

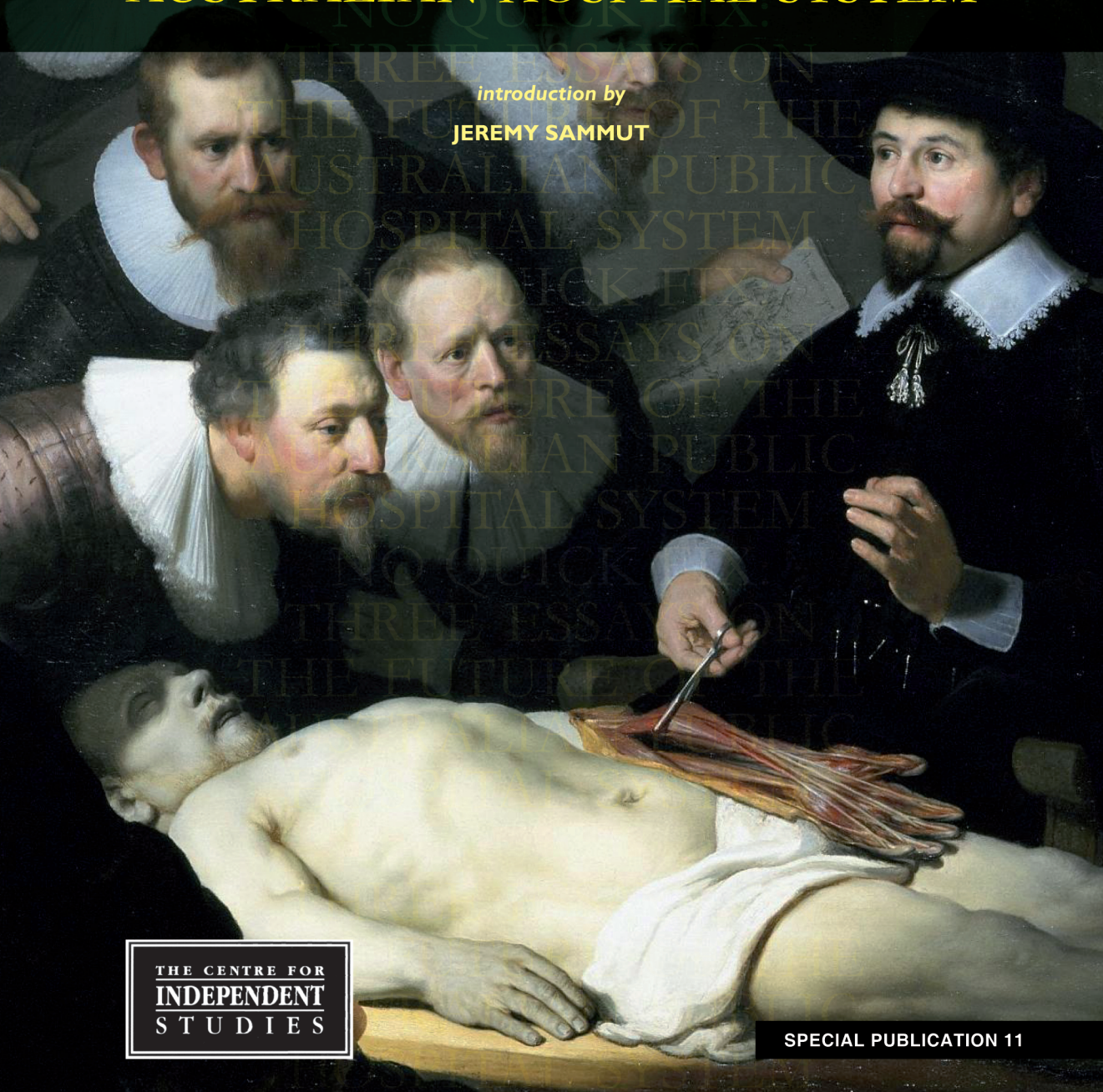
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NO QUICK FIX:

THREE ESSAYS ON THE FUTURE OF THE AUSTRALIAN HOSPITAL SYSTEM

introduction by

JEREMY SAMMUT



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No Quick Fix: Three Essays on the Future of the Australian Hospital System

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Introduction

Local Boards are Only the First Step in Fixing Public Hospitals

Jeremy Sammut



Until the mid-1980s, Australian public hospitals were managed by their own boards of directors. When hospital boards were abolished, state governments established centralised health bureaucracies to administer hospitals and other health services within designated regions, such as the eight ‘area health services’ in New South Wales and the 17 ‘health service districts’ in Queensland. In recent years, the best way to run public hospitals has become a contentious issue, attracting heated claims and counter-claims from diametrically opposed camps. Those who support re-establishing the traditional system of in-house hospital administration maintain that the loss of hospital boards has caused the endemic problems in public hospitals. Opponents of re-establishing hospital boards argue this is a simplistic and anachronistic ‘quick fix’ for what is justifiably called the ‘hospital crisis.’¹

Many health experts warn against going ‘back to the future.’ They maintain that when local boards ran hospitals, the result was financial irresponsibility and duplication and fragmentation of hospital and community-based services.² Such criticisms of the old system are not without substance. Although local boards were fully behind their hospitals, some boards, particularly those under the influence of empire-building clinicians, sought to maintain a fiscally unsustainable range of services. State governments would bail out boards that overran the budget, in part because public hospitals provided essential services to the community and in part because board members were politically well-connected. The administrative upheavals of the last 25 years were partly motivated by an understandable desire for financial discipline. However, imposing centralised bureaucratic control has ultimately created more problems than it has solved.³

Tangled up in waste, red tape, and marginal services

The bloated bureaucracies responsible for managing public hospitals are anything but skilled planning agencies and careful guardians of the public purse. In all states and territories, the public hospital system is crippled by budget blowouts and shortages of basic services. Metropolitan public hospitals experience increasingly serious emergency ‘access block’ and ever-longer waiting times for elective surgery. Hospitals across the country are overcrowded due to the critical shortage of hospital beds caused by decades of cuts to bed numbers. In country regions, severe cuts to rural hospital services force patients to travel hundreds of kilometres to receive simple emergency treatment. In NSW, thoracic surgery is no longer performed west of the Great Dividing Range, and half the maternity services in rural areas have been closed in the last 15 years.⁴

The hospital crisis is perpetually blamed on ‘under-funding.’ Lack of funding is not the problem. In fact, public hospital funding has increased by nearly two-thirds in real terms (adjusted for inflation) over the last decade.⁵ The real problem—as observed by professionals with years of first-hand experience in the system⁶—is that too much of the money earmarked for treatment is being spent on the burgeoning

bureaucracy rather than frontline service. But according to the NSW Minister for Health, Carmel Tebbutt, bureaucratic excess is overstated. Less than 4% of the NSW Health employees fill ‘corporate’ positions—a mere 4,000 or so employees out of the total workforce of 95,000.⁷ This means one highly paid administrator is employed for approximately every five public hospital beds in the state.⁸ NSW Health’s annual report reveals that non-clinical staff actually total 27% of employees. In reality, when cooks, cleaners and gardeners are excluded, NSW has nearly as many executives, clerks and other politicised and unaccountable bureaucrats (19,883) as beds (20,006).⁹

Just as bad as the high financial cost is the administrative dysfunction caused by the ‘rift between clinical and corporate accountabilities,’¹⁰ which was rightly identified by the final report of the National Health and Hospital Reform Commission as a major impediment to the operation of public hospitals.¹¹ Disempowered senior clinicians are forced to refer even minor operational decisions about their departments to out-of-touch managers located in offices far removed from the coalface. Protracted and frequently flawed decision-making causes further waste of funding that is not spent optimally inside hospitals. Meanwhile, doctors and nurses must complete the endless ‘head office’ paperwork to comply with detailed micro-management of daily activities, which wastes time and money, and adversely affects the quality of patient care. These problems, detailed in the findings of the Garling Special Commission into NSW public hospitals in 2008,¹² exist in all states.¹³

Most policymakers are cognisant of the impact of bureaucratic mismanagement, and at least pay lip service to the need for less bureaucracy and greater local management.¹⁴ However, state and federal leaders on both sides of politics reject local hospital boards in favour of running public hospitals as part of region-based, ‘integrated’ health networks due to a crucial misconception. They believe that the centralised bureaucracies plan and coordinate comprehensive health care services and offer ‘continuity’ of hospital and community-based care to patients before, during and after they enter hospital.¹⁵

In reality, hospital and primary care services in Australia are disjointed due to the division of health responsibilities between the federal and state governments. Rather than integrate services, the state health bureaucracies have increased the fragmentation, duplication and waste because they do not fulfil the role they were ostensibly created to play. The area health services in NSW, for example, are highly complex organisations that run 221 public hospitals and more than 350 stand-alone community health services. Although the community health services, which the Whitlam federal government established in 1975, were handed over to the states to run in the mid-1980s, the states never took responsibility for the non-hospital clinical care of most patients. Instead, the cost of pre- and post-hospital care has been shifted on to the federally funded Medicare (private general practice) scheme wherever possible.¹⁶ Although some community health services offer some duplicate (salaried) primary

health care services (usually for disadvantaged people) and some other important but often difficult-to-access services such as hospital in the home, most provide non-patient focused public health services, which are of limited utility to the efficacy of public hospital care.¹⁷ The diversion of funding to pay for these marginal services explains why, on top of the growth in bureaucratic overheads, only three out of 10 health department employees in Queensland is a doctor or nurse who actually delivers patient care.¹⁸

Politics of hospitals

The political support for retaining centralised bureaucracies can also be traced to the interest group-driven medical politics and ideology that underlies the debate about the future of public hospitals.

Following the eradication of air, water and blood-borne epidemic diseases in Western countries in the first half of the twentieth century, sociological theories of disadvantage were adapted and applied in the field of public health. The ferment that began in the academe in the 1960s centred on treating illness as a social problem caused by structural injustices rather than purely as a medical problem. The new 'population health' philosophy went beyond demanding that all citizens have taxpayer-funded access to health services. The traditional (class- and gender-based) health hierarchy was also singled out for 'deconstruction.' No longer was health care to revolve around medical intervention when illnesses occurred. An episodic, doctor- and hospital-centric approach was rejected in favour of community-based services delivered by multidisciplinary teams of health workers to prevent the underlying 'social determinants' of ill health (from poverty to smoking to poor diet and lifestyle) for whole populations.¹⁹

These ideas have had a pronounced effect on medical education, particularly nurse and health administration education. Since the introduction of university-based training in Australia in the 1980s, many graduate nurses prefer community-based and other public health roles and reject hospital-based careers. The heavily-unionised nursing and community health workforces, in unison with the vocal and well-organised public and community health lobby, have the political clout to influence the allocation of health dollars and the direction of health policy. These developments have coincided with the curtailment of advocacy for basic hospital services following the abolition of hospital boards. Small and relatively isolated hospital-based provider groups (emergency doctors and nurses and other hospital-based specialists interested in bed provision) have been unable to convince governments and health departments to cease bed cuts and open new beds to solve emergency overcrowding and shorten elective queues.²⁰

The latest manifestation of the public health ideology is the influential notion that the health system is too dependent on hospital care and must be reoriented around stronger community-based services. State and federal governments—who are

badly advised on this issue by pro-community care academic-activists, lobbyists, and fellow-travelling Commonwealth and state bureaucrats—are among the stakeholders who believe that coordinated primary health care services delivered in community health centres or GP Super Clinics will keep chronically ill patients ‘well and out of hospital.’²¹ State premiers and health ministers routinely blame overcrowded hospitals on gaps in the primary care system and the Commonwealth’s supposed failure to fund coordinated chronic disease care.* This blame game is ironic and disingenuous given the ‘make sure services are integrated’ rationale for centralised health bureaucracies.²² It also obscures the real cause of the hospital crisis—capacity constraints (lack of beds) rather than lack of access to primary care services. Numerous studies also show that coordinated primary care services increase the demand for hospital services by uncovering unmet need. Additional community-based services have not reduced hospital admissions or provided an alternative for hospital care.²³ The policy implications of these findings cannot be overstated. It would take a central planning miracle for Australia’s eight federal and state health bureaucracies to seamlessly integrate their services, a task that is now being attempted as part of the Commonwealth government’s takeover of full funding and policy responsibility for primary care services.²⁴ The point is that even if a miracle occurs, it would not fix the real cause of the public hospital crisis—the shortage of beds.²⁵

Nevertheless, the idea that public hospitals must be run as part of health networks to reduce demand for hospital admission is the policy myth that won’t die. Commentators recycle this flawed prescription for fixing the hospital crisis, ignoring the fact the ‘area health’ experiment has been tried and failed.²⁶ The idea of retaining state bureaucracies to ‘make sure services are integrated’ is routinely resuscitated by self-serving pro-community ideologues and state bureaucrats intent on protecting their turf and discrediting the better alternative—a return to local boards.²⁷

Quo Vadis?

The key insight into the hospital crisis is that the public hospital system exhibits all the systemic failures (service shortages, budget overruns, ignorance of real costs, crippled innovation, ‘capture’ by public sector unions, and de-motivated staff) typically experienced by stultifying Soviet-style monopolistic, central plan bureaucracies. So-called reforms that tinker with the scale of the bureaucracy will never fix the fundamental problem, which is the faulty way state governments have chosen to run public hospitals. The federal Labor government’s National Health and Hospitals Networks Plan will not devolve operational management to the

* In fact, the Howard federal government filled the gap by introducing Medicare-funded packages of chronic disease care in 1999. Since 2005, chronically ill patients have been able to access ‘GP Management Plans’ that provide up to five allied health services and three dental services per year.

local level as promised because the state bureaucracies are still in control of the overall management and funding of the system.²⁸ Creating ‘local hospital networks’ staffed by seconded state bureaucrats will only super-impose an additional layer of bureaucracy. Establishing governing boards to oversee hospital networks is a superficial gesture: full-time state bureaucrats will remain in charge because networks are always too large, too diffuse, and too complex for part-time board members to manage.²⁹ Bribing the states with billions of extra taxpayers’ dollars to sign up to a national agreement that does not significantly alter the existing administrative arrangements, other than making them more complex and confused, is a betrayal of hospital staff, patients and voters, who deserve and expect better.³⁰

The decline of public hospitals into their present state of disarray and torpor is proof, if further proof is needed, of what happens when dynamic, self-improving and self-determining parts of our society are subject to the dead hand of statist domination and bureaucratic ‘command and control.’ The only way forward is to unshackle public hospitals from the bureaucracies that otherwise will continue to restrict the hospital system’s ability to meet the health needs of the community. Abolition of the bureaucracy can only be accomplished if administrative responsibility for each public hospital is devolved to autonomous boards of directors.

Re-establishing local hospital boards is an important first step towards fixing public hospitals. Every insight into best business practice indicates that entities are most effectively managed at the local level. But hospital boards are only the first step. It is not a quick fix, nor does it mean a return to fiscally profligate boards. It is not another re-arranging of the administrative deckchairs, nor is it a plan to put the ‘doctor’s club’ back in charge as critics falsely allege. Fixing the public hospital system remains the unfinished business of micro-economic reform of the national economy and reform of federalism.³¹ Genuine hospital reform requires genuinely responsible federalism and genuine local autonomy and accountability. Judicious use of financial levers and competitive pressures, combined with managerial flexibility, must drive improved performance and return on each health dollar spent on public hospitals. Administrative reform must therefore occur in tandem with comprehensive structural and funding reform to transform public hospitals into what they are not: independent, competing, consumer-oriented, and *financially accountable*. Rather than be mired in the usual political wrangling about the problems in the health system, policymakers must focus on policy details that all credible reform plans must contain.

Autonomous boards

To insulate hospital boards from political cronyism, the appointment process must be merit-based, at arm’s-length from government, and subject to appropriate vetting and approval of qualifications. Board positions will need to be widely advertised to encourage leading citizens with suitable business, legal and accounting expertise to apply for pro bono appointments as a civic service.

The standard requirements of corporate governance must be applied. Hospital boards will have to:

- calculate the cost of their hospital's services and be cost-conscious to ensure long-term viability
- publish annual reports detailing the hospital's financial performance and transparently report on the ways they spent public funds
- take complete control and responsibility of their hospital's entire budget and financial management, and
- take responsibility for sustainable strategic planning in cooperation with the professional administrators overseeing the day-to-day running of the hospital.

Each hospital will appoint a chief executive officer answerable to the board. The CEO and other administrators will have full operational control of the hospital. Decentralised decision-making will end day-to-day bureaucratic meddling and restore clinical governance. The general medical superintendent, director of nursing, and medical staff council will have appropriate input into board and executive decisions.

Once hospitals are no longer controlled by faceless bureaucrats, they will be accountable to the people they serve. The local community will know who the CEO and board members are and who are responsible when things go wrong. Inclusive and responsive management by local boards will strengthen community 'ownership' and reverse the disengagement, disgruntlement and apathy that have seen the general public withdraw their support. Only when public hospitals are once again *of government* rather than part of the government will public-spirited citizens be willing to assist the work of 'their' local hospitals by making donations and participating in fundraising and voluntary activities.

Each hospital must also be free to negotiate flexible employment arrangements with its workforce and end restrictive practices that lower productivity and reduce access to care. Centrally-determined state-wide staffing and wage agreements must therefore be abandoned. Operational autonomy will not, of course, preclude hospitals in nearby locations from pooling their activities in administrative areas such as payroll and human resources, or from cooperating to strike better deals from medical suppliers and cleaning or catering companies by 'buying as a group.'

Structural reform

Most public hospitals in most states and territories are principally funded by global budgets, which are determined on a historic basis and adjusted for population and inflation. Each hospital department is paid up front to deliver a set quantity of services prescribed by the bureaucracy. Because public patients receiving 'free' care represent an impost on the hospital budget rather than an opportunity to earn income, 'block' funding destroys all incentives to increase productivity and deliver care to patients. To stay within budget, services are rationed by closing beds and

cancelling surgeries while the queues for treatment grow longer. The bureaucracy, under political pressure, responds by ordering hospitals to achieve unrealistic waiting time targets. Since capped budgets are not sufficient to meet demand, the statistics end up being fudged. Admission data, as revealed by recent scandals in NSW and Victorian hospitals, are systematically falsified to appear to reach politically-mandated performance standards.³²

The economic incentives in public hospitals must be fundamentally reordered if we are to get more and better services for the upwards of \$30 billion spent on the system each year. The old-fashioned, top-down, and ‘take what you’re given’ arrangements that limit choice and prevent competition should be replaced by a consumer-centred system.³³ Taxpayer subsidy for hospital treatment must be tied directly to patients and only be paid directly to hospitals at the point when care is actually delivered. To make sure the money is spent on patients, not bureaucracy, a transparent national system of activity-based funding (also known as case-mix funding[†]) must be introduced to pay hospitals on a performance basis so that each hospital’s budget is principally determined by clinical throughput (by the number, type and complexity of patients treated) and the income earned for providing services. Activity-based case-mix payments—which are calculated at the average or ‘efficient’ cost of providing each occasion of care according to best clinical practice across both public and private hospitals—create powerful incentives to innovate, increase productivity, and find the most technically efficient and cost-effective means of delivering the kind and quantity of services that patients need. Each activity payment should be set at the efficient case-mix cost of whole episodes of emergency and inpatient care, including the cost of capital.

To allow for competition between hospitals and improve the responsiveness of the system to market signals, case-mix-calculated and taxpayer-funded hospital vouchers for elective procedures (subject to clinical referral) should be issued. These vouchers should be redeemable for treatment at the public hospital of the patient’s choice. This will allow each hospital to compete for revenue and focus on delivering highest quality services at the lowest cost. Elective vouchers will further encourage hospitals to welcome patients, increase bed and surgical capacity, and reduce waiting times. Hospitals should also be free to set their own prices for offering additional services to those willing to pay for extras (such as a single room). Payments to hospitals will be principally in the form of case-mix vouchers based on a defined length of stay for each episode of hospital care. Vouchers will therefore not only encourage efficiency and cost-containment (so that the savings can be retained as part of the hospital budget) but also create incentives to improve quality and avoid complications such as hospital infections, which unnecessarily increase the length of stays.

[†] Case-mix funding was first introduced in Victorian public hospitals in the mid-1990s and is currently used to greater and lesser extents in all states and territories except the Australian Capital Territory.

Hospital vouchers for elective care will be issued through the offices of Medicare Australia. Emergency patients will be 'bulk billed' to Medicare by each hospital. Given the obvious lack of scope for choice and competition in emergency treatment, vouchers will make the funding arrangements as close to market based as possible. Medicare is a trusted brand and its involvement in the new system will build public confidence in the reforms.

