, privatisation and hospital costs. *Australian Health Review*. 20(2):13-25.