

# Let's ban drivels: commentary on A tale of a few hospitals

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Before you read on, this is a commentary based on anecdote - not the stuff of high-level evidence. But let me tell you, from the feedback I get from listeners across Australia, Anne Cahill's story is pretty mainstream. You can argue I'm talking rubbish – and I know there are many exceptions, possibly even a growing number of them – but many health service managers would not have a clue about what's going in their hospitals in terms of being service focused because they don't look and they don't measure.

There's one phrase I want banned. It's patient centred care. I reckon it tells you as much about a health service that professes it, as it does about a corporation which, under its mission statement, says something like: "Our biggest asset is our people." You just know that's one company to steer clear of, and I'd give the health service a very wide berth as well. These words trip off our tongues onto Word files and butcher's paper and might allow organisations to feel better. But they don't change the end result which, as Anne Cahill's experience and that of many others suggests, is that in some of our hospitals the patient is an irritant, a stone in the shoes of highly trained experts who have a job to do and know just how it should be done.

When you put this to health professionals and managers the response is usually about lack of resources. But as Anne's account illustrates, good service does not necessarily require much more money. You suspect, in fact, that it's often more efficient. What it does need though is competent management and confident, appropriate leadership to instill an attitude of mind focused on serving the community and individuals alongside the development of processes to ensure that service is maintained. All too often you hear of major hospital CEOs who are micro-managing either because they've been promoted far beyond their abilities, or more commonly they're good managers who've self-hobbled because their minister's office has scared the daylights out of them. They've become traumatized and risk averse lest the local tabloid discovers that tax payers' money is being spent on a free coffee machine in a busy outpatients' department.

I also suspect that public hospital services are seen by some consultants as poor-house charity for which we should be grateful. If you want comfort and privacy, that's what going private is for. Mind you, I'm impressed that Anne found a public outpatient clinic at all given the cost shifting that's occurred in several jurisdictions over the last few years. The reality is that public hospitals are not charitable institutions. They consume tens of billions of Australians' dollars, a reasonable proportion of which goes to put food on the tables in medical practitioners' homes.

The other phrases which I'm close to wanting banned are continuity of care and coordinated care.

Fixing up the interface between the hospital and the GP isn't rocket science, some institutions have been doing it very effectively for years – long before the advent of that other excuse: "no IT infrastructure". And as to coordinated care in the community, a few years ago I did some focus groups looking at how GPs might better coordinate care for their patients in the primary health sector. Interestingly when I asked consumer focus groups what they took the words 'coordinated care' to mean, they almost universally said it meant an outpatient clinic which was one stop shopping – where all their needs would be dealt with by whatever professionals they needed to see, without having to repeat their histories with every new person – during the course of a single visit.

When it came to their GPs, to our amazement, they expressed only huge satisfaction. But when probed they told us that they were happy with their GP because they'd tried so many before they found HER. SHE was caring and knew what was available and worked hard for them. I understand the statistics suggest that female GPs earn less per hour than male ones – perhaps this service focus is a reason.

The final thing in this diatribe that I'd like to say about Anne's piece is what she didn't say. In this era when doctors can prescribe subsidised, high end, expensive drugs with few checks and balances, Anne can't get something as basic as portable oxygen to allow herself to maintain her wellbeing as best as possible while waiting for a lung transplant. Most jurisdictions in Australia means test oxygen rather narrowly using clinical guidelines which don't cope well with obliterative lung diseases such as hers.

The consequence – in this patient focused, coordinated, continuous world we live in is that she's shelling out a fortune and causing additional heartache in a family having to deal with a potentially fatal illness in its midst.