The best way to end the fragmentation of health services and integrate hospital and other health care services around patients is to extend the voucher system to include community-based services. Federal government-funded vouchers should also be issued to sufferers of chronic conditions to finance the cost of care planning by a care coordinator and purchase multidisciplinary packages of health services (based on robust evidence-based practice guidelines) from either government or private providers. Care coordination will assist patients with ongoing and complex needs, particularly disadvantaged patients facing difficulties navigating the different services run by different government departments, and remove the barriers that limit access to care. The voucher system should also be extended to include community nursing, hospital in the home, and sub-acute and rehabilitation care. When central plan health bureaucracies try to provide these services, as is the case now, they are difficult to access and are rationed just like public hospital care due to the disincentives created by block budgets. Voucher-based funding will ensure community-based care is delivered in a consumer-oriented way by competing providers.³⁴

Responsible federalism

Converting all existing government funding for hospitals and community health into nationally consistent, per-patient funding will require the federal government to become the single funder of public hospital and primary care services system in the country (with appropriate adjustments to the National Health Care Agreement and allocation of GST revenue). A national hospital funding authority should set national prices for public hospital services and permit funding to be distributed directly to each hospital. This should be a stand-alone semi-government authority, separate from Medicare Australia and the federal health department.³⁵ Its charter should include determining the minimum set of hospital and community-based health services covered by case-mix vouchers based on the cost-effective impact on health outcomes. To fulfil this role, the authority will need to be tough-minded, evidence-based, and insulated from political influence and special pleading.

Full Commonwealth financial responsibility for public hospitals is required because of the intractable fiscal imbalances within the federation.³⁶ The current joint Commonwealth and state hospital funding arrangements not only encourage cost and patient shifting but also mean the Commonwealth lacks the authority and the states sufficient incentive to impose system-wide financial control. The Australian Treasury predicts that at current rates of expenditure growth, state health spending will outstrip

state tax revenue by mid-century.³⁷ In return for shifting the cost of the system off their budgets, state governments must agree to abolish their centralised bureaucracies and pass legislation to re-establish local hospital boards as independent statutory authorities. These terms should be set out in a National Public Hospital Funding and Administration Accord—a binding Council of Australian Governments (COAG) agreement, supported by ‘mirror’ federal and state legislation to give effect to the national objectives. A Commonwealth funding package should be made available to cover transition costs and the cost of the redundancies when superfluous, heavily-unionised, and politically-cosseted state bureaucrats are sacked. The devolution of operational authority by state governments to local boards that are re-established by an Act of Parliament will be the non-negotiable condition and trigger for federal case-mix funding on a state-by-state basis. A staged and staggered introduction on a state-by-state basis will help identify and solve problems as the national rollout proceeds. A National Health Reform Council (modelled on the National Competition Council of the 1990s) should be established to manage the transition process. The council should be answerable to COAG and be responsible for authorising the flow of federal funding for the reforms based on adherence to the terms of the national policy.³⁸

If state governments reject structural reform of the current unsustainable administrative and funding arrangements, they will continue to preside over a disaster that will exhaust the crisis management skills of even the best political operators. Refusing to ‘buy in’ to the reforms will undermine the standing of the states, embolden those who call for their abolition, and further erode public support for the federal system.³⁹ Rebuilding hospitals from the bottom up will require a significant change in the mentality of governments and the people. Politicians will need to restore trust in the willingness and ability of the community to run their own hospitals without bureaucratic interference. Citizens will also need to appreciate the true nature of policy problems and stop expecting that the top-down solutions promised by politicians and implemented by bureaucrats can fix the system.⁴⁰

Centralising health funding in Canberra, combined with administrative reform, will end the blame game by assigning clear and exclusive responsibilities to the Commonwealth and the states. The proposed governance structure will appropriately distribute and separate responsibility for funding, operating and regulating public hospitals across each tier.⁴¹ The Commonwealth will not take over or own and operate public hospitals, but it will be responsible for ‘purchasing’ hospital services at the efficient national price. Local community boards will be responsible for the ‘provision’ of hospital care within budget and subject to a minimum, nationally-agreed service charter mandated by statute. Public hospitals will be funded nationally and run locally, with state governments responsible for regulating hospital services. Instead of functioning as politicised provider-bureaucracies with an inherent conflict of interest, state health departments will ensure that boards comply with their statutory

responsibilities. They will also inspect and audit national hospital safety standards to guarantee that efficiencies are not achieved at the expense of quality of care. Disputes between local hospitals and state regulators will be resolved by referral to an independent hospital ombudsman in each state. A robust national hospital reporting system must also be developed to improve accountability and foster competition and informed consumer choice. Hospitals will be required to collect key clinical outcomes for patients such as medication errors, infections, complication, re-admission, and case-specific mortality rates. The tabulated data will be adjusted for risk to remove bias against hospitals treating the sickest patients, and will be published quarterly on the state and federal health department websites.⁴²

Market-based principles

The idea of channelling state and federal hospital funding into vouchers is not a plan to privatise the health system. It matches the ambitions of the left-of-centre proponents of market-design strategies and demand-driven reform initiatives that pursue both social and economic values in sectors of the economy plagued with inefficient public service delivery.⁴³ Equity concerns—the requirement that all citizens have access to necessary hospital care irrespective of their capacity to pay out of private income—are fully satisfied by issuing taxpayer-funded hospital vouchers according to clinical needs. The principle that will hereby drive hospital reform is that government purchasing of health care (using taxpayers' money to ensure universal coverage) may be acceptable but socialised production of health care is not. The comprehensive market-based reforms outlined in this book are consistent with the best practice design principles endorsed by the World Health Organization for health systems. Government involvement will retreat to the more appropriate role of funder of health care and regulator of safety and administrative standards but will no longer be the monopoly provider of taxpayer-funded health services.⁴⁴

Financial (and political) risk for the Commonwealth can be controlled via soft budget caps for each hospital to allow for fluctuations in emergency demand and to reward the most productive hospitals. A rational system of compulsory copayments for non-urgent emergency attendances and for inpatient hospital services (starting with daily bed charges that reflect the transfer of normal accommodation costs to the hospital) would enhance the financial integrity of the system. Requiring individuals to bear greater responsibility for their health care and spend their own money on hospital treatment will promote efficient use of medical resources and discourage over-admission and marginal elective procedures. Altering the philosophy of 'free' medicine that underpins Medicare will require educating the community about the benefits of becoming more informed and financially cautious consumers of health services. The trade-off for greater personal responsibility will be better access to expensive hospital services when needed most.

A federal funding takeover is not the cure-all it is sometimes portrayed to be. The public hospital system is struggling partly due to under-investment in infrastructure by state governments, which have been reluctant to pour money into low productivity services that are notorious fiscal black holes.⁴⁵ Under Commonwealth control, large quantities of capital (plus recurrent funding) will be required to rebuild hospitals and increase bed numbers to accommodate population growth and ageing. The federal government will need to be confident that structural reform of public hospitals can deliver more and better care in a financially sustainable manner before it is prepared to undertake these funding commitments.⁴⁶ Nevertheless, the capital required to meet the demand for hospital treatment may prove beyond the capacity of debt-averse governments. If so, the Commonwealth may have to extend the national voucher scheme to deliver taxpayer-funded hospital treatment of public patients in privately-owned facilities. A guaranteed stream of funding at activity-based prices, which include the cost of capital, may be needed to stimulate private investment in essential hospital services.⁴⁷

Financial accountability

The feasibility of putting local boards back in charge of public hospitals depends on the integrity of the financial governance of the system. The importance of ensuring hospital boards are financially accountable cannot be overstated. There must be no return to the days of fiscal profligacy, which will inevitably lead to the re-centralisation of the system.

To avoid the worst aspects of the old system of local boards, governments will have to enforce the rules and make public hospitals operate in a truly financially rather than a bureaucratically accountable environment. Politicians must no longer use state and federal treasuries as a fiscal magic pudding or as pork-barrels for their constituencies. Instead, they must ensure that boards make financially responsible decisions about the services provided by their hospitals to ensure that activity-based income covers budgeted costs and avoids the waste, duplication, special pleading, and associated political problems that contributed to the abolition of local boards in the first place.

Genuine local autonomy, combined with genuine financial accountability and the economic realities of activity and voucher-based funding, will give boards the incentive to specialise in certain services and close down loss-making services (outside of their community service charter).⁴⁸ Strict, competitive public tendering arrangements must be put in place to determine which hospitals will house high-cost specialist units. Financial accountability will also restrain excessive parochialism and encourage the integration and regionalisation of services 'from below.' Hospitals will network their services with other facilities, including creating city-country hospital networks. Rural hospitals will be keen to link up with city hospitals offering specialist treatment, while the latter will gain access to a new patient base.⁴⁹

Boards will also have to make a business case for long-term investment decisions. Requiring boards to secure private financing at market rates for capital works would further instil planning and budgetary discipline. The threat of removal of the board for financial mismanagement and the restoration of centralised bureaucratic control by state health departments (and the potential closure of smaller hospitals) will give hospitals the incentive to perform and operate within their means.

Public hospitals are different

The opponents of local boards maintain that activity-based payments will force many rural hospitals to close. Case-mix funding is best suited to larger urban hospitals with high and consistent demand. Smaller hospitals depend on the financial subsidies (the global budgets) provided by state health departments. Because the case-mix volumes in these facilities are low and variable, these smaller hospitals would struggle to survive purely on what they earn from treating patients.

These are valid but not insurmountable concerns. Approximately 50% of the cost of operating a hospital is made up by fixed costs.⁵⁰ Annual grants covering fixed costs can therefore be made to rural hospitals by the national hospital funding authority. However, the rest of the funding must be based on clinical throughput remunerated on a case-mix basis to promote efficiency and accountability. It is also possible to adjust activity-based payments for the different cost of treating patients in the country. These twin sources of funding will give all rural hospitals the chance to thrive in partnership with the local community. It will also allow for transparent decisions to be made about closing hospitals based on whether the fixed funding is justified by the output achieved under the management of the local board. This is far preferable to the current situation of death by a thousand arbitrary service cuts at the hands of the bureaucracy.⁵¹

Another limitation of case-mix funding is accurately reimbursing hospitals for the cost of treating non-procedural patients with varied treatment requirements. The national hospital funding authority must work with clinicians to develop a case-mix payment formula that is properly adjusted for the true cost of simple and complex patients who require bed-based medical and nursing care. Case-mix funding for procedural care (the cost of which is easier to measure accurately) also tends to encourage hospitals to operate at above 100% bed occupancy to maximise the treatment of 'quick and cheap' elective patients. This inevitably leads to emergency overcrowding when no spare beds are available to manage unplanned admissions. Hospitals with large emergency loads will therefore require additional 'bed vouchers' to cover the fixed costs of the spare beds (15% of total bed capacity) needed to manage demand for emergency admission. In-hospital nurse training should be reinstated in major teaching hospitals to facilitate the reopening of beds and train a new generation of nurses who are prepared to work on the wards.⁵² Finally, hospital boards will have to accept the limitations of case-mix funding. Some cross-subsidisation of emergency

and medical care from the more lucrative procedural care is necessary to sustain core hospital services.

Role of private health

Better costing of medical care, spare emergency bed vouchers, vocational nurse training, and cross-subsidisation are required to end the ‘inverse care law’ in the Australian hospital system. Public hospitals care for 60% of hospital patients in Australia. They treat 90% of emergency cases, and 75% of admitted patients require non-procedural medical care. The majority of private hospitals provide procedural services and are not equipped to deal with most emergencies. Public hospitals are always under pressure to reduce politically-sensitive elective waiting times, so elective procedures are maximised at the expense of the sickest patients, who are forced to queue on trolleys in emergency department corridors while waiting for a bed.

To ensure more Australians receive the right care at the right time, a better balance must be struck between procedural and non-procedural services, and between public and private hospitals. This requires recognising the limits of public hospitals and the need to deepen the role of private health insurance.

The community unrealistically expects governments to fulfil the promise politicians have made for a generation. No government will ever have the budget to afford unrestricted access to ‘free’ hospital care. Non-price rationing of hospital services is integral to all taxpayer funded universal health systems throughout the world. Reforms that eliminate waste and bureaucracy—and close the 20% productivity gap between best and actual practice in public hospitals⁵³—can save and reallocate substantial amounts of taxpayer dollars to pay for more frontline services. But reforms will never transform the public system into a demand-driven cornucopia. Budget limits, maximum elective service levels, and rationing by queuing will always remain. The key objective should be to ensure that rationing is performed ethically based on relative need, not irrationally and immorally by means of emergency overcrowding.⁵⁴

Governments seek to politically manage the rationing of care by setting maximum elective waiting times that are mostly honoured in the breach. The true level of rationing and waiting is obscured by focusing on the number of people who wait ‘too long’ beyond recommended waiting times. Instead, the *average* waiting time should be advertised, and policymakers should lower community expectations by informing them of *minimum* waiting times. Patients would know that waiting for treatment is the unavoidable reality of the public system because budgets are limited and more needy people are at the front of the queue. Those who do not want to wait can be encouraged through public education campaigns to take out private health insurance.

Private hospitals in Australia perform the majority of elective surgery and deliver far more timely care to the 44% of Australians who choose to pay insurance premiums. Every citizen should be expected to make a rational choice between time (waiting for

treatment) and money (paid for not waiting). The more people that choose to take responsibility for their health care by paying for private cover, the more affordable the premiums will become for all middle and lower income earners.⁵⁵

The better access more Australians have to private treatment, the better access all Australians (especially the most disadvantaged patients) will have to essential treatment in a public facility, and the more equitable and sustainable Australia's distinctive 'mixed' health system will be.

'Trilogy'

The policy recommendations outlined in this introduction are based on the findings of the 'trilogy' of essays collected in this publication, which were first published by The Centre for Independent Studies in 2009 as Policy Monographs in the *Health and Ageing* series.

In *Radical Surgery*, Wolfgang Kasper examines the massive systemic failures that plague public hospitals due to the wrongly conceived and untenable system of hospital management. Kasper argues that the underlying causes of the hospital crisis—the excessive, parasitic and superfluous bureaucratisation—can only be cured by removing the centralised bureaucratic control of hospitals and by creating opportunities for spontaneous, customer-oriented hospital care. The key challenge addressed is how taxpayer-subsidised access to hospital care for those in need can be combined with the provision of public hospital care with less bureaucracy and improved use of scarce resources. Kasper's solution is separate the provision of access to public hospital services from the decentralised production of public hospital services by independent and competing producers via a three-pronged suite of reforms:

1. Liberating public hospitals from the costly bureaucracy by abolishing the top-down, initiative-stifling, central plan health bureaucracies
2. Reinstating and strengthening local boards by giving them genuine budgetary and operational autonomy, subject to appropriate regulatory standards
3. Replacing direct budget allocations by obliging public hospitals to earn case-mix revenue for services rendered and to compete to treat patients who are free to choose their hospital where feasible.

John Graham's *An Insider's Perspective on Public Hospitals* draws on the author's 42 years of firsthand experience to tell us what working in public hospitals was like when they were not mismanaged by centralised bureaucracies. By telling the story of his 'medical home'—Sydney Hospital—Dr Graham illustrates the terrible consequences of obliterating the tried-and-tested administrative structure that had allowed self-governing hospitals to manage their own affairs in partnership with the clinicians and managers responsible for the day-to-day operation of hospitals. He details how the massive waste of taxpayers' money involved in the extraordinary growth in the size and cost of the stubborn, cumbersome and remote bureaucracy has

sapped the trust, morale, collegiality and institutional loyalty among hospital staff. He argues that putting boards back in charge of public hospitals would not only address the administrative chaos that severely restricts access to basic hospital services but also help restore public hospitals to what they once were: trusted, well-run institutions that are a vibrant part of civil society.

My own paper *Why Public Hospitals Are Overcrowded* traces the origins of the hospital crisis to the establishment of Medicare by the Hawke federal government in 1984 and debunks the myths that dominate the policy debate about public hospitals. It examines the ‘close a bed, open an office’ syndrome that has characterised the public hospital system over the last 25 years, which is a consequence of the massive expansion of the role of government in the health system. When the federal government promised ‘free’ treatment to all Australians, the state governments predictably responded by cutting costs and rationing care. Local boards were abolished and centralised bureaucracies established to force the closure of large numbers of hospital beds. I show that long queues for basic emergency and elective treatment in public hospitals are due to the 60% cut to public bed numbers since the mid-1980s, combined with the misallocation of vast amounts of health dollars to pay for the ever-expanding size and cost of the bureaucracy. The essay—and this book as a whole—calls on policymakers to set aside the flawed policy proposals that masquerade as solutions for the hospital crisis (including GP Super Clinics and higher government spending on preventive health) and instead implement the comprehensive market-based reforms—local boards, activity-based per-patient funding, and vouchers for elective surgery and spare beds—needed to close down the bureaucracies, open and staff more beds, and equip the hospital system to meet the health needs of a rapidly ageing Australia.



Endnotes

- ¹ Carmel Tebbutt, ‘Health fix needs a lot more than local boards,’ *The Sydney Morning Herald* (18 February 2010).
- ² Michael Moodie and Gavan Mooney, ‘Hospital management is too important to leave to medicos,’ *Croakey* (2 November 2009).
- ³ I am indebted to Ken Baxter, the former head of the Premier’s departments in NSW and Victoria, for drawing my attention to these issues.
- ⁴ Rural Doctors Association of Australia, *Emergency Medicine in Rural Australia* (Canberra: October 2007), 14.

- ⁵ And much of the extra money is consumed by wage increases in the public sector. Julie Novak, *A Growing Risk: The Impacts and Consequences of Rising State Government Employment*, Research Paper (Sydney: Institute of Public Affairs, October 2009).
- ⁶ John Graham, 'Turning back the tide of errors,' *The Australian* (4 October 2007).
- ⁷ Carmel Tebbutt, 'Health fix needs a lot more than local boards,' *The Sydney Morning Herald* (18 February 2010).
- ⁸ NSW Health, *Annual Report 2008/09* (Sydney: NSW Department of Health, 2009), 247.
- ⁹ These figures are derived by adding 'Corporate services,' 'Hospital support workers,' and 'Other professional and para-professionals.' See *NSW Health Annual Report 2008–09* (Sydney: NSW Department of Health, 2009), 246–247.
- ¹⁰ National Health and Hospital Reform Commission, *A Healthier Future for all Australians: Final Report, June 2009* (Canberra: Commonwealth of Australia, 2009) (*Final Report*), 52.
- ¹¹ As above.
- ¹² See Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling report), Final Report (27 November 2008).
- ¹³ Are 'not confined to NSW.' See David Pennington, 'Cure for an ailing system,' *The Australian* (24 October 2009).
- ¹⁴ Kevin Rudd, *Better Health, Better Hospitals: The National Health and Hospitals Network*, Speech to the National Press Club (3 March 2010).
- ¹⁵ NSW Opposition, *Management of the NSW Health System: Making It Work* (March 2009); Kevin Rudd, 'Moving Forward on Health Reform: Address to the World Congress of Medicine' (22 March 2010).
- ¹⁶ Integrated models of care have been pioneered overseas since the 1970s. Only recently have state health department begun to trial coordinated chronic disease programs, such as the NSW Health One, which hitherto have not been the core business of community health services.
- ¹⁷ As a frustrated hospital physician commented (in personal correspondence):
Creating them [Community Health Services] in the first place was pretty stupid because they simultaneously created Medibank (original Medicare) to fund fee for service private practice in the community—that is the parallel structure was created overnight with public hospitals as the third stream and then the potpourri of totally non patient based cash converters such as public health and other little empires like separate psych streams (outside Medicare, outside hospitals and outside Commonwealth health as well—can you believe it). Multiple streams and impossible to tell what's going on and virtually impossible to get them to take a patient—ever.
- ¹⁸ Tony Morris, 'The hospital cure: more spin doctors,' *The Australian* (8 March 2010).
- ¹⁹ To give these policy prescriptions their correct historical and political flavour, adherents are great admirers of the 'Cuban model.' See, for example, Gavin Mooney, *Some thoughts on 'A New Approach to Primary Care for Australia.'*
- ²⁰ For a fuller discussion of these issues, see Chapter 4.
- ²¹ See Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities* (August 2007); NHHRC, *Final Report*, as above (endnote 10).

