

2004 Chief Health Officer Seminar Series

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Abstract:

Current Issues in Health System Design and Management

Health systems are increasingly becoming the focus of public and political concern as they experience increasing demand from population growth and the ageing of the population as well as higher expectations from an increasingly assertive consumer and carer voice.

Health systems must respond by introducing innovative models of care in addition to the traditional expansionary approach allied with prevention strategies. Health systems must listen to consumers and build systems that provide supports for safe practice as well as accountability for all.

Transcript:

The interaction between service delivery and academia is essential.

I want to focus most of my strategic discussion on demand management and how we cope with the long term issues of the future - so if you are a quality and safety enthusiast please don't think that I have trivialised quality and safety. I basically assume it to be part of our routine day to day work.

Similarly, I've focused on service delivery aspects of health care rather than prevention, so if you're a prevention enthusiast, of whom there are many, please don't think that I've ignored your key issues.

It's important to remind ourselves exactly what we're here for - to work to allow people to enjoy a high quality of life and maximise their participation in society, particularly those who have the unfortunate fate of carrying the burden of chronic illness with them. Occasionally we do deviate from that path, particularly some of our provider colleagues.

As we move to the future we all know we will deal with growing demand and growing complexity of illness. At the moment many of our system overload issues are more due to complexity of illness than growing demand. I think we're able to keep up. If you look at the way governments have spent money in health care in Australia we're actually throwing vast quantities of money at the problem and you can argue that our expenditure is keeping up with growing demand. But what we are struggling with is growing complexity of illness.

We have a bevy of technological solutions at hand, but all of them come at great expense. They'll get even more expensive and more varied in the future. Heaven knows how we're going to apply stem cell technologies to some diseases. Gene therapy – who will get it, who won't? It will be an extraordinarily expensive solution.

How we will be able to afford universal access to these technologies is a bit of a challenge. The greater specialisation of the workforce is becoming more intense. Anyone working in service delivery land and having to manage patients knows that instead of talking perhaps to a GP and a couple of other people about the care of a complex patient, as we would have when I was a junior medical staffer 10-15 years ago, now know we're having to speak to 15 or 20 people about the care of a patient.

An 83 year old diabetic woman with vascular and ophthalmic complications could be seeing 15-20 allied health nursing and medical staff in the care of her illness, so heaven knows how she actually keeps track of who's seeing who. But also, how do we keep track of who's doing what for that patient? And are we intensifying our specialisation? That's going to create a major challenge for the health system.

Meanwhile we all know that demand is actually outstripping our workforce output. I think Australia made a mistake in the late 1980s to early '90s. With the best wisdom at the time we suddenly decided that we had too many doctors and we didn't think a lot about how many nurses we were training. Nor did we think much about how many allied health professionals we were training. We actually cut back the number of medical places and I don't think we sufficiently expanded nursing and other places. As a result we've got an across the board shortage now.

From our work on our own local clinical services plan we know that in-patient activity over the next nine years is expected to expand by 35 per cent. Outpatients and emergency department attendance, slightly more in the case of outpatients, will also increase even though we're actually strategically vacating some outpatient services. Our actual burden of chronic disease outpatient attendances will go up by about 40 per cent and the emergency department by about a quarter. Total ambulatory care activity per day will be up by about 500 attendances per day.

We will have to change our systems to meet the increasing demand, particularly in terms of chronic disease management. A substantial redesign of our system will be required, with greater emphasis on early intervention. Then there is communication, IT, innovation and research and health system management. Whether we like it or not the system, no matter how smart we get, will have to expand, but not necessarily in routine ward-based services. There is often a perception amongst the public that we need to build more hospitals, more routine wards (by routine I mean secondary level care wards), more hospital buildings and more beds.

In actual fact when you analyse the demand and the current trends we won't actually need more ward beds in the future. What we will need is more intensive care beds. Hospitals will progressively become more and more intensive care oriented over the next 10-20 years so that by 2020, unless there's some unexpected change, the vast majority of hospital expenditure will be on intensive care type care.

High technology, short stay care will intensify and we will get better at getting people through the system more quickly. We know from experience over the last ten years that in surgery we're getting better at caring for people in a day stay arrangement. But that is more expensive, in terms of many procedures, than a long stay in hospital because we're using sophisticated technology that requires a lot of theatre time and much higher skills in the theatre. With greater specialisation we will also need more skilled people to operate that equipment.

There will have to be a vast expansion of community-based services to cope with the large numbers of older people with chronic conditions. Our plans anticipate that and it's reflected in recent budgets. And, of course, we will have to intensify our prevention strategies. We've

certainly as a nation lifted our game in terms of immunisation, breast screening and cervical screening. These programs seem to be effective.

The next problem for us on the prevention landscape is the role of bowel cancer screening. The federal pilots have been extended for that program and it will be an interesting question for the Australian government over the next two years. Do they extend that program nationally? The evidence will, I hope, provide some answers.

What should we do to redesign models of care? The most important work we will be doing in the next two to three years will be redesigning our model of care for the chronically ill. At the moment the chronically ill bounce around the system; as I described earlier, the 83-year-old diabetic woman might be seeing 15 or 20 people. Our responsibility as health care managers will be to redesign the system so that someone knows exactly what is happening to that lady at any one point in time and preferably she will know too. The system is not currently geared up to do that so there'll be a greater emphasis on case management, a greater emphasis on teams.

