Submission

No 15

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation:

Name: Dr Peter Short

Telephone:

Date Received: 6/11/2007

Theme:

Summary

Submission to the Parliamentary Committee

The community should not be surprised with the quality of care that exists at the Royal North Shore Hospital. It is, in my belief, the logical result of the introduction of the new public sector management with its predominantly business and manufacturing principles into a system that is human-centred. Added to this is the failure of politicians at all levels to actually question what they do and to put forward policies that will impact longer than the current term of parliament. It is disingenuous for governments and departments to deny or elide their role in what is unfolding before us.

I do not believe that issues of care at RNSH can be discussed in isolation to changes throughout the health system particularly and public services more generally. Indeed it is imperative to pay regard to the philosophical changes that have led to the current practices. To do otherwise is to simply blame local staff and administration for what occurs when they have little or no control over Treasury, government policy and departmental actions.

Since the early 1990s there has been a gradual infiltration of business-style management practices into NSW public hospitals and public services. These have been well documented and discussed in management and public sector literature. These can be described, broadly, as economic rationalism in material form. We have seen, as a result of this philosophical shift, reductions in beds and staffing, changes in the locus of decision making and the enumeration of all activities within health care to enable efficient management, as well as limited-term contracts for senior staff, quality management programs, and a continual drive for efficiencies. Overall there has been a move of decision-making away from clinicians into the hands of people who have little or no experience in patient care and who are tied into a fixed-term contracts that an be terminated for essentially no reason by the minister of the day thereby eliminating the possibility of free and frank advice.

These ideas have been grafted on to a system that has historically been more concerned about the care of the individual patient and their context, not the throughput of the hospital. Staff who have been trained to privilege individual patient care in the first instance, are now confronted with making decisions based on throughput and costs. Clinical decisions are influenced by ideas that have nothing to do with the patient and their care but more to do with the need to reduce access block, improve throughput or reduce costs. All aspects of health are now enumerated and reported upon and this leads staff to be concerned with what their actual role is: caring for the hospital and its scoreboard results in key performance indicators, or the patient.

This inevitably leads to disillusionment as what staff believe they are employed for is not what they do, and decisions that impact upon patients are made further and further away from the patient's bed. This reduces staff satisfaction and negatively influences staff retention and recruitment. As if to add insult to injury complaints are ignored, critics are sidelined or sacked, the language is bastardized (for instance, describing a budget reduction as an efficiency dividend is a particularly offensive example) and what was once 'spin' becomes truth. This is not to say that the new style managers are destructive or deficient, they are neither. They, like everyone else, are attempting to graft ideas made for other places – the car factory – onto a place of healing and care.

The withdrawal, and outsourcing, of services not deemed core business has seen hospitals get dirtier, food get worse in quality and quantity, parking has become more expensive and patient care become more formulaic and less individualised.

Inevitably as these economic rationalist ideas have spread we have seen the gradual destruction of the hospital system that gave good individual care and in which staff wished to work. We now have to spend millions on recruiting staff to work in a system that is not what they want to work in. We have a system that patients don't like and about which they complain. We have a system that

has to continually employ consultants and bring in new ideas to remedy the faults that are being created by its slavish adherence to largely discredited manufacturing management ideas.

It is no surprise then that, inevitably, clinical care will continue to be compromised. The present philosophical course has not resulted in better care for patients nor are hospitals better places to be sick; they even fail their own acid test (of economic rationalism) as they continually go over budget. The response to these failures is usually simple – privatize or increase management accountability and scope – and does little to solve any problems other than those contained in questions directed to the minister at question time. The uncritical acceptance of advice from consultants and management gurus (in lieu of asking staff what to do) that better management or more efficiencies will fix the health system's ills has created little more than jobs for consultants and distress for staff who are implicitly blamed for the systemic failures.

It is disturbing to realize that much of what we see in all NSW hospitals could have been predicted had experiences from overseas been researched and understood. Much of what passes for new ideas in health management has been brought from elsewhere. If new ideas were subject to the same processes that now govern the introduction of new appliances in health, most would fail and would not be implemented. For example, local research showed that restructuring, as a rule, does not work in providing better care for sick people rather it suits the political ambitions of those who propose it. Yet we restructure and restructure. Conceptualising hospitals like factories misses the importance of what the hospital actually means to the community, as throughput replaces care. Sending sick people home early reduces hospital costs as it transfers the costs to families and community services. Yet we continue down this increasingly dangerous and intellectually suspect path.

A functioning health system is a marker for a civilized society. It is clear that much of the community concern about the health system has become more shrill in the past 15 years as rationalist ideas gain ground and primacy. By any measure what is being done to the health system in the name of efficiency, management and restructuring is failing to provide a health system in which people wish to work, where patients feel cared for and which meets the needs of the community.

I am not arguing that we should return to a 'golden age' when things were better, for there was no such time. Hospitals have always been caught between the need for services and the cost of those services. What I am arguing for is an ongoing dialogue between the community and health system where what is wanted and what can be afforded is discussed and agreed upon. The health system needs to tread a fine line between the burdens of its own traditions and the political demands of governments and oppositions who trumpet social democratic ideas and ideals but practice liberal democratic ideas and managerialism.

As a community we need to enter into a meaningful dialogue with governments and oppositions about what we want, what we can afford and what we need to pay to achieve it. That is, maintain what we value and be prepared to pay the cost.