- ²² The state's preferred solution recommends even more of the same. To overcome the fragmentation, the Victorian and NSW governments have proposed that all federal and state funding be pooled and distributed on a per population basis to state-run regional bureaucracies with complete authority over the mix of services provided for target populations. If Medicare funding for GP services was included in the pool, this would lead to the abolition of fee-for-service payments. In Britain, this structure has led to patients being required to enrol with a clinic to access subsidised GP services. Combined with the introduction of capitation-based funding, the ultimate effect would be reduced access to GP care. The state health bureaucracies would have even more funding to misspend on 'patient avoidance' schemes involving more 'jobs for the boys and girls' in community-based and public health roles.
- ²³ Jeremy Sammut, *The False Promise of GP Super Clinics Part 2: Coordinated Care*, Papers in Health and Ageing (4), CIS Policy Monograph No. 85 (Sydney: The Centre for Independent Studies, 2008).
- ²⁴ 'States will work together with the Commonwealth on system-wide primary health care policy and integration of service and planning delivery.' *Council of Australian Governments Meeting Communiqué* 19 (20 April 2010), 2–3.
- ²⁵ David Pennington, for example, has wrongly suggested enhanced primary care services would reduce demand for hospital care if only joint state-federal regional health authorities were created, area health services by another name. David Pennington, 'Health system is still ailing,' *The Australian* (30 April 2010).
- ²⁶ Kenneth Davidson, 'Rudd fluffed a chance at health reform,' *The Age* (26 April 2009); Michael Stutchbury, 'Odds are Rudd's funding model won't work,' *The Australian* (17 April 2010); Adam Cresswell, 'Trade-offs limit the utility of pact,' *The Australian* (12 April 2010); Ken Baxter, 'Avoiding the obvious on health,' *The Australian Financial Review* (24 March 2010); Alan Mitchell, 'A first step in reform,' *The Australian Financial Review* (24 March 2010); Jeff Richardson, 'Rudd needs to think again on health,' *The Australian Financial Review* (8 April 2010); John Dwyer, 'Health plan needs a few dollars more,' *The Australian Financial Review* (11 May 2008).
- ²⁷ See Premier Kristina Keneally, *Letter to Prime Minister Kevin Rudd* (5 March 2010) on the 'direct link between primary care and hospital admissions.'
- ²⁸ Like all well-entrenched vested interests holding strategic power in important parts of the economy, the state health bureaucracies are able to frustrate reform proposals not consistent with their interests. With the help of complicit state governments, the bureaucracies have been protected from the original and good intent of the Rudd Plan, which was to have hospitals funded nationally and run locally, with less state bureaucracy, and with funding delivered directly to hospitals in the form of activity-based payments.
- ²⁹ Wolfgang Kasper and Jeremy Sammut, 'Half a cheer for hospital reform,' *The Australian Financial Review* (9 March 2010).
- ³⁰ *Council of Australian Governments Meeting Communiqué*, as above, 3.
- ³¹ As Paul Keating recently pointed out. See Simon Benson, *Betrayal: The Underbelly of Australian Labor* (Sydney: Pantera Press, 2010), 283–284.
- ³² Nick McKenzie and Richard Baker, 'Hospital fraud claim goes to police,' *The Age* (16 March 2009); Stephen Rodgers-Wilson, 'A symptom of ill-health,' *The Age* (20 March 2009).

- ³³ See Jeremy Sammut, *Like the Curate's Egg: A Market-based Response and Alternative to the Bennett Report*, Papers in Health and Ageing (10), CIS Policy Monograph No. 104 (Sydney: The Centre for Independent Studies, 2009).
- ³⁴ As above, 19.
- ³⁵ Note that the Rudd government had taken up this idea and already announced the establishment of the 'Independent Hospital Pricing Authority' to set national case-mix prices, which is based on the similar proposal first set out in Jeremy Sammut, *Like the Curate's Egg*, as above, 20.
- ³⁶ As Ken Baxter has noted, federal fiscal arrangements are unlikely to change in the foreseeable future, and the federal government's financial dominance 'is clearly the simplest vehicle for the Commonwealth to use in securing changes by the States in the operation of the public hospital system.' Ken Baxter, *Structural Barriers to Reform of the Australian Health and Public Hospital System* (Melbourne: Australian Centre for Health Research, 2010), 36.
- ³⁷ Samantha Maiden, 'Kevin Rudd in alert on health spend,' *The Australian* (25 January 2010).
- ³⁸ This is based on the structure proposed in Nick Coatsworth, 'Australia's State of Health,' *Policy* 22:4 (Summer 2006), 24–28.
- ³⁹ Mike Steketee, 'Rising support to abolish the states,' *The Australian* (10 April 2010).
- ⁴⁰ In this respect, the failure of the recommendations of the Garling Commission to make a difference on the ground in the NSW public hospitals is instructive. An AMA survey of members found that three-quarters of doctors found the implementation of Garling's recommendations had not made public hospitals better places to work. Piers Akerman, 'Heart of the health debacle,' *The Daily Telegraph* (22 November 2009).
- ⁴¹ It is important to separate funding, operational and regulatory responsibility for hospitals across different governments to avoid the inherent conflicts of interests. When state governments are funder, operator and regulator, as is the case now, funding shortfalls and the resulting service problems are obscured by the bureaucracy 'blaming the victim' and imposing ever more onerous accountability measures on struggling hospitals and clinicians. For example, the use and abuse of assessment and quality procedures is the standard way the federal Department of Health and Ageing bullies providers in the chronically under-funded 'high care' nursing home sector. See Jeremy Sammut, 'Spin won't make the aged care sector sustainable,' *Online Opinion* (17 July 2008).
- ⁴² I am keenly aware that the proposed governance structure is not the 'pure' federalist solution. But it will achieve responsible federalism and is, in my opinion, the best achievable policy, given how unlikely it is that the states will agree to take back taxing powers and total responsibility for financing public hospital care. For further discussion see page 99–100.
- ⁴³ See David Hetherington, *Market Design in Health and Wellness and Education and Training* (Sydney and Melbourne: Per Capita, 2008).
- ⁴⁴ Josep Figueres, Ray Robinson, and Elke Jakubowski (eds), *Purchasing to Improve Health Systems Performance*, WHO European Observatory on Health Systems and Policy Series (Maidenhead: Open University Press, 2005).
- ⁴⁵ This is why the Howard government subsidised the private hospital sector through the PHI rebate plus 'Lifetime Cover' arrangements to get more bang for the taxpayers' bucks. Jeremy Sammut, 'Pragmatism not ideology drive PHI changes,' *Canberra Times* (19 May 2009).

- ⁴⁶ Jeremy Sammut, 'Hospital overhaul is our only hope,' *The Australian* (13 February 2010).
- ⁴⁷ Alternatively, more extensive reform of Medicare may be required, such as the de-nationalisation and re-mutualisation proposal canvassed by the National Health and Hospital Reform Commission under the title of 'Medicare Select.'
- ⁴⁸ In other words, the creation of local boards will not just be a means by which empire-building doctors will be able to feather their own nests, restore their lost power, and maximise their claims on the public purse, as is feared by some with previous experience of the workings of local hospital boards.
- ⁴⁹ To allay concerns about the impact on access to care, patients in rural areas forced to travel for major planned procedures will also receive extra vouchers covering travel expenses.
- ⁵⁰ This is the estimate of the experienced health economist and bureaucrat Stephen Duckett. Mark Metherall and Katherine Murphy, 'Top bureaucrat casts doubt on hospital overhaul,' *The Age* (5 March 2010).
- ⁵¹ Natasha Wallace, 'Cuts bleed Bellingen hospital: doctors,' *The Sydney Morning Herald* (23 February 2010).
- ⁵² Jeremy Sammut, 'Paying nurses to play doctor will make system sick,' *The Australian* (22 March 2010).
- ⁵³ The 'efficiency gap' in the public hospital system has been estimated at between 10% and 20%. There are approximately 600,000 elective admissions in public hospitals each year. As at June 2009, 160,000 people were waiting for surgery. A back-of-the-envelope calculation suggests that if productivity was optimal, around 40,000 people would still be waiting.
- ⁵⁴ The issue which will also need to be addressed to rebalance the health system is the excessive government spending on 'free' bulk-billed general practice services and the reallocation of these subsidises to fund for hospital care and chronic care vouchers. Jeremy Sammut, *Medi-Fraud*, forthcoming.
- ⁵⁵ Premiums would become even more affordable if governments reformed the closed-shop training arrangements which protect the specialist cartel. See Steven Schwartz, 'Medical Training: First Farce, Then Tragedy,' *Policy* 25:1 (Autumn 2009).

A 12-Point Plan to Fix Hospitals



A 12-Point Plan to Fix Hospitals

Funding—Public hospitals should be directly and transparently funded by the Commonwealth at the efficient national activity-based case-mix price, properly adjusted for simple and complex patients; funding must be tied to each service provided to patients so that each hospital's budget is principally determined by clinical throughput.

Administration—State 'area health' bureaucracies should be abolished; state health departments should be downsized; and full operational and budgetary control should be restored to pro bono local hospital boards.

Accountability—Politicians must enforce financial discipline, must not raid the Treasury to bail out mismanaged hospitals, and must require boards to make 'business decisions' about the services the hospital provides so income earned for services rendered covers budgeted costs.

Governance—The federal government should be the single funder of public hospitals; state governments should regulate hospitals according to nationally agreed hospital standards; and local hospital boards, in partnership with the local community, should provide hospital services.

Implementation—The national objectives of this plan should be set out in a National Public Hospital Funding and Administration Accord—a binding Council of Australian Governments (COAG) agreement supported by 'mirror' federal and state legislation. A National Health Reform Council answerable to COAG should be established to manage the reform process and enforce compliance with the national policy.

Competition—Vouchers should be issued by Medicare Australia for elective surgery to permit competition between public hospitals and foster higher productivity.

Beds—To prevent emergency overcrowding, hospitals with large emergency loads should receive additional 'bed vouchers' to cover the fixed costs of the spare beds (15% of total bed capacity) needed to manage demand for unplanned admission.

Rural Hospitals—As activity funding best suits larger urban hospitals, annual grants covering fixed costs should be made to smaller hospitals, but with the remaining funding provided on an activity basis. This will permit rural hospitals to thrive in partnership with the local community, while permitting transparent decisions to be made about closing hospitals based on the output achieved under the management of the local board.

Cost Sharing—Compulsory copayments for inpatient hospital services should be introduced to enhance the financial integrity of the system, promote responsible use of medical resources, and discourage over-admission and marginal elective procedures. Hospitals should also be free to set their own prices for offering additional services to those willing to pay for extras (such as a single room).

Debunk the myth of ‘free’ hospital care on-demand—The public should be informed through a *Your Health, Your Responsibility* national advertising campaign that non-price rationing of services by waiting based on relative need is an unavoidable feature of all government-run, taxpayer-funded health systems. While reforms might reduce elective waiting lists, waiting will never be eliminated because the health budget is limited and more needy patients at the front of the queue should be attended too first.

Highlight the immoral ‘hospital crisis’—The public should also be told that public hospitals are required to treat the sickest, most complex patients and 90% of emergency cases. Underlined should be how the political pressure to increase elective surgery has contributed to irrational rationing of care via long queues for unplanned admission in overcrowded emergency departments (aka the ‘hospital crisis’).

Strengthen Australia’s ‘Mixed’ Health System—Elective waiting times should be advertised to encourage private health fund membership and to praise the private sector for developing a highly efficient, procedurally-based private hospital system. What should be emphasised is that the more people take personal responsibility for their health care and pay for private insurance, the more affordable the premiums will be, and the better access all Australians will have to essential hospital treatment.

Radical Surgery: The Only Cure for Public Hospitals

Wolfgang Kasper



In a bureaucratic system, increases in expenditure will be matched by a fall in production. [This is the] *Theory of Bureaucratic Displacement* ... Savings can be achieved by the elimination of bureaucracy.

– **Dr Max Gammon** (*British physician who studied the British health system*) as quoted by the *Australian Doctors' Fund* (2008), www.adf.com.au/contents.php?subdir=library.

The public hospital system is acutely ill

Health expenditure in Australia now accounts for more than 9% of GDP, which is relatively high compared to other affluent countries. About 70% of all health expenditure is directly funded from taxes, paid either through direct payments to the health industry or subsidies to patients.

Over the past economically prosperous decade, public spending on Australian hospitals has gone up by 64%. It is funded largely by Commonwealth and state taxes. Compared with the population growth of less than 14% over the same period, this increase in hospital spending appears disproportionate, even if one allows for the progressive ageing of the population, massive advances in medical and pharmaceutical sciences, and consequent increases in the availability and cost of cures. Of course, it is legitimate and quite usual that we use a bigger share of our growing income and wealth to buy more and better health services—economists call this a ‘high income elasticity of health expenditure.’ Nevertheless, it is now an acute concern for policymakers worldwide to reconcile rapid rises in health spending with other priorities.¹ Hospital costs are blowing out, and may yet bankrupt the NSW budget despite a massive federal bailout under the COAG agreement. The situation requires dramatic and fundamental changes to hospital management—*not* additional layers of bureaucratic control or more federal subsidies.

Spending on hospitals of course only indicates the cost of inputs; it is not a measure of their output. Citizens and taxpayers appear to have received little quality improvement for the expenditure, and doctors and nurses who deliver hospital services appear acutely dissatisfied. The Australian Medical Association tells us that hospitals are not safe. The media inform us that hospitals are dangerously overcrowded. Preventable deaths in Australian hospitals are reported to exceed road fatalities. Pervasive cutbacks in public hospital bed numbers and frontline nursing staff have produced shortages of beds and overcrowded emergency departments. Elderly patients and birthing mothers have to be kept in parked ambulances, corridors and the storerooms of emergency departments because proper beds cannot be found for them. Emergency staff in Australian public hospitals spend 41% of their time caring for patients for whom no permanent hospital bed can be found. Psychiatry patients are being transported from hospital to hospital in the middle of the night because one

overcrowded hospital has to accept patients of unassessed acuity but has no spare bed. The situation often seems reminiscent of Third World conditions, not what one would expect of one the most affluent countries on Earth.

The hospital crisis seems to be particularly acute in NSW, although its population—and presumably the demand for hospital services—has grown markedly less than elsewhere, namely by below 10% between 1997 and 2007. The voluminous Garling report about the NSW hospital system spoke of ‘a system on the brink of collapse,’ in which systemic failures are endemic, excessive paperwork stresses doctors and nurses, and patients are suffering unnecessarily. The same problems afflict public hospitals in all states and territories. The Garling report highlighted poor infection control and a high rate of errors in prescribing medications. Over and above a long litany of clinical-technical failures in the public hospital system, the Garling report castigated a poor ‘culture’ in public hospitals and speaks of endemic bullying, fraud and neglect.² Peter Garling SC also predicted that the impending retirement of ageing nurses and doctors will worsen the situation. The public hospital system, which has been ‘free and accessible,’ might not survive the present crisis.³

The Garling report was correct and to the point in diagnosing the failures of NSW public hospitals. But the report failed to outline cures that can tackle the underlying causes of the health care crisis. Instead, it exhausts itself in numerous recommendations that amount to no more than marginal tinkering with a wrongly conceived and untenable system.

NSW public hospitals are managed by the Department of Health and its eight Area Health Services (AHS). Funding is allocated essentially on population criteria. Both the department and the AHS have become a rapidly growing, centrally directed bureaucracy that has replaced the traditional system, which ran with input from local and district hospital boards. The new bureaucracy has closed a large number of hospital beds, hospital wards, and even entire hospitals. For example, no fewer than 34 maternity units in country NSW have been shut down over the past 13 years.⁴ The tendency has been towards ‘big is beautiful,’ irrespective of what the clients may want. The trend has been to cut costs by reducing facilities and services rather than searching for improvements in productivity. This is of course typical of most central bureaucracies: Fewer and more uniform facilities are easier to plan and control, while the pursuit of customer service is seen as an inconvenient nuisance.

The closure of rural hospitals throughout NSW, indeed throughout Australia, has contributed to creating the much-lamented rural doctor shortage. If one classifies those medical practitioners who are qualified to conduct procedures such as anaesthetics, obstetrics or surgery (which, in the city, are typically performed by specialists) according to their location, and adds up full-time doctor equivalents for rural towns and remote locations (categories RAMA 5, 6 and 7), one finds that the density of practitioners in rural and remote areas has indeed been declining considerably in recent years—and this is despite targeted financial subsidies for rural proceduralists.⁵

Experts have identified the closure of small non-metropolitan hospitals as a major cause for this problematic decline. This is not surprising because the typical private non-metropolitan medical practitioner earns about one-third of his income from services rendered in hospitals as a visiting medical officer (VMO). The worsening 'rural doctor shortage' therefore is another unintended and deleterious consequence of bureaucratically driven centralisation.

Another factor that contributes to the thinning out of rural doctors, in particular obstetricians, has been the steep rise in indemnity insurance (costing an estimated \$30,000 or more per annum). The explosion in insurance costs was the consequence of aggressive litigation and court decisions, which attributed long-term health problems to actions by obstetricians at birth, in one case even 21 years later! The NSW government now covers insurance costs for obstetricians in public hospitals. However, the services of the state-contracted insurer fall far short of the quality of insurance that private insurers normally offer doctors, causing many to abandon obstetrics. Likewise, litigation and insurance costs have forced many midwives to abandon their chosen profession.

Of hotels and hospitals

An innocent observer is entitled to ask why we observe such acute scarcity, high cost, spin doctoring, fraud, and disregard for customers in the public hospital system. Why, for example, do the media never discuss shortages, public protests, and lying in the industry that supplies us with hotel beds or, for that matter, other services? What is so particular in the case of hospitals and health care?

There are several obvious differences:

- One is of course that health care products are often not as clearly defined before the purchase as in the case of hotel accommodation. Moreover, clients tend to know more about hotels than hospitals, as most of us book into hotels more often than into hospitals. The average customer is better informed about the quality of hotel services and can judge it better than the qualities that matter in the performance of hospitals. Moreover, not all dimensions of hospital treatment can be known before one enters a hospital, even for non-emergency treatment. Economists and marketing experts differentiate between 'experience goods' and 'search goods.' The latter are goods and services whose (variable) quality can be readily established by buyers at low information costs (for example, fruit in a market stall). In contrast, experience goods can only be assessed by consuming the product (for example, assessing the quality of what is in a tin of fruit by eating the contents or undergoing a prostate operation). For experience goods, suppliers typically develop brand names, cultivate a good reputation, and rely on similar devices to inspire trust; moreover, independent middlemen and information providers, possibly including government agencies, assist intending buyers in making

appropriate choices. In view of this, it is surprising that hospitals do not publish hard information, such as case-specific mortality rates and other data to demonstrate what share of promised outcomes they actually achieve. Indeed, such statistics, which are reputedly available internally, cannot be obtained by the public in NSW. The argument that members of the public would not be able to interpret such data properly seems vacuous. It is amazing how well patients and their kin are nowadays learning complicated medical details from the internet and from their chief advisors on such matters—their personal doctors.

- Another difference between hotels and hospitals is that the cost of hotel accommodation is much lower relative to one's income than the cost of most hospital services, so that the financial stability of individuals is less imperilled by recourse to the former than the latter. Ordinary Australians—and even medical practitioners—tend to have little idea of the total cost of standard operations, because the costs are disguised by government subsidies. For example, a standard hip operation in a private hospital is likely to cost the patient, the insurer, and the taxpayer together around \$30,000 as of 2009, and a standard prostate operation between \$35,000 and \$40,000. By contrast, hotels widely advertise their room rates, offer discounts, and reveal all supplementary charges.
- Patients normally turn to hospitals at times of great personal need and anxiety. This translates into what economists call 'price-inelastic demand.' People generally react to price differentials when booking hotels rather than staying at home. When you need hospital treatment because you are diagnosed with cancer, you and your loved ones are likely to buy the treatment, which your medical advisors tell you to buy, whatever the cost. Unscrupulous suppliers might exploit this inelasticity of demand to overcharge, demanding payment way above the cost of the service.
- A much greater share of the cost of accommodation in a hotel is paid by the clients than they would in hospitals. We know that people spend money most prudently when it is their own, and that money is spent most unwisely when third-party agents are making decisions on behalf of people they do not even know. In this context, it is worth noting that hospital costs are not only determined by governments, who may have all sorts of extraneous objectives, but are also in part borne by insurance companies, who may have objectives that differ from those of the patients. In short, hotels tend to be much more consumer directed than hospitals.
- Partly for the above reasons, the health and hospital industry is much more densely regulated than the hotel industry. Alas, we know that regulators easily become 'rent-seekers,' acting to gain material advantage and power from their role, even if it is at the expense of the professed ultimate objectives of

the industry—the care and healing of patients in the most cost-effective ways. It is easy to lose sight of rational cost/risk-benefit analysis, which is normal in most other service industries. Instead, direct controls and compliance costs multiply.

- The majority of hospital admissions are emergency cases—some 60% of all admissions in public hospitals in Australia. In these instances, patients and their kin are, of course, not in a position to evaluate the costs and benefits of alternatives before deciding whether to buy or not buy a particular service.

For these reasons, many argue that medical services are special and must not be treated like ordinary commercial services. Every industry is of course special. Yet, applying time-tested principles of economics to all industries allows for rational analysis, i.e. proper decisions about how much to invest in a particular service, how to raise productivity and improve the service, and how much of a service to supply. The escalation of hospital and health costs makes such a rational approach urgent, lest Commonwealth and state budgets collapse under the weight of relentlessly growing health expenditures—and the public hospital system collapses altogether. Special pleading, therefore, must be rejected and a case has to be made for why general, time-tested methods of management of service provision should not be applied to the hospital industry.

The decisive difference between hotel and hospital services in this country is that the majority of Australians do not consider personal health primarily a matter of private concern, but somehow think that illness should be a concern of ‘public health,’ never mind that the consequences of ill health—pain, incapacity and death—are irrefutably personal and private. Long gone are the days when ‘public health’ was confined to cases that had serious external effects, such as contagious diseases and vaccination, i.e. cases where private action or inaction led to existential consequences for others or even the entire population. Now, many aspects of personal health are considered by Australians as an obligation of public welfare, for which they are not really responsible! Persons, who have to cope with the flu, a cancer or a new baby, expect that ‘the authorities’ will have primary responsibility for the costs of these eventualities. This would have struck our forebears as very odd indeed, if not even outright dishonourable.

