The politics of public sector change

Trends in health and education sector change in South Australia

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BACKGROUND As the changes underpinning the Coordinated Care Trials in South Australia have become more apparent, similarities have emerged between the rationalisation of public schooling in the mid 1980s and the transformation of public health in the 1990s.

OBJECTIVE This article aims to discuss the evolution of health services in South Australia and help us answer the question of how best to manage our public and private health infrastructure in a changing economic and social context.

DISCUSSION Both strategies in education and health share common elements of cost cutting, attempts at improving efficiencies, a flirting with the private sector and the attendant risk of reduced quality of services to the public. This situation in both sectors is indicative of a shift in public policy and a growth in the belief that private management of public sector infrastructure can help resolve the funding crises around our education and health systems.

In the mid 1980s in South Australia, there was a crisis in the education system. Revenue for the management of state education was insufficient to meet the needs of burgeoning demand as more and more students stayed on at school to improve their employment prospects and governments sought to increase retention rates in senior schools.

To counter rising costs in education, the idea of reducing demand on the public system gained currency and governments attempted to shift responsibility for education to the individual and privately funded systems. New and efficient ways of delivering curriculum materials were developed for rural communities in particular, including the concept of distance education or open access education where students would work on predetermined curriculum content via telephone and later via computer.

A similar situation now faces our health system. The same funding pressures exist, the same high cost of staffing and personnel, the same major infrastructure costs and the same burgeoning demand for access to services are all driving reform of the public health system. As government contribution to these sectors is supposedly capped as a fixed proportion of gross domestic product, the solution is to either pass on some costs to other systems or find increased efficiencies in the current one.

Coordinated care

The idea of reducing utilisation of acute health services through improved coordination of primary health services[1,2] offered a possible solution to growing acute sector demand and at the same time introduced the potential of shifting responsibility for health care from the state to the private arena. According to this new 'market driven ideology'[3], in a time of increased technical capability, aging populations and more aware consumers, the current Medicare system was simply far too expensive for the revenue generated to meet these costs. In addition, inefficient service provision, duplication and lack of accountability left an open-ended system with unlimited liability underwritten by either the state for hospitals or the commonwealth for the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS).

This problem seems set to compound as the 'baby boomer generation', now in retirement, begin using more and more health care services and consumers become more and more informed and demanding of high quality services to ensure their health and wellbeing is maintained at a high standard.[4,5]

The idea of cashing out MBS services and capping the potential cost of general practitioner services was introduced based on experiences with fund holding and managed care in the UK and the US respectively.[6] In Australia however, this practice was called integration or coordination, not fund holding or fund management as it was in other countries.[7,8]

It was thought that if services could be coordinated and outcomes managed more effectively, a better link could be established between the funds going into health care and the desired health outcomes achieved through the use of those funds. In this way demand could be moderated with patients receiving the services shown to result in specific health outcomes and being supported through preventive primary health care and self management programs[9–13] to reduce the incidence of health crises and acute sector demand.[14,15]

Both GPs and hospitals were the focus of this strategy of coordinating and managing patient care, especially for patients with chronic conditions. The COAG Coordinated Care Trials introduced the idea of pooling resources and funding practitioners directly to achieve specified health outcomes for patients through more integrated primary care. This involved GPs coordinating other health professionals to deliver basic primary care while they managed the clinical assessment and treatment aspects of patient care. Recent innovations around the introduction of the Enhanced Primary Care (EPC) program, chronic condition self management[16] and other practice incentives for GPs to manage patients with chronic conditions are developing this concept further[17] as the government invests more and more resources in preventive care as a way of reducing acute demand and improving patient wellbeing.

The problem

The idea was to reduce the time GPs spent consulting in relation to routine patient visits and free them to manage the main clinical aspects of their service demand while others dealt with the day-to-day routine matters associated with patient primary care and preventive care. Some practitioners disagreed with these trends[18] and understandably saw this as interference in their business and their professional judgment as a result of the adverse impact of market forces.[3]

In America, the popularity of general practice as a profession and vocation began to decline with the number of students applying to medical schools dropping by 8% and this decline is expected to continue into the future.[19] It could become more difficult to attract students to medicine if the rewards of the profession are eroded by bureaucratic controls. Already in Australia, huge incentives are being offered to induce GPs to work in rural and remote communities while more and more GPs seek to work part time or reduce their involvement in the practice of medicine.

Health, as with education, began its program of reform with the best of intentions, but the health system risks creating an even more controlled and unresponsive system if new relationships between health professionals cannot be developed. For example, if GPs see the EPC process as a good way to work, but do not create an open environment in which it can function, they will ultimately create more work for themselves and confound the objective of making their working lives more professionally rewarding and less stressful. In such circumstances it is also unlikely that the other important goal of improving patient health outcomes will be achieved.

If, on the other hand, GPs were to embrace this idea, they could enhance their professional standing, improve the quality of their practice and diversify their interaction with allied health professionals for the ultimate benefit of themselves and their patients. Finally, they could contribute to reductions in the incidence of crisis events in the acute sector[20,21] and encourage patients to take more control of their health, which would enable them to share in any savings made in the hospital and acute sectors.

The lesson from education is that practitioners cannot have it both ways. They cannot have endless, indexed funding increases with improved working conditions guaranteed unless they are prepared to improve some aspects of their output.[22] They cannot expect to continue to do things as they have always done and be rewarded perpetually for this. The new rewards are in finding more effective ways of working. The farmer who broadcasts his wheat and harrows it in by hand cannot realistically expect to get the same financial gain in a competitive market from his wheat farming as his neighbour who invests millions of dollars in computer aided seeding equipment and a satellite navigation system.

Conclusion

If GPs manage their approach to change like teachers managed theirs, they may end up with more work and less satisfying conditions, but being pseudo-private business managers they will not receive the benefit of early retirement incentives and packages to go along with and soften the personal impact of change. It is interesting to note that the General Practice Strategy Review Group, after considering the prospect of retirement packages for GPs, concluded that: 'Making such packages available would not be a productive approach'.[23]

If we are to retain our public infrastructure in the interests of equity and social justice we will have to learn quickly the lessons of private sector management and change and apply these to our institutions of health and education. We will need to make the best use of the limited resources available in both sectors by employing new management processes aimed at achieving more with less, unless, as a nation, we decide to invest a greater proportion of gross domestic product in these areas than is currently the case. Such a policy change may enable us to expand our contribution across the board to health and wellbeing as a major national priority. This outcome however, is probably not a possibility under existing world political and economic constraints. We therefore may need to concentrate more on the former option rather than the latter!

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