



Agonising death by a thousand cuts

We are getting older and our health difficulties are getting more complex than traditional approaches to medicine can cope with, writes **Mark Metherell**.

Maggie was a sufficiently independent widow in her 70s until Australia's disconnected health system got in the way. An aged-care hostel resident who kept active despite moderately high blood pressure, diabetes and angina, Maggie's life changed when her doctor changed her medication.

The new drug triggered dizzy spells and Maggie fell and broke her hip. Within days of being rushed to a public hospital she had a new hip. Another triumph, surely, for Australia's health system – immediate world-standard care with taxpayers bearing the cost.

Well, not entirely. The orthopedic surgeon expertly fitted her new hip joint but Maggie's chronic diseases were pushed to the background. As a result, Maggie took a worrying turn because complications with her diabetes medication and her cardiovascular condition had gone largely ignored. Renal failure and chaos with her diabetes followed the hip operation; she became confused and deeply anxious.

The outcome was terrible for Maggie and for the system. She spent 50 days in hospital, at a cost to taxpayers of about \$50,000. Maggie's story is typical of a growing number of cases that elude what otherwise would be standard medical care here and in many other Western countries.

In medical parlance Maggie has comorbidities; like many patients her age she suffers more than one chronic condition. As baby boomers age, the challenge of co-morbidity will get harder, unless health policy changes dramatically.

The paradox of the health system is that while it offers the best and latest available care for specific diseases, it faces an increasing struggle dealing with the shift in focus to chronic disease care, in and out of hospitals. Most patients with diabetes, chronic obstructive pulmonary disease or chronic heart failure have other chronic conditions, according to research published recently in the *Australia and New Zealand Health Policy* journal.

Given the frequency of comorbidity, "future clinical policy ini-

tiatives need to move away from single-illness orientation towards strategies that embrace the needs of people with co-morbid conditions to strengthen patient capacity to self-manage", concludes the research, overseen by the Australian Primary Health Care Research Institute.

The frustration is that, just as with Maggie's case, most hospital admissions of elderly patients are avoidable if warning signs are picked up early enough. According to research published in the *Medical Journal of Australia*, up to 79 per cent of hospital emergency admissions for over-75s are avoidable if emerging problems are nipped in the bud.

So Australia has a substantial and swelling problem that is largely avoidable, but not without a big change to our health system, says Professor Katherine McGrath, a Melbourne medical specialist who turned consultant with wide experience in public and private health.

McGrath says Maggie's saga highlights the need for Australia to rethink the single-disease focus, and with it the inflexible nature of the public system, which is neither organised nor financed to routinely provide services tailored to individual patient needs. To do so would not necessarily generate higher costs. A healthier patient is generally a cheaper patient.

"The problem at the moment is the single-disease specialism. No one sits with a helicopter view from the patient's perspective," McGrath says.

Thirty years ago there were much fewer patients in their 60s and 70s undergoing dialysis or heart operations. Today these older patients represent 30 per cent of admissions but occupy more than half of hospital bed days because of their complications.

McGrath says: "They present the biggest challenge to the hospital system and it is not geared to manage them." These patients get confused, fall over, get bed sores. And previously there weren't so many of them."

McGrath says the solution is not in more staff alone. "There is no one with the responsibility to co-ordinate the other needs of a patient requiring a new hip, or who has diabetes and if

she does not go home soon, will lose mobility, motivation and the capacity for independent living."

A group of influential figures, including McGrath, argue the health system must focus more on individual patient needs than pouring good money after bad into slow-responding bureaucracies and hospitals. The reformers argue the solution requires more than merely installing the Federal Government as sole health funder to end the state-federal divide impeding co-ordinated care between hospitals, doctors and community care. They advocate Medicare Select, the radical ultimate goal proposed by the National Health and Hospitals Reform Commission.

Australians would retain Medicare's universal coverage and the Pharmaceutical Benefits Scheme, but would be able to choose from a variety of competing health "plans" – mega versions of existing health funds, not just paying the members' health bills but taking responsibility for the consumers' full health needs, with strong incentives to coax people into healthier lifestyles.

The plans would compete to provide superior care, including for those with multiple chronic care needs. According to the reform commission, innovative plans would improve patient care. Competition for care contracts would improve service providers, like hospitals and health professionals. As a first step to a "single health system", the commission recommended a Healthy Australia accord with the Federal Government funding all primary care as well as state-run community health and hospital outpatient services.

It is unclear whether the Prime Minister, Kevin Rudd, has the stomach for such an incursion into state services, despite his pre-election threat to take over public hospitals if the states fail them. NSW and Victoria publicly oppose even the limited takeover proposed by the commission, the former apparently because NSW fears loss of funding and the latter because Victoria might miss federal assistance to tardier states. Rudd and his Health Minister, Nicola Roxon, have attended many of the nearly 40 "consultations" on health reform launched since the commission reported in June.



Doctors, nurses and health-care representatives at these sessions have expressed avid support for reforms such as ensuring seamless links between community and hospital care. The commission chairwoman, Dr Christine Bennett, says: "The system cannot go on ... there needs to be a very major change in the governance of health."

Just Stoelwinder, a veteran of public hospital administration, says running a complex system like health is getting too hard for government, given the combination of risk-averse bureaucracy and the politicians' propensity for short-term solutions to avoid hospital "crisis" headlines.

Stoelwinder, a Monash University professor of health systems, says the takeover of all funding by the Commonwealth simply shifts decision-making to an even more remote bur-

eaucracy. He wants the Dutch system, where consumers can spend their government-provided allocation with the health fund of their choice.

The consequent competition, he says, means funds must get the best bang for their members' bucks in price and service negotiations with hospitals and doctors. Stoelwinder, a Medibank Private director, says he is not advocating a free-market approach. "Health does not work that way. But I think we have to engage the consumer directly in choices of health care."

Mary Foley, a former chief of St Vincent's and Mater Health, says primary care must be expanded, expertise must be developed to cope with comorbidity of patients, and electronic health must be exploited so that individual needs and circumstances can be tracked in a dysfunctional system.

Mark Metherell is the *Herald's* health correspondent.



Katherine McGrath ... rethink needed