However, since Australians seem to have taken a political decision to make health a matter of public rather than private choice, the hospital crisis should force us to think hard about how political and administrative arrangements can be reshaped to perform better in the citizens’ best interest. After all, one of the widely endorsed objectives of public policy in this country is equity. Many would consider this an aspect of a civilised, affluent and cohesive society, of which we can be as proud as we are of our rule of law and our record of decent democracy. I accept for the present discussion that most Australians do not want their average fellow citizens to be massively out of pocket for the cost of births, surgery and hospital stays although, in practice, many of us still

reveal our real preferences by opting for personal insurance for at least some hospital and medical outlays. This belief that hospital costs should not be borne by affected individuals underpins the political decision that the bulk of hospital costs should be borne by the community through taxes and subsidies. If we take this public choice as a given in our affluent and egalitarian society, it follows that every NSW citizen should have access to necessary hospital services irrespective of his or her financial condition.

The insistence that hospital and health care costs should be socialised at least in part does not, however, mean that the costs and the production methods should be immune from economic and commercial analysis. Nor does it mean that production should be run by bureaucratic coordination, top-down directives, and in government-owned facilities. It is the decision to rely on socialised, centrally directed production that has brought about perverse, costly and unjust results: Hospital care is now plagued by cost escalation, pervasive dysfunction, infighting, disgruntlement, waiting lists, and poor-quality service. Normal checks and balances of decentralised competitive decision-making are suspended in public hospitals. The industry could therefore be captured by the insiders, most notably the bureaucrats, who form an 'iron triangle' with politicians and particular interest groups, such as public sector trade unions. 'Capture' means that those with insider knowledge and control over day-to-day management decisions serve their own purposes to the detriment of the clients. Initially, the agents just are after improving their own work conditions and emoluments, but over the long term, they dominate everything and hinder improvements in productivity and customer orientation. Powerful insider groups will also engage in political games to ensure that the elected representatives of the people do their bidding rather than promote the public interest. Campaign funding and support in election campaigns, combined with complacency in political parties, tend to entrench the power of the agents. The most frequently used (and accepted) argument to justify steps that pave the way for the capture of an industry is safety and security. When a risk is cited (even a remote one), people are intimidated into accepting regulations, even if their real purpose is the featherbedding of regulators and administrators. 'Safety first' can easily prejudice all other social objectives and can well be exploited with the end result that entire industries become dysfunctional. There is a paradox here: what is deemed important is organised in ways that create shortages and dysfunction, while what is deemed unimportant is allowed to be organised in effective, customer-oriented ways. Do the sick really deserve no better?

One cannot but conclude that the manifold scandalous failures in NSW hospitals are a systemic consequence of them being run as a government department, under political direction, and micro-managed by self-seeking bureaucrats—and not as an open system with decentralised, accountable and responsible management.

Administrative agents, who work in secure public sector jobs, thus tend to fall prey to 'agent opportunism' or 'moral hazard.' They exploit their insider knowledge to enhance their own benefits, including indexed pensions for retirement, work comfort, and

on-the-job consumption, for example, meetings in comfortable surroundings, seminars, and business travel with good per diems. Why shouldn't public hospitals cut their workloads by reducing available beds as long as they are able to obtain revenue through political lobbying for direct funds from the centre? Why shouldn't they reduce their workload by providing less patient care? 'Work avoidance' is invariably an integral part of any centralised, top-down system of production. This was acknowledged in the Soviet economy and—unsurprisingly—is notorious in the NSW hospital system.

In addition, public enterprises, which do not have to earn their income by selling goods or services, are easily unionised to make life for the 'insiders' easier and more secure. For the modest payment of union dues, insiders can expect more job security, less onerous conditions of work, overstaffing, and more generous pay. During bargaining, their bosses tend to give in easily, for they are only handing out funds that are extracted from the citizens by coercive taxes. Why not shirk confrontations and strikes when the same asymmetric risk-benefit incentives apply that make them shirk innovations?

Anyone who doubts that the problems stem primarily from central direction and bureaucratisation should look at the woeful performance of other government-run services in other areas of public sector service delivery (public transport, public education, child protection, or water supply) or, for that matter, how the socialist regimes of the Soviet Union and Eastern Europe neglected to supply people with consumer goods and services. Except for a small, well-connected *privilegentsia*, the quality of services was invariably poor and unreliable, ranging from sullen to indifferent. The quality of public services is rarely improved and, indeed, often downgraded as the burden of a growing bureaucracy increases. In centrally administered systems, there is typically insufficient reinvestment, leading to shortages, which require rationing, queuing and long waiting lists.

A related aspect of a public service delivery system, which has been captured by the agents, is that no one owns up to ultimate responsibility: ministers hide behind bureaucrats, bureaucrats hide behind political directives, and full-time spin doctors obfuscate matters to appease an angry public. In Australia, blame shifting is also common between the states and the Commonwealth. The costs of bureaucratic complications, and the creation of more committees and layers of administration to oversight and correct these, gradually crowd out service delivery. Fiscal constraints are then cited to justify cutbacks in services and closure of frontline delivery operations. The growing bureaucratisation of the public hospital system and fiscal constraints have led to the progressive closure of facilities, a concentration of specific services in some designated hospitals, and the much-lamented overall bed shortage.

From the point of view of the citizen and taxpayer, the administered bed shortage is of course nothing more than a 'work avoidance scheme'—people get less for their money, and even when they do, the services are often in inconvenient locations. The traditional notion that communities had ownership of 'their' hospital is lost, and the citizens get angry about 'them'—an anonymous group of bureaucrats and

politicians. As a result, respect for the rule of law and trust in democratic government decline. In the long run, growing reliance on government services has invariably been, and continues to be, the source of high costs and economic stagnation because people feel disenfranchised and withdraw their loyalty to the wider community.

Capture of an industry by central planners, regulators and supervisors has been quite common in human history. All too often, the principals of an undertaking (in this case, the people) lose control to the agents (here, the hospital bureaucracy). We also know that agent-driven systems tend to switch from service delivery to infighting and self-serving. Moreover, top-down administrative systems typically favour selection mechanisms, under which the worst can elbow their way to the top—to paraphrase Friedrich Hayek's classical insight into this problem.⁶

This general observation does not, of course, prove that alternatives run without cost and mishaps. But, in the final analysis, we are well advised to apply the biblical wisdom: 'Thou shalt recognise a policy by its fruit!' and rethink the fundamentals of the public hospital industry and judge alternatives by what outcomes they produce for the citizens and taxpayers, and not by how well political or bureaucratic interests are served.

Since growing bureaucratisation and capture by insiders is the core of the problem with NSW hospitals, there is no way around asking these key questions: How can (tax-subsidised) hospital services be provided without a costly central bureaucracy? How can doctors, nurses and other frontline service providers be motivated, coordinated and directed to make client interests their priority? How can the social mechanisms that bring about the satisfactory production of hotel services be emulated, as far as possible, to improve the NSW hospital system?

Central bureaucratic control versus self-responsible competition for revenues

A first logical step to finding answers is to acknowledge what economists have long established: Access to goods and services, or their *provision* to everyone by government—i.e. tax funding of equitable access—does not mean that the *production* of these services needs to be done by government agencies and methods of top-down bureaucratic command and control.

Economists who have studied systems management can point to differing incentives that are at work in independent, competitive systems and under collective, centrally-planned production. Above all, decentralised producers have to compete for their revenues. They respond to market signals—expanding what is in high demand and, hence, profitable, and ditching loss makers where demand is insufficient to justify the costs. The signal of profits and red ink also impels producers to search for innovations, which cut costs and introduce new products (process and product

innovations). Major waves of innovation have reshaped entire economies and propelled material living standards to previously unimaginable levels. We had the agricultural revolution, the introduction of the steam engine, combustion and electric engines, successive transport revolutions, and the current computer and telecom revolution. We are also experiencing a veritable revolution in the possibilities of health care, which competing entrepreneurs will exploit, 'as if directed by an invisible hand.' In most historic cases, innovations have driven economic growth forward and reduced the costs—food, transport and communication have all become cheaper. Yet, the medical revolution has failed to lower unit-costs. This uncharacteristic failure to realise productivity gains and translate them into cost reductions can only be attributed to the fact that the medical and pharmaceutical revolution has largely been taken from the hands of competing enterprises and has been controlled or directly operated by government-run monopolies, which are largely shielded from the usual competitive disciplines. In Australia, nearly three-quarters of per-capita health expenditures are funded by taxpayers (the share has been rising) and controlled by government. A large proportion of production is run under bureaucratic control.

One revealing study about the differences between decentralised management of competing hospitals and central planning was published in New Zealand in 2005. NZ Treasury reported that the productivity in hospitals run by decentralised, autonomous boards. These boards decided how best to use government-supplied budgets, which had increased by 1.1% from 1998 to 2001. However, between 2000–01 and 2003–04, when central planners and administrators replaced this system of governance, hospital productivity dropped by 7.7%.⁷ The critical factor in the drop in value-for-tax-dollars was that many more administrators and controllers were employed under the centralised system introduced by the NZ Labour government. It was reported that the centralised administration increased the amount of paperwork, detracting nurses and doctors from their main job of caring for patients. The NZ report offers numerous valuable insights to Australians interested in learning the basic lessons of central *versus* decentralised governance and who are prepared to go beyond marginal administrative tinkering.

Going back to the earlier analogy, hotels that fail to adjust to what clients want or overcharge them are driven out of business. By contrast, the public hospital that botches operations, has poor hygiene standards, or falsifies performance data will at worst have to face a public inquiry. Such an inquiry may come up with recommendations, which will be routinely welcomed by government and opposition. Politicians may even throw more taxpayers' money at the problem, and the bureaucracy will create new committees and authorities—which mean better job and career opportunities for the bureaucrats. Pious political promises are rarely followed by real, durable improvements. It is a fact that (a) competing producers tend to solve problems, whereas administrators transform one problem into another; and (b) competitors respond by remedial action, whereas monopoly bureaucrats respond by spin.

Whereas competitors are guided by profits and losses, bureaucratic planners, who observe losses but have to do the politicians' bidding, tend to throw good taxpayers' money after bad—at least until the next election. Nor do they necessarily expand output where demand is high, and contract the supply of services where losses are incurred. They do not even know where profits and losses are because they do not operate with market prices. That is why we get, for example, queues for elective surgery and closures of hospital wards where the demand is high and urgent.

When hospitals act like private business enterprises under competitive pressure, one key advantage is that their managers have to search for cost-cutting process innovations and think about improving their products. Within a mere hundred years, such competition has driven the development of Mr Benz's rickety contraption to the sleek, petrol-efficient limousine of today, and the Wright Brothers' hedge hopper to the Dreamliner. Entrepreneurs risk innovations because they are confronted with a symmetric calculus of an expected profit against the assessed risk of a commercial flop or a cost overrun. By contrast, the bureaucrat in charge of, say, authorising a new procedure or apparatus in public hospitals is, in the first instance, faced with the prospect of inconvenient administrative hassles till the innovation works properly. He will also fear the risk that the innovation will fail altogether, in which case he will be reprimanded or even demoted. If successful, the administrator may be given a gong at some future date or a promotion, which he can earn more easily by risk-averse subservience. In other words, in public sector production there is no *quid pro quo* for taking innovation risks and cutting costs.

All too often, the production of a service under direct political control is distorted by extraneous political objectives. While hotels and businesses such as private medical practices are located close to the customer base, decisions to locate public services are often loaded down with confusing and contradictory objectives: considerations of patient care often matter less to where a hospital is located or when a ward is closed than promoting regional development in backward areas; enhancing someone's re-election chances in a marginal electorate; creating bigger hospital units that can be more easily directed from the centre and more easily unionised; or promoting the pecuniary interests of elected officials, who may own real estate near future hospitals.⁸ Service provision in country NSW is often influenced by central regional planning to promote politically picked district centres rather than where the people want to live and where they demand services. Hospitals should follow the patients, not the other way round!

It cannot be overlooked that power brokers in the political and administrative system see the involvement of private doctors in public hospitals as an affront to their collectivist-socialist ideology. Yet, doctors with private practices, who contract with the Department of Health to do service as visiting medical officers (VMOs) in public hospitals, are the backbone of country hospitals. They have often acquired a broad range of specialised medical expertise and keep upgrading their specialist knowledge

and skills. They do so to supplement their incomes from private practice, to enhance the challenge of their work, and to serve their patients. The managers of the public hospital system should foster and cultivate their VMOs because they are the most important part of the production function. Instead, administrators all too often persist with morale-destroying command-and-control methods, and often complicate the doctors' and nurses' work by imposing and changing contradictory and frustrating administrative directives. This is not surprising. Top-down command systems are typically poor at managing and fostering diversity; treat independently-minded experts with neglect or contempt; and give preference to uniformity and unquestioning compliance. Moreover, command systems tend to focus on the hardware (physical capital), which is more easily planned and managed than individuals with human capital. But it is the doctors and nurses who heal patients—not buildings and equipment!⁹

These insights are uncontroversial in the economic literature.¹⁰ The criticism is not a manifestation of an ideology, as members of the 'iron triangle' of bureaucrats, politicians and interest groups are quick to allege. It is the result of broad-based empirical evidence. Politicians and planners overestimate their capacity to marshal all necessary knowledge about the workings of a complex system and misjudge the effects of adverse incentives, which result from centralisation. The key message of this essay can be described by the words that philosopher-economist Friedrich Hayek used in his Nobel Prize lecture: The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design.¹¹ This essay is a plea for reliance on appropriate incentives to develop and use all relevant knowledge, and to facilitate the spontaneous coordination needed to produce the hospital services that the public want.

Efficient production and equitable access require a three-pronged approach

How do we resolve the evident conflict between ensuring an equitable access to hospital services and the efficient production of these services? The systemic failings that we have noted cannot be remedied by adding more supervisors, reorganising, and marginal tinkering to address the symptoms. As noted, the Garling report got the diagnosis and the prognosis right, but fell far short in proposing the right therapy. Inquiries and piecemeal reform proposals have been a dime a dozen, but these have fallen short of addressing the root cause of the failures.

A new entrepreneurial approach is required. A first step is to recognise that radical change can no longer be avoided or postponed. A second step is to *separate* the *egalitarian provision* of access to hospital care, as far as possible, from efficient and *competitive, quasi-private production* of hospital services. If the NSW government wants lasting improvements in hospitals, it can learn from emulating essential features of the hotel industry—without abandoning the political aim of open, egalitarian access. To this end, three major, inter-dependent changes need to be implemented:

- (a) *Hospital revenue only for service:* Non-emergency patients can decide where they wish to be treated and to pay hospitals with ‘hospital vouchers,’ which they obtain by presenting their hospital invoice to Medicare. Such a voucher scheme will protect Australians from at least the financial consequences of medical calamities. Patients may decide to augment what they pay hospitals from their own savings or their private insurance in the form of ‘\$ vouchers’ (aka cash), for example, when they opt for a more expensive, better-quality hospital or request additional procedures. Hospital admission requires that doctors and specialists assess what specific hospital procedures a specific patient requires. As is the case now, they will have to function as ‘gatekeepers.’ To that extent, the present system of referrals by general practitioners and specialists should stay in place.

Approximately 60% of hospital admissions are emergency cases, which means that public hospitals must also be able to earn government vouchers of a different type: Each year, they should be able to bid for ‘bed vouchers’; in return, they would maintain an appropriate number of hospital beds and corresponding staff. These two types of vouchers will constitute the revenue of hospitals. Such vouchers for service expose hospital managements to demand signals and ensure that they earn revenue only for services they provide.

- (b) *Hospital autonomy:* Hospitals need to be governed by individual, independent and self-responsible boards. They must calculate their costs and charge rates, and should have to get these periodically approved by independent assessors acting for the Department of Health. Hospitals will invoice patients for the various procedures either at Department-approved charge rates or at their own higher prices, which they then must advertise and quote to intending patients, as far as is feasible.¹² Hospital boards are autonomous and have the right to discontinue loss-making services or may charge more than the centrally approved prices.
- (c) *Saving administration and compliance costs:* The area health services and a large segment of the central administration in the Department of Health, which directs them, become superfluous and are abolished.

This system will simulate important aspects of what any producer faces in normal markets: The demand for products in such a system is expressed by tax-funded vouchers and possible private co-payments, and the supply is offered in response to these signals by autonomous, self-responsible producers—in this case, the hospital business.

Demand to drive supply

If given wider choices through vouchers, many patients will feel the need to inform themselves better. Some may well perceive this as a burden. However, it is wrong to assume that ordinary Australians are imbeciles incapable of choosing a hospital.

Most people are able to make informed choices when buying computers and cars; they study complicated instructions about complicated uses of cosmetics or complex electronic gadgets—if necessary, they will seek advice when in need of hospital treatment. The first source of specialist advice will be the general practitioners. Patients will soon react to the greater patient choice available to them and inform themselves accordingly. Doctors may have to become more cost-conscious and better informed about hospital costs to serve their clients in the new system—which is an improvement in itself. Those who argue that price quotes in advance of hospital treatment, such as surgery, are not feasible—given the unpredictability of mishaps during operations—should ask themselves why cosmetic surgery is price-quoted as a matter of course. Greater choice and transparent pricing help intending patients make economically rational decisions. Besides, many commercial contracts deal with hard-to-assess risks. For example, a contract with a builder may come with a detailed price quote but may have a clause that in-ground excavation work cannot be priced *ex ante*, so that cost over-runs will be at the client's risk. Similar contractual arrangements may develop in the hospital business.

In addition, specialist medical advisors will before long offer their services, just like financial and legal advisors. Moreover, hospitals have an incentive to publish relevant information, making the entire health system more transparent. It is of course likely that many patients will choose the nearest hospital for convenience, as is the case now. But what matters in shaping producer behaviour are those who make informed choices and move to reputable producers, shunning hospitals and doctors of dubious reputation. Economists know that the decisive impetus for improvement comes from what happens at the margin. Greater patient mobility, combined with the need to earn voucher income, is exactly what will drive improvements in the public hospital system.

When patients and their GP advisors become more aware of hospital cost, the now prevalent pernicious and socially corrosive 'claims mentality' will be contained. In this context, a major American study on behaviour in using health services is worth noting: A large number of families were randomly assigned to various co-insurance and deductible health cost plans. Those who received 100% tax-financed reimbursement for all health expenditures proposed to use 67% more health care services than those who had to foot virtually their entire bills.¹³

Some citizens may well be apprehensive about a voucher scheme because they fear that it offers less assurance of a reliable, dependable service than present-day government hospitals. The changes, therefore, need to be well explained in advance of any reform, and much will depend on the smooth and reliable implementation immediately after the reform. Citizens will then soon discover that they have wider choices and, most importantly, will see themselves as buyers of hospital services, not supplicants in a queue! For a wealthy, educated population like Australia's, this is a more worthy way of providing public access to hospitals. Such a fundamental change could therefore become extremely attractive to the electorate and would signal

that the sponsoring political party is prepared to think creatively. Familiarity with this method of paying for hospital care will anchor the reformed system in the public mind, making it much less likely that particular interests can get the next government to turn back the clock and re-centralise hospital management on behalf of their rent-seeking cronies.

The use of tax-funded vouchers to empower buyers of public-domain services is not new. It has been tried successfully in many countries to provide public services, such as giving people access to basic education, food and clean water. The voucher concept was first discussed at length in Australia in the wake of a study I helped put together called *Australia at the Crossroads*. It in turn gave rise to the *Crossroads Group*, which did much to promote the economic reforms of the 1980s and 1990s, paving the way for Australia's prosperity and self-confidence over the past two decades.¹⁴

It does not necessarily matter in a voucher-funded system whether the hospitals are owned and run by private firms, by clubs (e.g. as charter hospitals), or by public bodies such as local or state governments. Nor does it matter whether they are run for profit or as non-profit organisations, or whether they are big or small. As has been the case in the Australian school system, demand has been drifting steadily away from public sector providers in the direction of private suppliers: private hospitals now carry out 60% of all surgery (which earns them some \$7 billion every year) and are able to provide virtually all types of treatment (658 of the 662 listed procedures). Forty percent of 'hospital separations' now occur in private hospitals; private hospitals seem to be able to provide beds at an 80% occupancy rate and, in most cases, offer prompt admission when patients turn up. This contrasts with the long queues at the doors of public hospitals. When the Howard government injected massive new Commonwealth funding into the hospital system, the private hospital industry was able to grow once the vicious cost circle for the privately insured was broken. The reason for the growth of private hospitals is that individually insured patients are choosing more and more to be treated in private hospitals, albeit by drawing heavily on government subsidies for their treatment, and doctors increasingly choose to work there because of better, more patient-oriented work conditions.¹⁵ As in education, many Australians prefer the private to public choice.

