

# THE FUTURE OF CHILDREN'S HEALTH CARE

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## **HEALTH SYSTEM REFORM**

Capability/technology/knowledge  
Expectation/demand/aging  
Culture/accountability/pressures  
Resource scarcity/rationing  
Change process/comprehensive/  
challenging

## **COMPLEXITY OF HEALTH INDUSTRY**

Inputs/outputs/outcomes/quality  
Range of services/scenarios/interactions  
Illness/wellness/prevention  
Professionals/autonomy/reform  
Consumers/authority/data/choice  
Funders/markets/economics

## **AUSTRALIA'S HEALTH SERVICES EXPENDITURE 1997-1998**

Total \$47.38, up 5.1%, annual 4.1% (\$50B)  
Since 1989-90, up 40% real, 64% current \$  
Per person expenditure \$2,536 (1997-98)  
Since 1989-90, up 25% real 50% current \$  
GDP% was 7.5% in 1989-90 now 8.4%

## **FRAGMENTATION OF HEALTH SYSTEM**

Philosophy/access/equity/international  
Agencies/'non health' input/geography  
Levels of government/bureaucracy  
Providers/purchasers/funders  
Private sector roles and options

'We still have in Australia a curious system where we have Commonwealth and State funding for health services and gamesmanship either on the Commonwealth's part or the State's part in how we shift the dollar implications of our funding arrangements from one sector to the other.'

'The duality of funding has been a major difficulty in Australia and it tends to mean that funds are spent more on the basis of functional responsibility rather than true need. I would argue that we need, at some level in our system, a single pool of dollars in order to plan the best provision and usage of those dollars.'

Mick Reid, Healthcover August 99

'There is going to be some stage in the short to medium term future where the balance of advantage will swing in favour of structural change rather than incremental change.'

Dick Sutton, Healthcover  
August 99

## **FUNDING MODELS**

Philosophic vs economic  
Population vs individual  
Sources/balance/integration/models  
Provider remuneration/income  
Retrospective/uncapped/FFS  
Prospective/risk share/capitation  
Casemix/limitations/child unfriendly

‘The new health universalism welcomes diversity and, subject to appropriate guidelines, competition in the provision of services. At the same time, it recognises that if services are to be provided for all, then not all services can be provided.’

Healthcover August 1999

### **PRIVATE/PUBLIC INTERACTION**

Philosophy/choice vs rationing  
Health insurance/subsidies  
Supplementary and controlled vs independent and competitive markets  
Dick Scotton: Management Competition  
Coloration/integration/barriers

‘Health insurers may find it easier to pass on inefficiencies in the form of higher premiums and allow high out-of-pocket expenses rather than tackle inefficiencies early.’

Andrew Podger, Healthcover

### **EVIDENCE BASED MEDICINE**

Autonomy/variation in practice  
Literature/guidelines/pathways  
Appropriate/efficacious/effective  
Outcomes/health improvement  
Accountable (measurable and reported)  
Efficiency: allocative and technical

‘Traditional management information systems nearly always fail to reflect the underlying clinical work processes by which hospitals and clinics care for patients. Because we do not measure the actual and full range of outcomes of care delivery, we cannot manage care. We are reduced to trying to manage costs, but without the information necessary to understand and manage the clinical processes that produce those costs.’

Brent James 6/99

### **HOLLISTIC/ALTERNATIVE/ COMPLEMENTARY**

Costly but growing industry  
Criticism/lack of evidence base  
Lessons for providers/system  
Paradox/psyche/needs/control  
Communication/remuneration  
High tech vs high touch (N Swan)

### **CONSUMERS OF HEALTH CARE**

Individual family vs systemic  
Representation/opportunity/input  
Press/expectations/context  
Educated and informed/challenges  
Data/impact/complexity/paradox

### **NURSING**

Multidisciplinary teams/outreach  
Roles/scenarios/rural and remote  
Hospitals/units/skills/‘non-clinical’  
Education/positions/CNS, CNC, PA  
Research/specific and collaborative

## **WORKFORCE AND CULTURE**

The paradox of technology  
Pressures of system reform  
Accountability/ scarcity/reporting  
Expectations/ethics/exposure  
Workforce planning/RMOs  
Stress/hours/rewards

## **MANAGERS IN THE HEALTH SYSTEM**

Expertise/systematic/planners/policy  
Provider professionals/roles and responsibilities  
Clinician managers/levels  
Education/commitment/accountability  
Culture/tribes/research

‘It is not in the interest of society, patients, healthcare systems, or even the doctors themselves for the doctors to continue to operate as independent advisers concerned with diseases. I believe that we can serve our patients’ best interests, and retain the necessary degree of independence to be the patient’s advocate, by participating more fully in the problems that our society faces and in the healthcare systems that we have developed.’

Prof Sir Cyril Chander Laneai 4/99

‘The public and medical professionals want physicians, and not administrators of health maintenance organisations (HMOs) or government bureaucrats, to remain the primary decision makers for health care. We agree. Who will prepare them for this demanding role? Managed-care bashing is counterproductive. Enlightened medical education for the future is urgently needed.’

NBJM August 1999

## **PSYCHOLOGICAL FACTORS IN CHILD HEALTH**

Family role critical and multifaceted  
Support systems/hospital and beyond  
Partnership in care extended/scenarios  
Information/participation/choices

## **CHILDREN’S HOSPITALS**

Hub of networks/continuity  
Spectrum of care/integration  
Chronic illness and disability  
Intensive/structured/brief LOS  
Informed/participatory families.

## **NETWORKS AND OUTREACH**

The nature of specialised paediatricians  
Relationships/teams extended  
Continuity of care/integrated roles  
Funding and systemic support/  
technology

## **MULTIDISCIPLINARY TEAMS**

History/child health/patient specific  
Units/policy, protocol, pathways  
Examples/progress/limitations  
Professional autonomy/trust/challenges  
Hospital structure/funding/culture

'Medicine used to be simple, ineffective, effective and potentially dangerous. The mystical authority of the doctor used to

be open and work in partnership with our colleagues in health care and with our

Prof Sir Cyril Chandler Laneai 4/99

## RESEARCH AND TEACHING

Inseparable responsibilities/costs  
Hospital role in relevant lab. research

Teaching/training/all professionals  
Informing/educating community

equally concerned about the dangers of avoiding the issue.'

Andrew Podger, Healthcover, August 1999

## FURTHER CLINICAL

Knowledge/complexity/specialist expertise

Surgical: neuro/cardiac/endoscopic/laser  
'ICU': diagnose/monitors/support

## URTHER

## TRENDS

Labs/molecular specificity/genome projects

therapy

Cancer:dx/protocols/targets/molecules/

quality/research

