# *Health Policy Newsletter*

**Volume 8, Number 1** **January, 1995** **Article 7**


## Nash at Monash


**David B. Nash, MD, MBA ***

*Thomas Jefferson University, David.Nash@jefferson.edu





**Suggested Citation**:
Nash, DB. Nash at Monash. Health Policy Newsletter 1995; 8(1): Article 7. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol8/iss1/7

# Nash at Monash

In the late fall, I had the privilege of serving as a Visiting Professor of Quality Evaluation at the Monash Medical Center in Melbourne, Australia. Monash University is a major public University in the state of Victoria, Australia, and the Medical Center serves as the 650 bed central teaching hospital for Monash Medical School. I'd like to reflect on my four intensive days of workshops, lectures, and visits with the faculty, administration, and staff at Monash.

While generalizations are always suspect, it is fair to say that the Melbourners I met were gregarious and friendly. The city of four million is the financial hub of Australia and a polyglot of cultures from the world over, especially Southeast Asia. Violent personal crime is rare, gun control strictly enforced, and the arts are flourishing in a temperate climate almost free of industrial pollution.

Health care in Australia, like America, is delivered by caring professionals working within a system of constrained resources. Monash is a "public hospital," supported almost entirely by the central federal government and the State of Victoria Department of Health. Thus, many of the salaried faculty, and virtually all the senior administrators, find themselves subject to the vagaries of election year politics and legislative bumbling. While Australia's universal health insurance system guarantees access to medical care for all of its 17 million citizens, it also means there will be long waits for elective procedures, regionalization of expensive technologies and more explicit budgetary controls than those found in the USA. Given this centralized system, what are some of the important similarities and differences then with TJU?

Since all the dollars from the state go to the Hospital Director and his staff, the administration makes most of the resource allocation decisions. As a result, the Medical School Dean and department Chairmen focus their efforts on the educational and research agendas of the College. Non-salaried community physicians can opt to see public patients at the centrally set "Medicare" fee schedule, and also bill privately insured patients at a premium. Public patients are seen at public institutions and privately covered patients (those citizens electing to have additional insurance) have additional options. Everyone, however, is guaranteed access, choice of physician and choice of public hospital or clinic. There are no uncovered citizens.

In my workshops with different Monash executives and senior faculty, their devotion to the institution was evident. Monash ties, scarves and sweaters were worn with obvious pride and the atmosphere was very collegial with everyone on a first name basis, especially the physicians and nurses. Nearly 40% of the patients at Monash do not speak English as their principal language, giving new meaning to "training for diversity."

Only 100 house staff collectively care for more than 600 patients in a hospital with perpetually 100% occupancy! It is not uncommon for patients to "queue" in the Emergency Department for two days, waiting for a bed to be freed up. House officers come from more than two dozen countries from all over the world and are supervised by a mix of full-time medical school "professors," salaried hospital "lecturers," and community general practitioners.

Finally, from the quality evaluation perspective, Monash is wrestling with many of the same issues as TJUH, including benchmarking best practices, protocol development, and the tenets of continuous quality improvement. The main purchaser of care is the State, so the political health appointees are powerful and exert great influence. There is no "managed care" and little private health insurance to speak of. Hospital accreditation is voluntary!

Like those at TJUH, the leaders of Monash know that resources are limited while the demand for medical services is potentially unlimited. The dynamic tension this creates requires an ongoing dialogue to preserve the quality of care. Health care providers half-a-world away are promoting a vigorous dialogue amongst themselves, with their patients and their elected leaders. While no single system is flawless, we have a lot to share, and much more to learn.

**About the Author**

David B. Nash, MD, MBA, is Director of Health Policy at Thomas Jefferson University.