The reforms proposed in this essay could well pave the way towards more individuals funding their own health care and less dependency on government. In a society whose average real per-capita incomes have risen 40% over the past two decades, it is advisable to foment greater individual engagement and less reliance on social welfare—whatever the perceived social preferences of the Australian population may be at the moment. A gradual shift in the direction of self-responsibility and reliance on private provision would, in any event, seem preferable to a traumatic collapse of the public hospital system. Moves in this direction have been discussed for more than a decade by leading economists, including Nobel Prize winner Milton Friedman.¹⁶

Although it appears that independent local hospital boards would be generally welcomed, the wider public will probably need more convincing to subscribe to the notion of vouchers. In reality, administrative devices that resemble vouchers are already in place in Australia. In 1998, the Australian Refined Diagnosis Related Group (AR-DRG) scheme was introduced. It was based on payment for a case mix of 668 types of acute-care episodes. Victoria introduced a similar method of hospital funding in 1993–94, followed by South Australia. Although the implementation of case-mix based voucher payment led to significant cuts in hospital budgets, it was responsible for significant gains in hospital productivity. This is not surprising: after all, anyone who gets funded according to output will try to enhance productivity. Nor is it surprising that public sector unions intensely disliked the reform. It is also worth noting that a quasi-voucher system of the case mix kind has been tried in Queensland and Western Australia but abandoned and then reintroduced. NSW has always opposed this rational funding approach.¹⁷

Decentralising the management of hospital facilities without anchoring the reform in at least partially patient-driven demand seems akin to one hand clapping: Simply introducing local hospital boards would not be a very effective signal that basic attitudes must change. Individual hospital boards could be easily dismissed again when political and bureaucratic rent-seeking reasserts itself, as is bound to happen. Only an institutional anchoring of the understanding that the ‘buyer is king,’ and that demand steers the evolution of hospital facilities, will overcome the prevailing, entrenched central-plan mentality, which is the root cause of the crisis. Just as the combination of self-responsibility and profit motivation of producers through consumer sovereignty and the market economy was necessary to break the woefully under-performing Soviet economic attitudes, so will the public hospital system require a two-pronged attack—embracing supply and demand.

Management by autonomous hospital boards

Almost all management and governance decisions in hospitals under a reformed system can be made by independent hospital boards. These should be composed of a mix of medical and nursing professionals with local knowledge and citizens with commercial and financial expertise. The tenure of a board member should be six years, with half of the members stepping down after the first three years in the first instance, so that, in the long run, there is an overlap of tenure, continuity and maintenance of ‘institutional memory.’ The boards, assisted by an executive hospital director and a chief nurse, will have to be cost-conscious and maximise the value of the vouchers they earn. They will not have to apply and lobby for direct government grants (a huge cost saving) because their revenues are derived from what they are paid for treating clients. Nor will they have to engage in bureaucratic infighting with Health Department officials because they no longer have ultimate decision-making powers over what happens at specific hospitals. This promises to attract people with an entrepreneurial frame of mind.

Hospital boards will be able to decide what bed and other capacities to maintain. They will also be able to decide where to buy needed inputs; whether to employ visiting medical officers from among the local private practitioners or hire salaried doctors; whether to fill gaps in coverage with locums; and whether to subcontract cleaning and meal services or organise these in-house. Hospitals may also decide to:

- rent out unused facilities to private doctors; for example, unused operating-theatre capacity could be sold to private surgeons who pay for the use of the facility¹⁸
- buy or lease equipment as they see fit
- charge ‘congestion prices’ if certain services exceed what they and their staff can handle at certain times, which would divert some elective demand to other hospitals or into other time slots, and
- offer new, or close down existing, specialities—structural changes, which may in specific circumstances have to be negotiated with the Health Department to ensure compliance with the hospitals’ minimum service charter.

Ultimately, hospital boards’ decisions will be determined by whether their costs can be covered by vouchers and other revenues. In many locations, hospital boards will discover that ‘small is beautiful’ and why mega hospitals are so difficult and costly to administer. Hospital boards should, of course, be made accountable through an obligation to publish annual reports; they might report more frequently to local councils and chambers of commerce.

Last but not least, hospital boards will need to calculate their prices and costs with a view to their long-term viability. According to experts in the United States (where fundamental economic conditions do not vary all that much from those in Australia), a hospital will need to calculate around 3% of all revenue as an operating margin, plus 6–7% of revenue to meet overhead expenses, such as depreciation of capital, replacement of plant and equipment, and maintenance of facilities.¹⁹

Some experts and state bureaucrats have argued that customers want hospitals everywhere, but that many smaller, remote-area hospitals are unsafe and economically unsustainable.²⁰ This is a bone of political contention in non-metropolitan areas, precisely because decisions on hospital location and hospital closures are made by the Health Department or area health bureaucrats. By contrast, decisions to open or close hotels, because they are decentralised market decisions, rarely attract any public ire or political noise. Fears that the proposed reform package would hollow out the rural hospital system do not seem justified. Why, for that matter, does one not expect hotels to disappear from country areas? Non-metropolitan producers face lower costs for many inputs, for example, land rentals. Independent boards will search for and find low-cost inputs.

In any event, independent hospital boards will try hard to find novel ways to attract the necessary VMOs or visiting specialists to regions of genuine demand or to

overcome shortfalls in coverage by contracting regularly visiting specialists who offer ‘fly-in/fly-out’ services. Another argument for local communities reclaiming a degree of local ownership in ‘their’ hospital is that hospitals attract business to local towns and are good for real estate values. There is nothing wrong with rural communities enhancing the quality of life by exploiting synergies and making their local hospital a central part of the effort. Admittedly, remote-area hospitals may offer only limited services, but such a first point of call in an emergency—a nearby place where children are born and the elderly receive medical care—is often perceived as an essential part of what non-metropolitan citizens expect as a matter of course from an Australia that professes egalitarian ideals. All too often, implicit technocratic ‘big is beautiful’ argument colours the debate about small rural hospitals, and unmeasurable human factors—such as patients being close to family and friends, or local hospital auxiliaries supplementing government support—are neglected.

Only the hospital equivalent of five-star hotels—hospitals offering costly, capital- and skill-intensive procedures—will be in capital cities, exactly where they are now. Country hospitals will never become centres for specialised radiotherapy or brain surgery. But it is quite possible that enterprising hospital boards, in conjunction with local VMOs or visiting specialists, will develop lines of business that are commercially viable in specific country locations.

Local hospital boards are not a revolutionary experiment in NSW. In some respects, they are a return to what worked reasonably well for many decades up to the mid-1990s. Local and district boards fed local information into the hospital system, and citizens serving on these boards gave much of their time and expertise to help running something in which local communities took a proprietary interest. Things deteriorated in NSW hospitals and in other jurisdictions when the Department of Health phoned to dismiss the boards with the argument that the policy had changed, and a less centralised, more open, and better-informed governance system was replaced with central planning. Admittedly, the worldwide political trend is to divert decision-making and control to faraway centres, where local interests and information have less influence. All too often, this trend goes against the interests of local residents and deprives the political enterprise of their loyalty.

Here, we do not argue for a return to the old system, in which local and district boards primarily had an advisory function and were often locked in argument with the central health bureaucracy. Our argument is for autonomous local boards that are fully responsible for the financial management of the hospital and are not second-guessed by bureaucrats. For this to work, the independent boards will require properly qualified and trained executive directors in charge of day-to-day management. Given their greater responsibilities and an absence of having to engage in bureaucratic infighting, boards are more likely to attract members of a higher calibre. Hospitals may need to consider whether to pay competitive market rates for the management services of those they wish to serve on their board.

Saving central administration costs

What the proposed reform renders superfluous is the bulk of the huge, costly and rapidly growing bureaucratic apparatus that strangles public hospitals. At the head of this essay, we cite Gammon's *Theory of Bureaucratic Displacement*, which Milton Friedman restated as follows: 'In a bureaucratic system, useless work drives out useful work.'²¹ Dr Max Gammon told the *Australian Doctors' Fund* in 2005:

I discovered a close correlation between the increase in the numbers of National Health Service [NHS] administrative staff [in the United Kingdom] and the fall in NHS hospital beds that had occurred over the preceding nine years. For statisticians: linear regression analysis showed a correlation coefficient of -0.99 . For non-statisticians, I should explain that this figure presents an almost perfect correlation between the growth in numbers of administrators and the fall in numbers of beds. (*idem*)

The social mechanisms behind Gammon's Law have been the major reason for the explosive growth of hospital costs in Australia. We have witnessed an enormous increase in the number of highly paid public officials who pretend to manage and plan hospitals.²² The administration offers sinecures for well-connected and unionised health professionals, who typically prefer the administrative desk or the staff seminar to hard work in the ward. Attending staff meetings and seminars, going on business trips, writing vacuous survey reports, whether useful or not, and working on computer screens have become more desirable than doing night duty with patients, looking after frail old patients and sick children, making beds, and taking responsibility for the right dosage of medication.

The cost of a proliferating bureaucracy does not stop there: administrators keep inventing paperwork that occupies more and more of the time of the frontline doctors and nurses and displaces productive activity. The managers of the central bureaucracy are by now operating as if they had been handed a blank cheque by the government, had been guaranteed fairly safe tenure of employment, and were owed only pseudo-accountability to their political masters and the taxpayers. When challenged on details, they will refer the public to some political directive or claim that the matter is confidential.

The NSW health administration was given *de facto* monopoly control by the NSW Labor government after the ALP's election win in 1995. It has burgeoned ever since, and only its abolition will excise the intractable cause of the NSW hospital crisis. The key problem has been that frontline hospital services—the number of hospital beds and the workforce that actually cares for patients—have been cut back steadily while the administration has grown. Many a nurse and doctor have been pushed from patient care and the ward into administration by pay relativities and career opportunities, which make frontline service unattractive. For others in the system, mere menial nursing and clinical work have become no more than a stepping stone to the higher realms of hospital management. This attitudinal shift has to do, in part, with the

transformation of nursing education from practical training of useful skills to tertiary level education ('professionalisation'). Nursing graduates now frequently appear to deem duty in hospital wards as below their standing. The reform package proposed here would open the way for returning clinical work to where it used to be—and would save the health system from bankruptcy.

The dismissal of a large number of NSW health administrators will not come cheap. Considerable redundancy payments will have to be made by the state and Commonwealth governments to eliminate the entrenched tenured bureaucracy, just as the costly, intractable malfunctioning of Australian ports required that waterside workers had to be compensated for the loss of their long-term contracts and pension entitlements before our ports could be freed from the stranglehold of the Maritime Union of Australia. Alternatively, we might socialise all hotels and create public 'Hotel Area Services' to employ the bureaucrats who will lose their hospital-management jobs ...

After the proposed reform, the only functions of the NSW Health Department would be to:

- ensure the strict and transparent adherence to standards of hygiene and medical practice
- run those hospitals in competition with private or local hospitals that the politicians may choose to keep in central public ownership, and
- supervise self-responsible hospital boards as to whether they adhere to generally agreed administrative and accounting practices.

Once direct responsibility for running hospitals has been removed from the NSW Minister for Health, and the Department of Health is reduced to the role of funder and quality controller, this post will become less of a 'political suicide commando.' Political and administrative energies will be freed from the need for *dirigiste* micromanagement and reacting to crises, and the minister will be able to set big, strategic goals and promote research and education in health care.

Use of knowledge

In the modern knowledge economy, the creation and exploitation of knowledge is the decisive factor in productivity and quality of services. Much relevant knowledge and knowhow is local and keeps changing all the time. This is why dispersed, self-responsible units are more agile in discovering and using new information and reacting constructively to changing circumstances. By contrast, large top-down plan-and-command systems depend on averages and abstract statistics, which become available only after a time lag. The management of small local hospitals will, for example, know of the availability of part-time support staff and make arrangements to draw on them, if necessary. They will be able to negotiate contracts for cheap local supply of, say, laundry and meal services, which a centralised system does not know about or finds too cumbersome to administer. It is a well-known fact that companies

in socialist economies tried to do everything needed for their operation in-house; although costly, the challenge of sub-contracting was just too great in a centrally planned mega system. Nor was there any incentive to economise and risk innovations, as discussed above.

The incentives in centrally planned systems work with the 'sticks' of command and coercion rather than the economic 'carrots' of material reward. Because relevant information has to be digested and implemented centrally, there is always an incentive to lie with statistics. Central planners, therefore, often do not even get the correct statistical information. This was a major problem in the socialist system of economic coordination. It is not surprising that, according to a recent press report, some public hospitals (Ryde and Gosford in NSW) also falsified performance figures.²³ Friedrich Hayek got a Nobel Prize in Economic Science primarily for highlighting this fundamental problem endemic in all top-down centralised systems.²⁴

It is also well known that command systems inevitably lead to bullying of subordinates rather than treating them as valuable, respected contributors to a common goal. The 'culture' of customer service under socialism has been so notoriously poor that it needs no further elaboration here. The Garling report is correct in castigating the poor 'culture' of work in NSW hospitals and in calling for a re-orientation of the entire system towards serving the patient. Alas, it offers no credible ideas how to achieve these essential changes.

Openness

A single state government could, if necessary, go it alone to introduce such a decentralised decision regime, as seen in the variety of styles of hospital administration of various Australian state governments. NSW-based Medicare offices could be given the funds that now go directly to the Department of Health to pay for NSW hospitals and use them as vouchers for NSW residents.

Neither is there anything wrong with a degree of international competition: Many Australians already shop around to have elective surgery performed in private hospitals overseas, often by Australian surgeons. Contrary to what is often alleged, these operations go far beyond plastic surgery. The option of using Australian vouchers to pay overseas health providers would recognise the reality that hospitals, too, now work in an open, globalised market. More openness will enhance the competitive discipline imposed on local hospitals.

Similar reform concepts are making waves in the education debate in numerous Western countries. In Britain, Holland, Sweden, and New Zealand, politicians are implementing education voucher schemes or are discussing advanced plans to do so. Funding follows the student, not the other way round anymore. After coming to power in 2008, Prime Minister John Key announced that such a free, more competitive school system will be introduced in New Zealand to improve performance, choice and flexibility. Even Australia's Commonwealth government has confounded some of its traditional supporters, especially in the teachers' union, that it, too, will promote choice,

performance pay for teachers, and accountability of school management. Why not apply such a basic concept to the health care sector? The Commonwealth government has already challenged the ‘public is best’ mentality and proposed a quasi-voucher system that would see taxpayer funding used to pay for the elective surgeries of public patients in private facilities.²⁵

Conclusion: avoid bankruptcy now!

In the course of human history, more and more human activities that require scarce resources have been subjected to economically rational methods of allocation. The spread of a business-like approach and accountability has been one of the major driving forces of progress. As a result, the living standards of the broad mass of the people in the now developed countries have risen tenfold over the past hundred years. This has benefited life expectancy and standards of health massively and in unimagined ways. The reorganisation of life along rational, business-like lines has also freed people from many customary strictures and compulsions and given them choices, which better-educated generations are in a position to make. Efficiency in production need not be at the expense of equity. That rational economic behaviour does not mean a ruthless neglect of the essential needs of the less well off should be evident from our proposal to issue vouchers to needy patients.

Improvements in efficiency are sorely needed to stem the seemingly inexorable growth of health costs. As long as a bureaucratic monopoly displaces the time-tested mechanisms for cost discipline and productivity increase on the part of the producers (the hospitals) and a degree of self-responsibility on the part of the buyers (the public), the hospital crisis will continue. Eventually, it will cause a crisis of state and federal budgets. Over the past decade, the annual rate of increase in Australian hospital spending has been 5.1%. At that rate, public hospital spending would be 10 times what it is now by 2055. Throwing more Commonwealth money at the problem through politically convenient COAG deals remedies some symptoms of the present crisis, but it does not cure the underlying causes—to the contrary!

Present trends in public health expenditure are simply not sustainable, so that the cherished goals of equity and world-class health care will have to be abandoned—unless the elected politicians marshal the intestinal fortitude to embark on radical surgery. The time for tinkering, for facile short-termist political compromises, and for cowardice in the face of powerful interest groups has run out.

Radical reform is never easy and naturally meets with scepticism. It is the role of the policy analyst to develop alternative ideas, however costly and uncomfortable, and expose them to public and expert scrutiny—so that political leaders can implement them, as and when the old system fails so badly that even politicians discover that radical surgery is the only politically convenient solution.

The public hospital system has—in my opinion—reached this tipping point.

Endnotes

- ¹ On average of all OECD countries (except the United States), the income elasticity of health spending was 1.7 during the early 2000s. OECD, *OECD Health Data 2004* (first ed.) (Paris: OECD, 2004).
- ² Peter R. Garling, SC conducted an inquiry into and reported on the state of acute care services in NSW public hospitals in 2008. The three-volume report was commissioned by the Governor of NSW—Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals (Garling report), *Final Report* (27 November 2008), www.lawlink.nsw.gov.acsinquiry.
- ³ An internet search yielded only one website that carried positive news about public hospitals in NSW, announcing that ‘NSW hospitals [are] performing above national benchmarks.’ When I clicked to read the good news in full, I was however told—‘Oops!’ to quote the website—‘this article is only accessible to members of the Labor Party,’ inviting me to join!
The sound bite from the Leader of the NSW Opposition was that he welcomed the Garling report but blamed Labor mismanagement for the shortcomings. To date, there is no indication of a constructive alternative strategy on how to cope with the costly hospital crisis at a time when the NSW budget deficit has climbed to \$1 billion.
- ⁴ ‘Pregnant Pause,’ *The Sunday Telegraph* (12 October 2008), 29.
- ⁵ This information is based on a private communication from someone familiar with the ‘Minimum Data Set (MDS) survey’ conducted by the *Queensland Workforce Agency*—see, www.healthworkforce.com.au/main.asp?NodeID=27677.
- ⁶ Friedrich A. Hayek, *The Road to Serfdom* (Chicago: Chicago University Press, 1944), chapter 10.
- ⁷ An updated analysis of the NZ experience was published in 2008: *Productivity Performance of New Zealand Public Hospitals 1998/99 to 2005/06*, www.nzbr.org.nz. This report, written by the former chairman of the NZ Health Funding Authority, Dr. Graham Scott, was influential in the outcome of the 2008 NZ election.
- ⁸ David Leonhardt reports that in the United States, efficiency and customer orientation rank very poorly in local government decisions. David Leonhardt, ‘Piling up monuments of waste,’ *The New York Times* (19 November 2008). Is there any proof that things are any better here—better, that is, from the standpoint of the citizen–taxpayer?
- ⁹ Anyone who doubts that a major driving force in NSW health policy is collectivist ideology should look at the NSW government’s plans to charge private hospitals for blood and blood products that have been donated by Australians through the Red Cross and other organisations. The proposed ‘blood tax’ will be to the detriment of private hospital patients, who have insured themselves and who have thereby taken pressure off the overloaded public health system.
- ¹⁰ See for example Wolfgang Kasper and Manfred E. Streit, *Institutional Economics—Social Order and Public Policy* (Cheltenham, UK-Manchester, US: E. Elgar, 1998), chapter 10. Readers who wish to familiarise themselves with the basics of health economics might wish to turn to David R. Henderson (ed.), *The Concise Encyclopedia of Economics* (Indianapolis, IN: Liberty Fund, 2007), in particular the articles ‘Health Care’ (Michael A. Morrissey, 235–241), ‘Health Insurance’ (John C. Goodman, 241–245), and ‘Competition’ (Wolfgang Kasper, 73–76).
- ¹¹ Friedrich A. Hayek, ‘The Pretense of Knowledge,’ reprinted in Chiaki Nishiyama and Kurt R. Leube (eds.), *The Essence of Hayek* (Stanford: Hoover Institution, 1984), 266–280.

