Policies — clinical and political — for better health

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The federal government, less than 6 months old, faces many challenges in health care. Establishing priorities will be useful if they guide attention and resources towards where they are likely to offer the best yield in promoting health and providing care for sick and injured people, while honouring the principles of efficiency and equity in the way that we do things and to whom we attend.

The Journal has asked six health leaders to suggest policy pointers — matters that, in their opinion, warrant the attention of the new government and about which policy might be developed for effective action. The first response is by eminent Melbourne health economist and academic Stephen Duckett (*page 138*). Duckett sets out his call for policy under three headings — keeping the Medicare promise, going beyond the provision of services and ensuring good governance. He splits his proposals into what a first-term and second-term government might aspire to do. His wide experience in health service management makes his recommendations especially pertinent.

Brian Head, program leader in policy analysis at the University of Queensland, wrote "Policy decisions emerge from politics, judgement and debate, rather than being deduced from empirical analysis. Policy debate and analysis involves an interplay between facts, norms and desired actions, in which 'evidence' is diverse and contestable" (*Aust J Public Admin* 2008; 67: 1-11). Policy that works distils evidence from several sources. It includes the kind that supports evidence-based medicine, but there is also the evidence that comes from an assessment of political feasibility and evidence that comes from what we might call experience. Doctors are often frustrated when the evidence they present, from both basic and clinical science and from professional experience, is trumped by politics. But the nature of a democracy is such that this is to be expected.

Policy on initial screening for acute life-threatening disease benefits greatly from medical input. Although, strictly, it is case finding, the study by Parsonage and colleagues (*page 161*) evaluates the use of a more sensitive troponin test for more quickly determining the presence of myocardial damage in line with an "accelerated biomarker" strategy for assessing and managing suspected ischaemia and infarction. Their findings validate the use of this strategy, formulated by the National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand. Here, medical evidence informs the policy that governs the interaction between patients and health care provision.

Because enthusiasm frequently runs ahead of utility when it comes to screening, Maxwell and colleagues (*page 142*) advocate for a national framework for newborn bloodspot screening. Such frameworks have proved their worth in other countries, and one is needed here. Kane and colleagues (*page 140*) welcome progress in the use of cell-free fetal DNA tests of maternal serum for aneuploidy screening (and the extension of related tests to pregnancy outcome prediction) in the first trimester even though these tests have some distance to travel before sensitivity, specificity and predictive value will be clear.

Ah, the delight of reading an article that describes *success* in closing a gap — any gap! Gaps so often cause lamentation with no design for a bridge. Tideman and colleagues (*page 157*; see linked editorial by Carroll and Thompson [*page 131*]) describe a splendid cardiology network in South Australia that supports patients who have had acute myocardial infarction and who live in places remote from major hospitals in receiving appropriate timely and evidence-based care. The network involves providing advice from metropolitan hospital specialists to rural health practitioners, carefully stratifying patients into three risk categories to determine who needs reperfusion angiography most urgently, and then organising it. The mortality gap between city and rural dwellers was consequently abolished. Here, policy built the bridge to bring rural outcomes closer to city ones.

In all of these examples, policy served as a vehicle for organising thought and care. It is critical to achieving the best clinical outcomes. The challenge to our nation is to ensure that our state and federal policies are as sound as we can help make them. We doctors do not make the policies, but we contribute positively and importantly to them.

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Honouring the leaders of Australian medicine

Professor Sam Berkovic leads a large group of Australian doctors and researchers who were recipients of Australia Day Honours recently. Professor Berkovic, who discovered the first gene associated with epilepsy in 1995, says rather than being disappointed with the progress of gene therapies since then, as the lay media is inclined to be, he is "excited" by the challenges, particularly in neuroscience. "We don't know how many layers to the onion there are", he tells the MJA on *page C1*. "That's the excitement of science." See the full list of medical recipients of Australia Day Honours, including profiles of Professor Christine Bennett, Professor David Celermajer, Professor Michael Cousins, and Professor Michael Daube, who spoke with Cate Swannell. ❑

Careers follows p 182