There is evidence out of New South Wales that their two chronic disease management programs set up in 2001 had varied results. One was in chronic heart disease and one in chronic respiratory disease. Both were implemented state-wide and had large numbers of patients moving through and both were summarised recently in official department evaluations. The chronic heart disease program went extremely well. There was a reduction in patient admissions and quite a reduction in patient length of stay. The patients were better managed outside the hospital so they went to hospital less frequently, not much less frequently but significantly, so I understand. Further, when they were in hospital there was a definite decrease in their length of stay. So they were obviously coming in earlier in the exacerbations of illness. We can learn a lesson from that and apply that model across the board.

In chronic respiratory disease they had less success. There was a reduction in length of stay but no reduction in hospital admissions. What that tells us, without being overly scientifically definite about it, is that there are some disorders like progressive chronic respiratory disease that, no matter how well you look after the patient, they are going to continue to decline. It suggests that investment is probably more effective elsewhere.

Locally, diabetes is a big issue. In the Australian Capital Territory we've got to lift our game in diabetes care and that's something I will be addressing in the next twelve months. We don't coordinate the care of diabetics very well. We have a program where patients get drawn out of general practice and become lost in the miasma of hospital endocrinology. I think quite frankly, with all due respect to the endocrinologists who do a great job, it's more appropriate that the long term care should be with someone who sees the patient more frequently and as part of their holistic care.

So, looking at these models of care, what will we see that's different? Greater emphasis on case management, greater emphasis on routine contact with patients, more education of the patient about their own condition so they can monitor and, if necessary, adjust treatment for their own condition - most diabetics are very good at that - and a greater emphasis on integration of communication.

So not only in chronic diseases, but also in more episodic care where a whole range of specialists are required, such as in cancer, we will be working on those models of care to integrate care. Those of you who have relatives with cancer, or have even been unlucky enough to have major cancer yourself, know that the vast majority of patients are absolutely traumatised by the fact that it is so easy to get lost in the system.

It's a terribly daunting prospect to have cancer. But to find yourself also immersed within this spiral of specialists and experts and within a system in which it is so easy to get lost must be even more daunting. But the breast cancer nurse model, where a breast care nurse will manage a patient through the whole process, is a great example of what we can do for cancer patients in helping them through the system.

If we redesign our models of care well, we will hopefully have less demand on the hospital system. The evidence I've seen to date tends to indicate that in certain conditions, such as I've just talked about in diabetes, we can make a big difference and help people outside of hospital. To do that we'll need to build better communications systems and information technology is obviously the key.

Our IT systems traditionally in health have been built up around interested clinicians who want to build data bases for their own purpose or for financial management systems for hospitals. Managers and clinicians are moving out of that framework but we, as managers, have to push that process so that we concentrate our IT systems on connecting providers and consumers together rather than building up vast swathes of information that's duplicated across many silos.

Integration between IT systems will be a key process with a particular emphasis on linking GPs. Our IT strategy, which will come out soon, will emphasise integration with GPs a great deal. I've got to say we have a fair bit of work to do to convince elected officials of the importance of the information technology process. At the moment it's not well understood at the various Parliamentary and Assembly levels around the country. It's not just local, it's a national issue.

We really have to convince our elected officials that investment in integrated IT will have major benefits for patients. They can't see that at the moment, they just see IT systems as being management behemoths that go terribly wrong in implementation and they've all got a horror story about an IT implementation. I know this because I speak to ministers about it. We've got to turn that understanding around. It's not through ignorance that ministers are doubtful. We've allowed a reputation to grow up around our IT systems that they're clunky and they cost a zillion dollars to implement and then, when we implement them, they don't work anyway. It's over to us to convince those who make the big decisions in our community that it's worthwhile investing. Building innovation into our culture is a tricky issue.

Most of the really impressive innovations in healthcare actually occur at the local level. I hate to say this as a senior manager but there's not a lot of innovation coming out of senior managers. Most of it emerges at local level and is then expanded through the system. All the great changes in hospital care have come from people doing local research who then expand it through the system.

I think the message is that topdown brainstorming is not perhaps the greatest way to innovate in the health care system. The manager's role is to make sure that the local culture encourages innovation and disseminates that innovation through the system. Governments have a role in disseminating that information through the jurisdictions.

We've got to be careful our culture doesn't stifle innovation. I'm particularly concerned about the tendency that emerges every now and again in health care to 'paramilitarise' our professions, to get our professions to be more disciplined. We have to be careful that our culture isn't stifling people through excessive rigidity so that we never innovate. And if we don't innovate, if we don't find new ways of doing things, we won't manage to cope with the vast increase in demand that's heading our way. Research is a fundamental part of that process in formalising innovation,

assessing its validity and transmitting its use across the world, so the Chief Health Officer and I will be working a great deal on building that culture of research locally.

As a practical perspective about the future, assuming that we continue to work on safety and quality agendas and continue to find new ways of preventing illness, we will need to continue to expand and innovate. This is bad news for governments, particularly I think for the federal government, but as managers we need to find new ways of doing things and we won't do that without an innovative culture.