- ¹² There is nothing wrong with different producers quoting and charging different prices for similar or the same product. I may be content with buying a Hyundai car, but you may prefer to pay for a Mercedes. I may want a \$50 razor hair cut; you may opt for the \$8, Wednesday morning pensioner special. People differ, and saving to buy quality health care must remain one of the most respectable motives to save. An exception is emergency admission to hospital, when circumstances dictate immediate treatment and preclude price comparisons and shopping around for the most preferred deal. These conditions can be handled by special administrative arrangements.
- ¹³ Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).
- ¹⁴ Wolfgang Kasper et al., *Australia at the Crossroads* (Sydney: Harcourt Brace, 1980) and Wolfgang Kasper, 'The Market Approach to Social Welfare,' in Ronald Mendelsohn (ed.), *Australian Social Welfare Finance* (Melbourne: Allen & Unwin, 1982), 80–93. These Australian applications were inspired by the pioneering work of Milton Friedman, 'The Role of Government in Education,' first published in 1955, www.schoolschoices.org/roo/ried1.htm.
- ¹⁵ Henry Ergas, 'Why We Need to Revive Federalism,' *Quadrant* LIII:12 (December 2008), 48. During the early Howard years (1997–2002), public health spending in Australia was pushed up by 4.6 % p.a., compared to 2.5% p.a. on average of all OECD countries—the most recent time span, for which internationally comparable data are available. (OECD, 'Health Spending in Most OECD Countries Rises' and 'OECD Health Data 2004,' Table 1).
- ¹⁶ Milton Friedman, 'How to Cure Healthcare,' *Hoover Digest* 3 (2001), www.hoover.org/publications/digest/3459466.html; Cato Institute, *Cato Handbook for Congress: Healthcare* (Washington, D.C.: 1996), www.cato.org/pubs/handbook/hb105-24.html.
- ¹⁷ I am indebted for this information to David Gadiel, an independent economist with an extensive work experience in Australia's health system (personal communication). Overseas, for example in the Netherlands, government-subsidised health provision is delivered by giving individual citizens age/sex specific vouchers, which they can use to pay for a health insurance contract of their choice.
- ¹⁸ It could be argued that, under the current VMO system, a kind of barter deal takes place: the visiting practitioner uses hospital facilities and provides teaching and nurse supervision. Outright commercial contracts would be more transparent and efficient.
- ¹⁹ Steven Lipstein, 'Lipstein on Hospitals—hosted by Russ Roberts,' in *EconTalk—Library of Economics and Liberty* (December 2008), www.econtalk.org/archives/2008/12/lipstein-on-hos.html. Steven Lipstein is CEO of BJC Healthcare, a billion-dollar hospital system in St. Louis that covers a diverse array of non-profit hospitals.
- ²⁰ David Gadiel and Lee Ridoutt, *Towards a Rural Allied Health Strategy—A Workforce and Economic Analysis of Allied Health in New South Wales* (North Sydney: [NSW] Department of Health, 1993), and *The Specialist Medical Workforce and Specialist Service Provision in Rural Areas* (Canberra: AGPS, 1995).
- ²¹ Max Gammon, 'Gammon's Law of Bureaucratic Displacement,' note on a teleconference of the *Australian Doctors' Fund* (January 2005), 24–25, www.adf.com.au/archive.php?doc_id=113.
- ²² Table 8.21 in *Australia's Health Report 2008*, www.ajhw.gov.au/publications/aus/ah08/ah08.pdf.
- ²³ Natasha Wallace and Louise Hall, 'Revealed: How hospitals lied about records,' *The Sydney Morning Herald* (27 November 2008).

- ²⁴ Friedrich A. Hayek, 'The Use of Knowledge in Society,' *American Economic Review* 35 (1945), 510–530; see also his Nobel Prize lecture titled 'The Pretense of Knowledge,' reprinted in Chiaki Nishiyama and Kurt R. Leube (eds.), *The Essence of Hayek* (Stanford: Hoover Institution, 1984), 266–280.
- ²⁵ 'Kevin Rudd's health plan allows for elective surgery at private hospitals,' *The Herald Sun* (13 April 2010).

An Insider's Perspective on Hospital Administration

John R. Graham



Introduction

During my 42-year medical career, I have witnessed first-hand the descent of public hospitals from a position where they were wonderful and rewarding places in which to practise down to their current state of commonplace chaos, tragedy and sometimes even farce.

Public hospitals were once some of the most trusted and well-run institutions in the country supported by altruistic citizens with generous donations. To restore public hospitals to what they once were, I firmly believe that the disastrous reorganisation of public hospital administration of the last 25 years must be reversed. The problems in public hospitals stem from the regrettable decision taken in the 1980s to abolish local hospital boards and replace them with centralised command-and-control bureaucracies. This obliterated the tried-and-tested governance structure that had essentially allowed hospitals to manage their own affairs unfettered by outside interference.

It is blindingly obvious and should go without saying, but ensuring that our hospitals are governed efficiently and effectively is critical to the future of the Australian health system. Policymakers need to understand and reverse the causes and consequences of the major problems in our public hospitals and take appropriate action to fix the administrative dysfunction that has robbed our hospitals of their autonomy, seriously compromised their ability to properly serve the community, and severely restricted ordinary Australians' access to basic hospital services.

This essay is an insider's account (and mini-history) of hospital administration. The policy recommendations are based on my experiences of more than 40 years of practice at Sydney Hospital. The story it tells of Sydney Hospital since the mid-1980s is a case study in hospital maladministration, and it demonstrates the problems that are endemic in the public hospital system, both in NSW and throughout Australia.

Then and now

My clinical career began in 1966 as a medical student at Sydney Hospital. After graduating in 1969, I became a doctor at Sydney Hospital, and by 1973 had risen through the ranks to become Senior Medical Registrar. In the same year, I was appointed Honorary Physician at St Luke's Hospital, Potts Point (a position I held until 1986 when St Luke's ceased to be a public hospital).

Subsequent appointments included Honorary Physician at Balmain Hospital (1974–78) and Ryde District Hospital (1974–79), Honorary Clinical Assistant in Gastroenterology at Sydney Hospital (1974–77), Honorary Physician (and later Visiting Physician) at Sydney Hospital (until 2004), and then Honorary Emeritus Consultant Physician.

From 1983, until forced to retire by other commitments in 1991, I was also Honorary Physician/Gastroenterologist at the Prince of Wales Hospital. Administrative positions held have included Chairman of the Medical Staff Council of Sydney

Hospital (1995–97) and Chairman of Sydney Hospital's Department of Medicine (from 1997). External positions held have included Chairman of the Hospitals Committee of the NSW Branch of the Australian Medical Association (1984–85) and President of the NSW Council of Professions (1991–92).

In all, I have had more than 40 years of intense involvement with the public hospital system in NSW, with lengthy appointments at five public hospitals (two major teaching hospitals and three district hospitals). Such a long and intimate experience with public hospitals obviously permits a perspective that is both broad-based and well-grounded in factual observation regarding how hospitals should and shouldn't be run.

Although I have held a variety of positions at a number of hospitals, I proudly remain a 'Sydney Hospital doctor.' This may strike those familiar with the realities of the contemporary workplace as somewhat odd and rose-colored. Young doctors, in particular, are usually aghast. 'I have not experienced an environment less interested in motivating and developing its workers than the workplace of the public hospital,' one recent product of the system wrote earlier this year.¹ Yet the sentimental attachment I feel to the place that trained me is commonplace among clinicians of my generation. Not only did Sydney Hospital give me my start, but it was, especially during my early career, a wonderful and rewarding place in which to practise.

Many factors contributed to the success of Sydney Hospital, including, of course, the quality, commitment and collegiality of its staff. But comparing then to now, one factor stands out. The key factor that made public hospitals the great public institutions they once were was the way they were run by local boards, setting their own goals and destinies. The passage of time, combined with what continues to go wrong with the public hospital system, has only intensified my commitment to the principles that Sydney Hospital once exemplified with respect to the administration of public hospitals.

The Icon

Sydney Hospital was Australia's first hospital. Two centuries of service to the community began on 26 January 1788 when Captain Arthur Phillip stepped ashore and tents were pitched near the current site of the Museum of Contemporary Art at Circular Quay to care for the sick members of the First Fleet. By 1816, the main hospital building had been completed in Macquarie Street, Sydney, where it overlooked the Domain, and now sits between Parliament House and the Mint Building.

By the 1960s, the hospital had grown into a thriving centre of clinical excellence and was renowned for pioneering developments in almost every aspect of medicine, nursing, medical research and education in Australia. It was a leading player in clinical and non-clinical research, particularly through the work of the Kanematsu Memorial Research Institute (which earned a Nobel Prize) and the Sydney Eye Hospital.

So important were some of the initiatives and discoveries that occurred within its walls that Sydney Hospital rightly earned its reputation as a pre-eminent Australian hospital, standing as one of the leading hospitals of the world. The interaction between clinical and research activities was intense. The collegiality within the entire institution was a catalyst for innovation. One hundred and seventy years of struggle to produce the finest work cultivated a legendary *esprit de corps* among the staff. The board of directors nurtured this spirit.

To illustrate the huge impact of Sydney Hospital on the Australian and international scenes, it is worth noting but a few of its most important achievements:

- First post-mortem examination in Australia (1827)
- First general anaesthetic (chloroform) in Australia (1852)
- First specialist unit in Australia (eye department, early 1870s; later to become Sydney Eye Hospital)
- First Australian use of X-rays
- First Australian use of radium for radiotherapy
- First Australian blood transfusion
- First Australian coronary care unit (second in the world)
- First Australian renal unit and first haemodialysis
- First Australian liver transplantation
- First Australian leukaemia unit
- First melanoma unit in world
- First Australian colorectal unit
- First Australian hand surgery unit
- First Australian occupational health academic unit

Not surprisingly, trainee doctors and trainee nurses gave their back teeth to get their education at this world-class hospital. The competition amongst qualified specialists to gain honorary staff appointments at both Sydney Hospital and Sydney Eye Hospital was equally intense.

Sydney Hospital had trained the very first medical student in Australia in 1849, well before the University of Sydney or the Royal Prince Alfred Hospital had even opened their doors. When I was a student, the Medical Faculty of the University of Sydney's undergraduate program was a six-year course, with students required to spend the last three years working in a teaching hospital. Sydney Hospital ranked among the top two or three major clinical schools,² with the in-hospital teaching delivered primarily on an honorary basis by the best clinicians in the country.

Like so many big and small public hospitals, Sydney Hospital had its own on-site Nursing School—the first such school in the nation. Since commencing in 1868 (when Lucy Osburn was sent from England by Florence Nightingale to found the

nursing profession in Australia at the request of Premier Sir Henry Parkes), the school had proved itself a brilliant training ground for countless nurses.

Trainee nurses lived on-site or in nearby quarters owned by the hospital. Nurse training was provided over three years both by the senior nurses and (in a pro bono fashion) by the resident and honorary doctors. Teaching was concurrent with practical, on-the-job graded clinical service in wards and operating theatres.

It is no longer politically correct to say so in the age of university-trained nurses, but the nurses trained in the traditional vocational way were the best nurses that most doctors and patients have ever known. They were compassionate, caring and capable, and were able to provide the essentials of true nursing (washing, feeding, monitoring and medicating patients as opposed to trying to be doctor-like). Most importantly, nurses were fully prepared to take responsibility for running a ward once they had graduated. The system also reduced the budgetary pressures on the hospital. Trainee nurses performed about two-thirds of the ward work at wages that were significantly reduced, but offset to some extent by the costs of their residential accommodation and education. Today, that same work is often by necessity carried out by highly paid registered nurses.

The shift from in-hospital training to the universities (where it is too remote from the essentials of nursing) was only achieved because a small number of vocal discontents got the ear of government. Nurses deserve to be an influential lobby group. But the changes that were perceived to be in best professional interests of nurses should never have taken precedence over the needs of patients and the quality of public hospital care.

In the 1960s, Sydney Hospital had about 450 beds (including an eight-bed Intensive Care Unit), six operating theatres, and major teaching facilities. Down at Woolloomooloo, the Eye Hospital (part of Sydney Hospital) had about 50 beds and three operating theatres. Despite the best efforts of successive NSW Labor and Coalition governments, aided and abetted by NSW Health, to close down Sydney Hospital and appropriate its matchless and increasingly valuable real estate, Sydney Hospital remains a beacon of hope and excellence. With just 100 beds and six operating theatres, and perched above a 380-space underground car park, Sydney Hospital continues to provide the public with Australia's best clinical and research centres for eye and hand surgery. This work is supported by an exemplary Department of Medicine, comprising 10 general physicians with a vast and unique mix of skills. Sydney Hospital also operates the world-renowned Kirketon Road Clinic at Kings Cross and the Sydney Sexual Health Centre on Macquarie Street.

Managing excellence

The 1960s saw Sydney Hospital free to truly live up to its motto: *Ut primus, sic optimus*: Just as the first, so the best.

The principal reason Sydney Hospital was able to determine its destiny according to its own high standards was the way the hospital was independently governed under its own Act of Parliament. As a statutory creation of the Parliament (as opposed to a creature of the political class and the bureaucracy), the internal activities and processes of Sydney Hospital were essentially unfettered by outside interference. Under the *Sydney Hospital Act*, an autonomous board of directors (which included two ministerial appointees) controlled the hospital's entire annual budget.

The membership of the board of directors was broadly representative of the community, including leaders of commerce, professionals with accounting and legal skills, ministerial and other community representatives, plus a small number of doctors. The board also welcomed contributions (from the shop floor, so to speak) from the Hospital Secretary, the Medical Superintendent (a doctor), and the Matron (Director of Nursing).

Board meetings were held monthly. Doctors and senior nurses had input into the board's deliberations via representations made by the Medical Staff Council, the Medical Superintendent, and the Matron. These open channels of communication made for quick decision-making based on accurate information and comprehensive feedback from clinical staff. Active board members also took the time to inform themselves about the frontline needs of staff, patients and researchers.

Good communication between the staff and the board led not only to speedy resolution of problems but also superior planning. By being singularly devoted to advancing the interests of the hospital, the board helped foster a culture of cooperation, high morale, and institutional loyalty among doctors and nurses, which proved self-sustaining and self-perpetuating.

Community trust

When controlled by autonomous hospital boards, public hospitals were a source of civic pride. Appointment to a public hospital board anywhere in the state was regarded as an honour and a matter of distinction. Members of the Sydney Hospital Board of Directors (like all hospital boards) gave their services pro bono.

Community trust and participation was also high. An enormous amount of work within and for Sydney Hospital was done by volunteers out of a spirit of service to the community, including frequent visits from the clergy and a daily in-ward service from the ladies of the Hospital Auxiliary and the Friends of Sydney Hospital. The honorary medical and surgical staff provided their services to patients, medical students, and nurse trainees for no financial reward. (Their rewards were personal satisfaction and a limited right to admit private patients, coupled with the obvious benefits of networking, collegiality and access to diagnostic and research facilities.) Resident medical officers lived on-site and worked long hours with no overtime payments. (Their reward was a superior education.)³

So admired were the achievements of Sydney Hospital that private donors contributed considerable sums to fund research programs and finance new cutting-edge equipment that otherwise could not have been afforded through the normal budget. Donations to public hospitals were then, and still are, tax deductible. Donors could be certain in those days that their donations went precisely to the recipients or recipient departments that they had designated. Shamefully, in the absence of local boards and autonomous budgets, donors have no such confidence these days.

Administration—then and now

Principally due to the administrative changes in the mid-1980s that flowed from the creation of the area health system (see below), the situation at Sydney Hospital could not be more different today. Sydney Hospital, like the overwhelming majority of public hospitals, is no longer governed by its own board. Many loyal (though increasingly elderly) people still volunteer their services but, in general, public hospitals have lost the public esteem and community support they once enjoyed. Donors are (understandably) reluctant to give money to hospitals mismanaged by gigantic government bureaucracies. Sydney Hospital still manages to do great work against the odds (severely reduced beds and service capacities) to the enormous credit of its stressed, frustrated and resource-deprived staff. Like all public hospitals, Sydney Hospital's performance is impeded by the current governance arrangements, which are stacked against quality, efficiency and effective administration.

The importance of the local boards to the proper functioning of public hospitals has become clear in retrospect. I chair Sydney Hospital's Department of Medicine. The proceedings at our bi-monthly department meetings provide a telling insight into the extent of administrative dysfunction in our public hospitals. The department is mainly occupied in dealing with directives issued by the South Eastern Sydney and Illawarra Area Health Service (SESAHS) and NSW Health. Some of the protocols that the department is obliged to acknowledge or ratify are routine to the point of pointlessness. (Experienced clinicians are being told, in short, 'how to suck eggs.') All too often, the (ever-changing) initiatives that are being mandated by centralised bureaucracies, and that each hospital department is expected to implement, involve an inappropriate one-size-fits-all approach. The uniqueness, the skills-base, and the diversity of each hospital in different parts of the state are being completely ignored.

This dire mix of useless paper shuffling and managerial rigidity is a direct and predictable consequence of the area health system and the ridiculous attempt to micro-manage hospitals at a distance from the reality on the ground.

When centralised bureaucracies try to manage hospitals in far-flung corners of the state (and about which they know so little), they feel pressurised to invent and enforce policies and protocols more for their own defence and protection than for that of the patients—but these devices are counterproductive; they become an added and

unnecessary interference for doctors and nurses who are simply trying to get on with the job at hand.

Doctors and nurses these days are forever wasting time and energy complying with the new sets of orders issued by an intrusive, arbitrary, and seemingly unaccountable bureaucracy.

Starkly different outcomes were achieved under the old, highly-responsive local board governance structure compared to the current, highly-reactive command-and-control system. A dynamic and innovative culture of continuous improvement existed at Sydney Hospital when the board operated close to the ground and worked pro-actively with the Superintendent, Matron, and clinical staff.

Because each public hospital now forms part of a network overseen by a remote and faceless bureaucracy, it is easy to think that nobody is really in charge anymore and that no one cares enough about optimising the various services that each individual hospital should be providing on a daily basis. The resulting administrative vacuum allows problems to proliferate as services stagnate, at best, and degenerate, at worst. When the resulting disasters hit the headlines, public hospitals are subjected to repeated bouts of 'crisis management.' The imposition of a yet another catalogue of revised protocols and accountability measures turns out to be the top-down bureaucratic equivalent of rearranging the deckchairs on the Titanic.

The hospital revolution

Ironically, the slow decline of public hospitals began in response to rapid advances in the science of hospital care.

In the 1960s, it was commonplace for patients to be admitted for at least a month, and rarely fewer than five days. Bed numbers had to be high to provide patients with timely access to care.

In the late 1960s, technological breakthroughs revolutionised my specialty—gastroenterology. Modern fibre-optic endoscopes replaced the old reliance on standard X-rays and other modalities that had required a lot of guess work and inferential diagnosis. These innovations made quick and accurate histological diagnosis possible. Patients with suspected malabsorption, who previously endured hoards of tests and a stay of up to four weeks in hospital, could now be fully diagnosed with just a day in hospital and a few laboratory tests.

In the mid-1970s, biomedical engineers developed laparoscopes and other surgical endoscopes. This had a dramatic and beneficial effect on general and orthopaedic surgery. Operations that used to have in-hospital recovery times of up to two weeks now had an entire in-hospital time of 48 hours or less.

Around the same time, coronary artery surgery and joint replacement surgery also became available. These innovations, together with coronary artery stenting, brought

huge benefits to patients. New and more accurate diagnostic modalities were also developed during the 1970s through to the 1990s. Ultrasound, CT scanning, MRI scanning, and PET scanning largely superseded older and more cumbersome radio-isotope scanning and barium radiology techniques. These new tools and innovations improved the speed and accuracy of diagnosis but greatly added to the overall health costs.

The impact of the technological revolution on hospitals was threefold:

- All of a sudden the need for beds was reduced.
- The cost of a bed-day rose because the shorter time patients spent in hospital involved intense clinical activity.
- Doctors realised the surplus supply of beds, combined with the potential for much higher rates of clinical throughput, meant patients would no longer have to wait so long to be treated for elective work such as hernia repairs, cataract surgery, and cholecystectomies.

Upheaval

In other words, the advances and efficiencies in hospital treatment promised to deliver more care more quickly to more patients, albeit at an increased cost. This promise was however never realised, in part because the technological revolution coincided with the health policy upheavals of the early-1970s to mid-1980s, which culminated in the creation of Medicare and the start of the era of 'free' public hospital care for all.

Before 1984, every member of the community could receive treatment in a public hospital. However, a wealth (means) test applied. Only the less well-off were admitted without charge, with senior doctors providing care without remuneration in their capacity as Honorary Medical Officers (HMOs). This meant that the less well-off received the best possible treatment in public hospitals given by the best doctors in Australia. The 'price' of this equitable outcome was that those who could provide for themselves were expected to take out private insurance, which essentially covered the cost of their hospital bills in full. This ensured that doctors were well paid for their work on private patients in public hospitals.

Following the introduction of Medicare and the abolition of a means test, doctors gradually started accepting payment for the services they used to provide in a truly honorary capacity. Governments promised that everyone could be treated for free as a public patient in a public hospital. As stands to reason, few people thereafter declared they wanted to 'go private' when they could be treated by the same doctors for nothing.

The ideologically-driven decision to allow all-comers to be treated for free regardless of their means fundamentally changed the dynamic that underpinned the successful operation of the public hospital system. Doctors lost their independence once they accepted contract payments or salaries from government, and they lost much of

their independent income stream for work on private patients in public hospitals. Public hospitals also lost their financial independence and became overwhelmingly dependent on global budgets allocated by health departments. Ultimately, these arrangements (combined with the frustrations of working in the contemporary public hospital) drove many doctors into the private hospital system and made it harder to get specialists to work in the public system. One serious outcome has been the deterioration in the opportunity for providing a comprehensive clinical training to students and young doctors.

The final and crucial effect was that the cost of all the hospital care that used to be borne either by private insurance, or had been performed without charge by HMOs, was transferred on to government budgets. If the tried and tested system had remained in place, private health premiums would have increased to accommodate the changed cost structure in hospitals, which now achieved outcomes in two days that formerly took two weeks. Australians would have spent more on health care but received more, better and faster hospital care in return. Instead, as the record of the last 25 years demonstrates, governments have poured increasing sums of taxpayer money into public hospitals for poor returns as measured by ever-lengthening waiting lists and quite unbelievable levels of waste on useless bureaucracy.

A further adverse reaction

With all these policy and clinical changes of the period as the background, in the early to mid-1980s the Wran government in NSW, along with its counterparts in every state, decided to curtail the good fortune for patients. With constraints on the level of hospital funding received from Canberra, state governments simply hated the burgeoning productivity of public hospitals. To control the cost of 'free' hospital care, the NSW government set out to restrict the ability of clinicians (who were mostly, and still are, workaholics) to achieve all the efficient extra throughput that technological advances made possible.

The method employed by governments was to drastically cut the number of beds available in order to ration hospital care. But to achieve this, the autonomous administrative structure of the public hospital system had first to be dismantled.

It is important to stress that there was a good case for temporarily reducing bed numbers in the 1980s, even in the context of steady population growth. This was especially the case at the largest hospitals—the teaching hospitals. However, teaching hospitals were reluctant to accept even sensible bed cuts or any reduction in their clinical, teaching or research capacities. The success and world standing of the top hospitals in NSW was significantly related to the strength and vigour of their boards. These hospitals had the greatest advocacy opportunities in the community and thus the greatest ability to resist bed cuts by stirring up political trouble for the government.

A plan was therefore devised to enable bed cuts to proceed without the Wran government, or any subsequent government, having to wear the political opprobrium. At a stroke, public hospital boards were abolished with only a very few exceptions. In the greater Sydney region, through the grace of good political contacts, St Vincent's General Hospital at Darlinghurst managed to avoid the rout and remain under the control of its own board.

Hospital boards were replaced by Area Health Services (AHS), and the Area Board at each service was given complete oversight of several hospitals in a designated region. Medical Superintendents (who actually knew what was going on inside each hospital and made sure that the interests of patients were paramount) and Matrons (who actually ensured that clinical nursing was always at the highest standard) were also removed from each public hospital.

The only strength of the AHS was that it enabled bed cuts to be imposed on hospitals at arm's length from government.

If only there had been a sunset clause in the *NSW Area Health Services Act of 1986*, the subsequent disasters under a continuing AHS model need never have occurred.

The job of cutting beds was quickly achieved in full by the late 1980s.

By the early 1990s, it was time to rebuild the public hospital system to meet the evolving health needs of a changing and growing population. This has however proved impossible under the AHS structure that has long outlived its usefulness. Symptomatic of the deleterious impact on public hospital administration, the remoteness of AHS means the bureaucrats with overall managerial responsibility have very little understanding of the frontline realities in our hospitals.

An audit of the decay

Periodic waves of reorganisation and consolidation have reduced the number of the AHS to just eight covering the entire state of NSW. Under the current NSW government, even AHS boards have been abolished, though this is no great loss since these entities were often heavily loaded with board members responsive to the wishes of the government of the day. Public hospitals across the whole state are now basically run by a Director General and eight AHS CEOs.

The Wran government is not solely to blame. The idea of regionalised and integrated hospital networks has appealed to politicians of all persuasions. The Greiner, Fahey and Carr governments have all been keen on the AHS concept because it promised to minimise the cost of high-tech specialty services and yield significant budget savings. Yet Minister for Health after Minister for Health (and there have been countless ministers since the mid-1980s) have each, in their short times in the office, overseen a quite unbelievable and totally inappropriate growth in the size and cost of NSW Health and the AHS bureaucracies at the direct expense of the public hospitals. By my calculations, nearly three-sevenths of the entire salaries paid

out annually by NSW Health (almost \$3 billion out of \$7 billion) fail to reach those giving in-patient care in public hospitals, but mostly get directed to bureaucrats, consultants and others who are achieving far less than the pro bono boards of directors achieved for the system just 25 years ago.⁴

Excessive bureaucratisation and totally inappropriate resource allocation has led to a catalogue of disasters for public hospital staff and patients. An ever-diminishing proportion of the ever-increasing health budget has been available for doctors, nurses, clinical work, teaching, and research. A critical shortage of beds has led to constant blowouts in waiting times for elective admissions. This has also resulted in dangerously overcrowded emergency departments due to chronic 'access block' (with difficulties finding in-patient beds for those needing unplanned admission).

The state governments have also attempted to cost-shift hospital expenditure to the federal government, regardless of impact on clinical ethics and outcomes. For example, nowadays discharge prescriptions for public hospital patients are generally restricted to no more than one week's supply so that the cost is quickly switched back to the federally-funded Pharmaceutical Benefits Scheme (PBS). And the majority of outpatient clinics in NSW public hospitals have been shut down, with the result that their running costs (nursing, allied health, and prescriptions) have also been shifted to Medicare. Rural hospitals have been badly damaged, with essential hospital services (basic obstetrics, basic orthopaedics, minor surgery, radiology, and pathology) withdrawn from local communities.

Most importantly, the centralisation of policy, planning, funding, and decision-making to the AHS has obliterated the governance structures that once ensured the proper administration of public hospitals. The chain of communication that existed between the coal-face and those in charge has collapsed. With a few notable exceptions in each Area, clinicians, especially senior doctors, have been disempowered. With no Superintendent, no Matron, and no independent Board receptive to feedback, there are no managers in hospitals with operational authority to make swift decisions to resolve problems.

The spirit of cooperation required to make all organisations successful has also been lost. Doctors and nurses are constantly being pushed too hard to achieve impossible outcomes with inadequate resources, only to find their best efforts repeatedly frustrated by a stubborn and slow-moving bureaucracy that lacks the hands-on knowledge to understand what makes a hospital tick. The morale and institutional loyalty that were once the life-blood of the public hospitals have inevitably been sapped thanks to the decline in trust between doctors, nurses, and those in positions of ultimate authority.

One does not have to be a professor at the Harvard Business School to realise that all these factors have coalesced to ensure the worst possible outcomes. The bottom-line is that the efficiency of public hospitals has been compromised and funding is not spent optimally.

Another flow-on effect has been a massive reduction in the donations to public hospitals, owing to the breakdown in trust between the community and the disempowered and/or dysfunctional hospitals that altruistic citizens are no longer prepared to support.

Confirmation of the root cause of destruction of virtually every good aspect of our once great public hospitals in NSW was provided by the findings of the Garling Special Commission of Inquiry into NSW public hospitals in 2008. Particularly important was the evidence provided to the inquiry by several senior specialists. Professor Michael Cousins of Royal North Shore Hospital told the commissioner there had been an 'increasing erosion of morale, commitment and loyalty to the institution' since the loss of its board. In stark contrast, Professor Jock Harkness from St Vincent's General Hospital highlighted the obvious differences at one of the only hospitals allowed to retain its own autonomous board of directors. Little wonder St Vincent's attracts the top clinicians and researchers, and has plenty of donors. The amazing outcomes achieved at St Vincent's special units (such as the Garvan Institute and the Victor Chang Cardiac Unit) illustrate the obvious superiority of the board-led hospital model. Similarly, the Westmead Children's Hospital, which also has its own board, has managed to maintain donor-support and excellence in clinical services and research despite heavy service burdens.

Unfortunately, NSW Health presumably outranked and outflanked the senior clinicians in hearings before the Garling inquiry. This possibly explains why the Commissioner did not feel at liberty to recommend the re-establishment of hospital boards. A great opportunity, and a lot of time, effort and money, was wasted. Alas, the end result of the Garling Inquiry has been even more bureaucracy, with an entirely new centralised agency established to police clinical standards across the system.⁵

Remedy

The only way to fix the problems in public hospitals is to reverse the disastrous mistakes of the last two decades.

All AHS should be immediately abolished and (pro bono) boards of directors⁶ restored at each and every public hospital. The position of a General Medical Superintendent should also be reintroduced at all hospitals with an in-patient bed number exceeding, say, 80 beds.

The membership of the board of directors should include:

- A Chairman—a leading and respected member of the local community
- A representative of the local business community
- A community representative with media or public relations experience
- A lawyer, an accountant, and a member of the clergy or an ethicist

- Two members of the medical staff (appointed by the Medical Staff Council or its equivalent)
- The Medical Superintendent and Director of Nursing
- The hospital accountant or chief executive
- A fund raiser, and
- An appointee of the Minister for Health (if required).

Every public hospital should receive an autonomous budget based on expenditure history over the past three years. But where cuts to services and other activities over the last 25 years have been irrational, and especially in rural hospitals deprived of basic services, baseline budgets should be restored commensurate with the resumption of the services, teaching and research activities of the mid-1980s. The ambulance matrix (which is the protocol-based triaging system used by ambulance officers to indicate the optimal destination hospital, according to service capacities, for the sick or injured being transported) will also need to be revised in line with the resumption of previously abolished services.

Funding arrangements should ultimately revert to the pre-1980s position. Every hospital budget should principally be based on clinical throughput, allowing for local demand as well as referred cases, whilst making appropriate use of case-mix payments to ensure efficiency and equity.⁷

Sydney Hospital, capital cities, and national security

Reversing the mistakes should start with Sydney Hospital coming back under the control of its own autonomous board of directors. It is a glaring example of a critically important public hospital needing urgent restoration to its former capacity to ensure that it can again deliver the essential services it did in the 1980s. Sydney Hospital is the only readily accessible hospital for the fastest growing residential population in Australia. Whereas in the early 1990s, only 15,000 people resided in the Sydney CBD in the middle of the night, there are now at least 70,000.

Across Australia, there are about 2.7 public hospital acute beds (excluding psychiatric beds) for every 1,000 citizens. On that basis alone, Sydney Hospital should immediately be expanded to a minimum of 190 beds (from its current 100 beds).

Sydney Hospital is also the only hospital inside the Sydney CBD. In the middle of every working day, it is the only easily reachable hospital for the 500,000 people inside the city. As events in recent years have shown, the CBD area is reduced to gridlock by even minor incidents in the normal life of the city.⁸

In October 2005, just three months after the London bombings (where the emergency response was outstanding, in no small measure due to the fact that there are 50 hospitals scattered throughout the city of London), NSW Health removed

the departments of General Surgery and Orthopaedics from Sydney Hospital. This action defies belief, but is typical of the way the remote and arbitrary health bureaucracy operates in NSW.⁹

As the Australian Strategic Policy Institute warned in its April 2007 special report, *Are We Ready? Healthcare Preparedness for Catastrophic Disaster*, Sydney Hospital's critical role as a national security hospital demands immediate action to upgrade its emergency department and triaging capacity to deal with a catastrophic disaster.¹⁰

Every capital city CBD in Australia needs to designate and empower the most centrally located public hospital to have a role as a national security hospital.¹¹

Conclusion

What began as an administrative restructure to facilitate bed cuts across all the public hospitals has proved to be a complete disaster for the public hospital system. The negative impact of the abolition of autonomous hospital boards and their replacement with AHS on communication, cooperation, morale, loyalty, trust, efficiency, and excellence has been obvious to doctors, nurses, patients, and all citizens who spend even the briefest time in a public hospital.

Bureaucrats and assorted health experts and other stakeholders stubbornly deny the truth of the appalling situation. Meanwhile, governments have continued to expand the size of the bureaucracy at the expense of spending more money in the only places that count ... the public hospitals themselves.

It is high time our political leaders wake up and impose some serious cuts on the health bureaucracy in this country. Desk cuts, not bed cuts, should be the priority. This cannot occur unless autonomous boards of directors are put back in charge of our public hospitals. For the sake of the health and welfare of all Australians, our public hospitals must be set free to once again become the great public institutions they used to be.



Endnotes

- ¹ Tanveer Ahmed, 'Unshackle our Leninist hospitals,' *The Australian* (18 February 2009).
- ² Students could choose between Sydney Hospital, Royal Prince Alfred, St Vincent's, Royal North Shore, or Concord.
- ³ Frank Bowden, 'A chance to get the balance right on young doctors' working hours,' *The Sydney Morning Herald* (11 September 2009).

- ⁴ This conclusion has been based on an analysis of the NSW Health annual report (2005–06), which included modestly disaggregated financial data after excluding those salary costs not directly linked to the day-to-day in-patient operation and upkeep of public hospitals. The total salaries budget for that year was approximately \$6.9 billion. Hospital staff (including medical, nursing, allied health, other health professionals, oral health practitioners, and ambulance clinicians) accounted for merely 65.3% of the employees of NSW Health.
- ⁵ NSW government, *Caring Together: The Health Action Plan for NSW* (Sydney: NSW Department of Health, 2009).
- ⁶ Statutory immunity from being sued for other than criminal negligence should also be extended to all Directors.
- ⁷ This is largely the kind of funding arrangement proposed by the Rudd government's National Health and Hospital Reform Commission. See National Health and Hospital Reform Commission, *A Healthier Future for all Australians: Final Report, July 2009* (Canberra: Commonwealth of Australia, 2009).
- ⁸ Such as the 50% electricity blackout in the Sydney CBD on the afternoon of Monday, 30 March 2009 and a harbour visit by two large ships in February 2008.
- ⁹ Due to chronic overcrowding and shortage of beds, leading experts in emergency medicine have warned that the public hospital system will not be able to deal with a major incident. Professor Drew Richardson of the ANU told the *Sydney Morning Herald* NSW would be unable to deal with a major incident or multicar accident. Natasha Wallace, 'Casualty crisis: many wait eight hours,' *The Sydney Morning Herald* (2 August 2007).
- ¹⁰ This is a new and important concept which the federal government is yet to properly recognise pursuant to the defence power of the Commonwealth Constitution.
- ¹¹ John Graham, 'The security of the Sydney central business district through the eyes of a medico,' *United Service* 58 (December 2007), 21–24.

Why Public Hospitals Are Overcrowded: Key Points for Policymakers

Jeremy Sammut*



* The author owes an enormous debt to Dr Paul Cunningham, FACEM, for generously sharing his experience, expertise and ideas, and providing valuable feedback. The author also thanks Dr Tony Joseph, FRACEM, for reviewing the paper and providing helpful and insightful comments.

If we are to address the bottlenecks that form in our emergency departments, we cannot afford to think there is a simple solution ... that beds are the solution ... I believe that the solution is far more complex than that—that it is a product of a health system which has focused too exclusively on acute care.

— **Hon. Nicola Roxon MP**, Minister for Health and Ageing¹

The hospital crisis

Besides the perennial and serious problem of ever-lengthening waiting lists for elective surgery, Australian public hospitals are unable to provide timely emergency treatment and unplanned admission to a hospital bed for significant numbers of acutely ill patients:

- More than one-third of emergency patients requiring admission to a public hospital wait more than eight hours for a bed.²
- One in three emergency patients—two million people a year—wait longer than clinically recommended for assessment and treatment.³
- Fewer than two-thirds of emergency patients classified as urgent are seen within the recommended time of 30 minutes—a smaller proportion of patients compared to a decade ago.⁴
- The Australasian College of Emergency Medicine’s Snapshot reveals the problems are getting worse. Forty-one percent of emergency patients requiring unplanned admission wait for a bed, and 81% of these patients wait beyond eight hours—one-third more than in 2004.⁵

Twenty-five years of nationwide cuts to the number of acute public hospital beds means our public hospitals are dangerously overcrowded. In the context of population growth, the ageing of the population, and rising demand for admission, public hospitals are unable to operate at a safe level of 85% bed occupancy due to the national shortage of acute hospital beds.⁶ Academic research links overcrowding with 1,500 avoidable deaths per year—more than the national road toll. But not even headlines that screamed ‘1,500 die waiting for bed’⁷ have generated an appropriate policy response. In the age of spin and media management, only a ‘brave’ health minister would be honest about the scale of the crisis in our ‘free and universal’ hospital system and admit that *public hospitals don’t have sufficient beds to provide a safe standard of emergency care for acutely ill patients who require unplanned admission and cannot be treated elsewhere in the health system.*

Access block

Hospital overcrowding (access block) occurs when emergency departments contain more acutely ill patients, who require admission than there are free staffed beds available in hospitals that are near or at full capacity. The technical definition of access block is that emergency patients are forced to wait more than eight hours for admission to an inpatient bed. Because major metropolitan hospitals regularly operate at above 100% bed occupancy to maximise elective patients and shorten politically sensitive elective waiting times, hospitals frequently have no spare beds to cope with unplanned admissions. Patients, the majority of whom are frail and elderly, are deprived of sleep and privacy and forced to queue for hours, sometimes days, on trolleys in overcrowded emergency department corridors (and even in storage cupboards).

Surveys show that caring for access block patients constitutes more than 40% of the emergency staff workload in major public hospitals,⁸ resulting in prolonged delays and extended waiting times before new patients can be assessed and treated. Emergency departments are unable to function efficiently and safely deliver the acute care they are meant to provide. When corridors and treatment cubicles are full, and it is physically impossible for emergency departments to accept more patients, ambulances are ramped outside or forced to circle the hospital. Sometimes the doors are shut, and ambulances containing urgently ill people are sent to other hospitals kilometres away.

So endemic has access block become that emergency staff call it ‘the new normal.’⁹ Overcrowding leads to higher emergency costs and compromised patient safety. It causes unnecessary suffering and is associated with longer stays and poorer clinical outcomes for admitted patients, including higher morbidity and mortality rates.¹⁰ Because the cancellation of elective surgery is the standard crisis response, bed shortages also contribute to blowouts in elective waiting times.

Overcrowding also takes a heavy toll on the overworked, stressed and burnt-out emergency staff, upon whose professionalism and dedication the health and welfare of every Australian could one day depend.

The groundbreaking 1999 study by Bagust, et al. found that increased risks to emergency patients—incidence of access block, admission beyond a clinically safe time frame, longer length of stay, and higher mortality—were discernable once average occupancy exceeded the safe level of 85%.¹¹ Once bed occupancy rates regularly exceed 90%, lack of spare bed capacity means public hospitals can expect regular bed shortages and overcrowding. Once occupancy exceeds 95%, emergency departments will almost always operate in crisis mode. They will not have the spare bed capacity to cope with surges in demand for admission without unacceptable delays.¹²

Average occupancy in public hospitals is 90–95%.¹³ Studies conducted in Australia, the United States and Canada (where the problem has been studied in the greatest detail) have all identified lack of available beds as the single-most important cause of overcrowding in emergency departments.¹⁴ These studies all point to the same

solution—hospitals need an adequate supply of acute beds per 1,000 head of population and the nurses to staff.¹⁵ Hospitals need to operate at 85% bed occupancy so that emergency patients can be transferred to wards without undue delay and new patients can be seen in a timely fashion.¹⁶

Closing beds to open desks

The technical cause of hospital crisis is 25 years of excessive cuts to acute inpatient bed numbers. The systemic causes of the nationwide shortage of beds are the misallocation of resources away from frontline services and the corresponding growth in the size and complexity of state government health bureaucracies that mismanage the public hospital system.

In the 1980s and early 1990s, local hospital boards were abolished and centralised health bureaucracies were established to administer public hospitals on a regional basis. These bureaucracies are responsible for allocating state and Commonwealth funding to public hospitals; for planning hospital services, including bed numbers; and for overseeing the rationing of ‘free’ public hospital treatment. They have unacceptably low percentages of staff directly involved in patient care (perhaps as low as one in five employees¹⁷); have developed top-heavy and complex corporate structures; and are notorious for being overstaffed by ‘countless people who have ... spent their working lives attending endless meetings, staring at computer screens, and doing precious little else.’¹⁸

The cost and complexity of the state health bureaucracy was also considerably increased by the state takeover of the Community Health Services from the federal government in the 1980s. Annual expenditure on community health is approaching \$4 billion a year, but providers generally don’t have to account for services delivered and funding received. They are also notorious for administrative excesses, over-staffing, and creating work-avoidance havens for public sector employees in marginal, non-patient focused public health roles. The absence of national performance data means there is no way of knowing what the public is getting for the billions of taxpayer dollars diverted from public hospitals and spent on community health programs.¹⁹

Commentators claim that public hospitals are underfunded. The accompanying assumption is that massive funding boosts will fix the problems in the system.²⁰ Over the last decade, real expenditure (adjusted for inflation) on public hospitals (funded overwhelmingly by Commonwealth and state taxes) rose from \$17 billion in 1996 to \$27 billion in 2006–07. This 64% increase in expenditure has resulted in only a 28% increase in activity (number of patients treated).²¹

The problem is not lack of money but that not enough of the money pays for patient care. The size of the hospital bureaucracy is different in each state and is difficult to calculate accurately. Inadequate financial and other data make it impossible to measure the administrative costs as well.²² Estimates therefore vary.

(But legion tales told by clinical staff about the army of clerks warehoused in the bureaucracy who ‘don’t do any work’ is telling.) Ken Baxter, former head of the NSW and Victorian Departments of Premier and Cabinet, estimated that anything between 20% and 40% of state health department employees occupy ‘administrative’ or ‘other’ roles.²³ Anthony Morris QC, former head of the commission of inquiry into the Dr Death scandal at Bundaberg Base Hospital, estimated that just 20% of Queensland Health Department’s 64,000 strong workforce is a doctor and nurse ‘who actually deals with patient care.’²⁴

Because hospital funding is not tied to the treatment of patients, taxpayer dollars are being diverted and wasted on bureaucrats rather than beds. Despite the massive increase in real funding, the number of acute public hospital beds actually fell by 18% per 1,000 between 1996 and 2006,²⁵ while the number of bureaucrats rose by 69% between 2001 and 2005.²⁶ This is an example of the ‘closing beds to open desks’ syndrome,²⁷ whereby growth in funding correlates with growth in bureaucracy and reduction in bed numbers.²⁸

Systemic dysfunction

Defective funding and administrative arrangements have also created a range of additional systemic dysfunctions:

- **Progressive centralisation of control over local hospitals by remote and unwieldy state government bureaucracies and ‘command and control’ micro-management of hospitals by central plan-bureaucracies.** The wide disconnect between the bureaucrats with final authority for hospitals and the staff responsible for delivering services have, in effect, left no one in charge of running hospitals on a day-to-day basis.
- **Lack of local accountability and the disempowerment of both clinicians and the community.** The abolition of local hospital boards has led to the breakdown of the relationship between budget enforcing/target monitoring managers on one hand and resource and responsibility deprived clinical staff on the other. The relationship between management and frontline staff is marred by a lack of mutual respect and trust, perpetual infighting, bullying of staff, and plummeting morale.
- **Diversion of staff time and effort into useless paperwork.** Complying with centralised accountability requirements has produced more wasteful layers of bureaucracy and channelled further resources into administrative positions at the expense of delivering consumer-oriented, patient-centred care. This has led to gaming and fraud—with hospital data being manipulated to appear to reach politically mandated benchmarks.
- **Distortion of policy and funding outcomes based on special pleading and political influence rather than clinical need and patient demand.** Bed numbers

have been cut to fund the expansion of elective services. Policymaking has also been captured by bureaucracies and select public sector interest groups that (a) exert strong influence over governments keen to further the interests of political allies; and (b) result in taxpayer dollars being thrown at reforms that fail to address either the technical or systemic root causes of the crisis.

The systemic problems that plague public hospitals across the country are experienced by all bureaucratically run, government-owned and -operated agencies that receive block funding from taxpayers and cannot go bankrupt regardless of how poorly they perform. Normal market incentives that apply in private enterprises do not apply to public hospitals. As monopolistic providers of publicly funded hospital care, public hospitals are shielded from competition. They have no real incentive to improve efficiency, increase productivity, allocate resources efficiently, and respond to the needs of patients. Rather than seek to maximise service delivery at the lowest possible cost, public hospitals instead focus on enforcing budget limits by closing beds or shutting down entire hospitals or restricting elective surgeries. Service delivery is also crowded out by a growing bureaucracy. Costs rise and productivity plummets despite an increasing demand for services. It is the ‘customers’ of the public hospital system who ultimately suffer as queues for treatment grow longer.²⁹

Policy challenges

The challenge confronting policymakers is to rise above the white noise of the highly politicised debate surrounding the hospital crisis. Few policy issues are subject to as many confusing claims as hospitals. These claims and counter claims must be untangled and rigorously scrutinised to accurately assess and understand the problems. Policymakers must be wary of the flawed arguments employed, all too successfully, to deny and avoid the truth that hospital overcrowding is caused by excessive bed cuts and bed shortages.

These claims fall into three basic categories:

- Bed numbers in Australia are ‘internationally comparable.’
- Bed cuts have not gone too far because hospital bed numbers in Australia are less important owing to falling length of stay and rising day surgeries.
- More beds are unnecessary and alternative models of primary care and chronic disease care can substitute for beds.

These routine and untrue claims are not evidence based and obscure the real problems. They are based on highly flawed and outdated central planning assumptions and represent the policy outcomes preferred by politically cosseted and influential health bureaucrats and select public sector provider groups. The community health sector and nursing unions, supported by public health lobbyists and academics, exert substantial and misleading political influence over the policy debate even though they have little genuine knowledge or interest in the real problems in hospitals.

The expansion of the health bureaucracy has been sustained by drawing resources away from hospitals and holding down bed numbers. Bureaucrats have a vested interest in the status quo, which is why they protest loudly about beds being 'less important' and promote policies that involve new funding for so-called solutions that fall well short of extra staffed beds. These policies will only waste further resources while protecting the bureaucracy's share of the public purse and control over hospital planning.

Policymakers should be equally wary of provider groups seeking greater government funding for their health silos. Because policy and funding decisions are a highly politicised process, the most coherent, vocal and politically active health lobby groups pursue their own agendas under the rubric of solving the hospital crisis. The community health sector has been remarkably successful in promoting its preferred policy agenda and in convincing governments that greater spending on prevention, primary care, and chronic disease care will alleviate the pressure on hospitals. The squeakiest wheels have received the policy grease.

By contrast, emergency doctors and nurses and other hospital-based clinicians with an interest in bed provision are but one small provider group competing for government funding amongst a myriad of competing groups. Lacking political clout and the ability to lobby effectively for adequate bed numbers, they have been unable to convince health authorities to properly resource hospitals. As a result, beds have been cut to a level far below the bare minimum, and there is no institutional will at both the bureaucratic and political level to rebuild the bed base despite the deleterious impact on the standard of patient care.

The Labor state governments have been in power for most of the last decade and are complicit in the process. Unwilling to stare down the vested interests of political allies or overcome the institutional obstacles to opening more beds, they have instead caved in to special interests. Bed-phobic governments, state and federal alike, argue that opening more beds is unnecessary and tailor their health policy to suit more influential groups within the public health system at the expense of emergency staff and patients. As a result, politically convenient myths and misconceptions concerning the alleged causes and cures for the hospital crisis have become conventional policy wisdom at both state and federal levels. This includes perhaps the biggest myth of the policy debate: the erroneous idea that the state-run public hospitals are swamped by GP-style patients and are overcrowded due to a national shortage of Commonwealth-funded Medicare bulk-billed GP services.

It's all about beds, beds, and lack of beds

The key statistic is the number of *acute* hospital beds per 1,000 population. This is the figure used to determine and allocate the optimum number of beds in a geographic region. In Australia in the 1960s, 1970s and early 1980s, hospital beds averaged between 6 and 6.5 per 1,000. In 1983, there were 6.2 beds per 1,000. By 1990,

the number of beds had fallen to 4.8 per 1,000. Since 2000, bed numbers have plateaued at around 4 beds per 1,000. In 1983, there were 94,000 beds in total, with 74,000 beds in public hospitals. In 2007–08, Australia had 84,235 beds. Private hospital beds had increased to 27,768. Public hospital beds have been cut by one-third in the last 25 years. Between 1995 and 2006 alone, total bed numbers fell by 3.2% and by 11% per 1,000 population. The fall was entirely due to an 18% reduction in public beds.³⁰ The reduction in bed numbers is bigger than it seems taking population growth into account—a 60% fall from 4.8 public acute beds per 1,000 in 1983 to around 2.5 per 1,000 today. The number of public acute beds troughed at 49,004 in 2001–02, and has since increased to 54,137 in 2007–08. This represents an increase of just 0.04 beds per 1,000 from 2.51 beds to 2.55.

Since the mid-1980s, government policy in all states has been to cut bed numbers. Entire wards once filled with beds, patients and nurses are now closed and padlocked. Wards have also been converted into offices for state health and hospital administration—the ‘close a ward, open an office’ syndrome.

The dramatic reduction in public hospital beds was not due to population increasing and bed numbers holding steady. The real reasons for bed cuts include:

- **Technological advances and changes in clinical practice.** Innovations such as less invasive key-hole surgery and growing numbers of day surgeries have achieved dramatic falls in length of stay in the last 20 years—from an average stay of seven days in the mid-1980s to fewer than four by the end of the 1990s. Bed cuts were initiated and initially justified by falling length of stays.
- **Rapid development of an array of specialist procedures.** The increasing cost of more sophisticated hospital care and procedural equipment encouraged health departments to cut bed numbers (to cannibalise existing ‘old fashioned’ services) to control costs and fund other services.
- **The growth and growth of day surgery.** Together with the steady decline in the percentage of the population with private health insurance, the rising number of procedures that could be provided on a day-only basis created a nightmare scenario for budget-conscious governments. The costs associated with every hospital admission are concentrated in the first day or days of treatment. Reductions in length of stay therefore yielded a relatively small saving. Had bed numbers remained stable, the capacity to treat more patients for more conditions in a shorter time would have led to a cost explosion.
- **Fundamental distrust of doctors by budget-enforcing managers also influenced the drive to close beds.** Managers feared that if beds were plentiful, doctors would abuse the situation and bankrupt the health system by employing loose admission and discharge practices. The alternative path to efficiency—managers actually managing and monitoring and enforcing admission and length of stay standards—has been eschewed in favour of cutting bed numbers to the bone.

The shift from hospital-based to university-based nurse training and the withdrawal of trainee nurses from the wards in the 1980s also made cuts in bed numbers possible and desirable. These cuts helped obscure the now gaping nurse shortage: increasing numbers of tertiary educated nurses are moving out of bed-based nursing to out of nursing altogether or into positions in community health services and the health bureaucracy. The shortage of hands-on nurses prepared to work in hospital wards complicates the task of opening new beds. The heavily unionised and politically powerful nursing profession opposes more beds and prefers investing in prevention and community-based care to avoid forcing nurses back into the wards and do the jobs many university trained nurses no longer wish to do.³¹

The rise of big government health

The overarching factor was the Hawke government's decision to create Medicare (Australia's universal taxpayer-funded health care system) and the consequent impact on the quantity and quality of hospital care received by Australians. Prior to 1984, only the less-well off received treatment in a public hospital without charge, while those who could provide for themselves were expected to join a health fund to cover their hospital bills. The introduction of Medicare entitled all Australians to receive bulk-billed GP consultations on demand, heavily subsidised pharmaceutical medications according to need, and 'free' public hospital care at point of access—inviting unlimited demand. Very quickly, many formerly self-reliant people dropped their health fund membership, and state governments were forced to bear the cost of the 'free' care promised by the Commonwealth. The states' predictable response was to control spending by cutting beds. Establishing centralised health bureaucracies made it easier for governments to implement bed cuts without politically embarrassing confrontations with summarily abolished local hospital boards. Bed cuts enabled public hospital care to be rationed and made lengthy waiting lists for elective surgery the norm.

The need to contain the cost of a 'free' health system explains why governments remain bed-phobic and are determined to hold down bed numbers despite rising demand and chronic emergency access block. Tightly capping global hospital budgets and restricting the supply of service is the surest way for government to control the cost of expensive hospital care. Cutting beds is the point in the system where real cost controls can be imposed. Each additional bed represents a huge potential cost, especially on the elective side of demand for hospital care, which is why governments prefer to latch on to flawed solutions that don't involve opening more beds.

Supporters of Medicare, including bureaucrats, academics and politicians, are understandably reluctant to draw attention to the shortage of hospital beds and the extent to which government is failing to provide 'free' hospital care. They do not want to admit that the hospital crisis is the long-term result of a deliberate strategy to cut beds, ration services, and control frontline costs. Nor do they not want the public to realise how the massive government expansion into the health sector has squandered

resources on costly bureaucracy and led to fewer and fewer health dollars out of ever-increasing health budgets reaching the frontline.

Hospital planning

The official rationale for establishing centralised health bureaucracies was that region-based administration at arm's length from local interest and political considerations was essential to create a properly networked hospital system. The thinking was that only impartial bureaucrats—as opposed to local boards—could judiciously cut bed numbers, close hospitals, and make wise funding decisions regarding new, high-tech and expensive medical technologies to avoid over-servicing and prevent duplication and waste.

Australia's large and costly health bureaucracies are supposed to operate as planning agencies responsible for identifying strategic needs and coordinating service provision. The idea that they are skilled at allocating resources efficiently is belied by the reality of public hospital overcrowding.

Initially, falling length of stays, increasing numbers of day surgeries, and the delayed impact of population ageing (see below) masked the effect of justifiable bed cuts without reducing levels of service. The efficiency gains offset increases in day separations and demand for admission, and allowed hospitals to treat increased numbers of patients with fewer beds.³² Cutting bed numbers appeared to simultaneously improve services and lower costs.

Though reasonable at first, these assumptions have unravelled since overcrowding first became a major problem in the late-1990s. Admissions are currently growing by over 4% a year. This is twice as fast as population growth and attributable to the severity of illness experienced by an ageing population. Due to excessive bed cuts, instead of rationing care based on relative need, the queue for 'free' hospital treatment now starts in and outside of emergency departments in the form of unacceptable delays in emergency assessment and admission, especially of frail and elderly patients.

Health bureaucrats and hospital planners routinely claim that Australia has an adequate and internationally comparable number of hospital beds in line with the OECD average. (This is the meta-myth of the policy debate concerning the hospital crisis.) The Garling report took the NSW Health Department at its word and dismissed the issue of bed numbers in a single sentence. The report claimed NSW hospitals were world class because the number of beds per 1,000 population was close to the top four or five OECD countries.³³

The OECD average is four beds per 1,000 population. Official bed numbers tabulated by the Australian Institute of Health and Welfare appear to show that Australia has an equivalent number of beds—3.9 beds per 1,000.³⁴ This is misleading. *Public* acute bed resources are only two-thirds of the OECD average and well below international par in every state. (See table below)

Of the total number of beds, 2.6 per 1,000 are public hospital beds (including psychiatric beds). Private hospitals contribute 1.3 beds—33% of the national total. Including private beds in the national count hides the lack of bed capacity in the public hospital system. It also ignores the artificial barriers that prevent efficient use of private hospital beds and prevent public health funding from following patients to private hospitals. The majority of patients who present at public hospital emergency departments cannot be admitted to private beds. These beds are either occupied for privately funded elective surgery or are located in private hospitals, which are not equipped to deal with emergency cases. Due to rapid growth in day surgeries, many private beds are often under-utilised (used mostly for procedural patients during the day) or are unoccupied (mostly overnight). But in relation to public hospital overcrowding, the vast majority of private hospital beds do not make up for the shortage of public acute beds. Outside of specific contractual arrangements, most private beds cannot be used to provide care for publicly funded elective patients.

Table 1: Public acute beds per 1,000 population* 2007–08—by state and territory

State or Territory	Public acute beds per 1,000 population	Available beds per 1,000 population—major cities
New South Wales	2.7	2.7
Victoria	2.4	2.4
Queensland	2.4	2.3
South Australia	3.0	2.8
Western Australia	2.4	2.6
Tasmania	2.4	n.a.
Australian Capital Territory	2.5	2.6
Northern Territory	2.8	n.a.
Australia	2.5	2.5

Source: AIHW, *Australian Hospital Statistics 2007–08*.³⁵

* Excluding psychiatric beds.

A generous estimate is that around 0.2 beds per thousand in private hospitals may at any one time be occupied by acute cases (that is, patients admitted through private emergency departments or patients with private insurance transferred from public hospitals). Only 10% of all admissions identified as emergency admissions occurred in private hospitals in 2005–06. At best, this means that on average there are just 2.7 acute beds per 1,000 in Australia, which ranks at the bottom end of the OECD spectrum.³⁶

To appear to bring bed numbers up to the OECD average, bed planners count private bed numbers and allocate public beds accordingly. Public hospital funding is generally allocated on a regional basis based on population. But as the *Sydney Morning Herald* reported in October 2007, the NSW Health Department employs a secret ‘redistribution formula.’ Regions with high levels of private health insurance and private hospital beds receive less funding and have fewer public hospital beds.³⁷ This is a formula for disaster.

Overcrowding is especially critical where private bed numbers are the highest, for example, on the North Shore of Sydney. In September 2007, the hospital crisis attracted national attention. Jana Horska miscarried in the emergency department toilets at the Royal North Shore Hospital. Under intense media pressure, the NSW government hastily convened an inquiry into the Third World standard of public hospital care. The inquiry made no finding on the crucial issue—the unavailability of acute care hospital beds.³⁸ The issue was ignored despite the fact:

the sole reason that Ms Horska miscarried in the toilets was because the hospital was full to capacity and no bed was available ... At the time ... there were 46 patients in the ED, with all beds occupied, and 16 admitted patients waiting to go to the ward.³⁹

Are bed numbers ‘less important’?

Public hospital bed planning is, to say the least, an imprecise science because of the problems of imperfect knowledge that plague all exercises in top-down central planning. Estimating the required number of beds (establishing bed norms) must take into account a range of variable and often difficult-to-calculate factors such as the demographic and disease patterns that influence patient demand and characteristics. The former is easier to gauge. The latter is much more difficult to calculate in the absence of comprehensive epidemiological data.

Bed planning therefore tends to be based on limited knowledge rather than evidence or outcomes. Bed numbers are often deemed adequate by relying on unquestioned assumptions about usage and the adequacy of alternative models of care. These assumptions invariably reflect preferred policy outcomes and systemic dysfunctions—such as the need to ration hospital services and funnel resources

into paying for useless bureaucracy.⁴⁰ Regardless of the reality that in recent years, ‘the actual trend has been towards higher demand for inpatient beds,⁴¹ the orthodox position among planners is still that total bed numbers, together with the concept of available beds, is increasingly ‘less important.’⁴² The erroneous assumption remains that bed cuts have not been excessive because demand for hospital beds will continue to fall and the hospitals of the future will focus on procedures. Further reductions in the average length of stay will be generated by technical innovations, rising numbers of same-day only admissions, and by less need for overnight and multi-stay admissions. The resulting efficiencies will make up for rising demand and allow hospitals to treat more patients with fewer and fewer beds.

Whether hospital beds are less important depends on case-mix, which refers to the range of patients cared for, the proportion of procedures or surgery undertaken, and the overall nature of the care and treatment provided.

Hospitals with a higher proportion of procedural and same-day patients benefit more from rising day surgeries and falling length of stays than hospitals with a higher proportion of non-procedural and multi-day-staying patients. In 2006–07, the average length of stay was 2.5 days in private hospitals compared to 3.6 days in public hospitals. Private hospitals had a higher proportion of same-day procedural separations (66.9%) compared to public hospitals (54.2%).

In 2006–07, one-fourth of public hospital separations involved no procedure at all compared to just 7% in private hospitals. This reflected the fact that 73% of public acute separations were associated with medical (non-surgical) Diagnosis Related Group (DRG) categories compared to just 38% of private hospital separations. By contrast, surgical DRGs accounted for 20% of public separations compared to 41% of private separations. Since 2002, medical DRGs have been growing at double the rate of surgical DRGs in public hospitals.⁴³ Sixty-seven percent of patients admitted to public hospitals receive acute medical care compared to just 18% requiring surgery.⁴⁴

In isolation, the figures that show rising same-day admissions and falling length of stays do not consider total demand against total bed capacity. Nor do they consider the critical relationship between rising demand, reduced bed numbers, increased bed occupancy rates, and hospital overcrowding.

More day surgeries can take the pressure off hospitals if growth in same-day admissions substitutes inpatient admissions for patients who once had to stay overnight. Yet a substantial proportion of the growth in day surgery has been and continues to be generated by new technology stimulating new demand for elective procedures. As a result, day surgery takes up beds rather than replacing and reducing multi-stay demand.⁴⁵

Same-day separations in Australian public hospitals have increased steadily since 1996. Overnight and multi-day separations (which fell only slightly in the late 1990s) have increased by 12% since 2002, in line with increasing demand for hospital

care associated with an ageing population. Average length of stay with same-day separations excluded is 6.2 days in public hospitals. This has remained relatively stable over the last decade, falling by less than 5%, a result that is also attributable to the impact of population ageing.

The idea that rising day surgeries make up for rising demand also overlooks the fact that public hospitals need free beds around the clock for unplanned emergency admissions. Because of beds being occupied by procedural day patients, many emergency patients are forced to wait longer than eight hours for a ward bed. Increasing numbers of same-day separations thereby contribute to hospital overcrowding.

This problem has been intensified by rising demand for day surgery and ever-increasing political pressure plus financial incentives to cut long and politically sensitive elective waiting times. Hospital managers have been encouraged to both cut bed numbers and run hospitals at maximum efficiency, or at least at maximum capacity, to maximise elective surgery. Running hospitals at full throttle has proceeded to the point that major Australian public hospitals routinely operate above 100% occupancy. Endemic access block is the inevitable outcome in hospitals with zero spare bed capacity.

If bed numbers were less important, and if cuts to bed numbers were an efficiency dividend reflecting surplus capacity and reduced need and usage, then there should be no hospital overcrowding. In fact, falling lengths of stay have not offset bed cuts nor made up for rising demand. Demand for bed-based hospital care—measured by hospital occupancy rates and endemic emergency access block—has clearly outstripped the supply of acute beds.

Delayed demand[†]

Some analysts still claim hospital bed numbers are less important despite demographic change. They maintain that the ageing of the population has not been associated with an increase in the proportion of hospital beds used by older patients and that the demand for hospital beds has decreased because the elderly population is healthier. This claim relies on a trick in the hospital usage statistics. When carefully examined, these statistics demonstrate why bed cuts have gone too far and more beds are needed.

In the 1990s, demand for hospital beds remained static in the over 65 demographic. Bed usage by those aged 65–74 fell by 6%. The proportion of bed days in this age-group declined from 18% to 16%. One-off falls in demand among healthier people aged 65–74, together with reduced lengths of stay for elderly procedural patients, helped to temporarily mask the effects of bed cuts. But between 1993 and 2001, the population

[†] I acknowledge my debt to Dr Paul Cunningham, who drew my attention to the concepts of 'deferred illness,' 'delayed demand,' and the 'success of prevention' and their significance for the future of hospitals and the health system.

aged over 75 increased by 36%. Hospital separations in this demographic increased by 89%. Bed utilisation—or number of days in hospital—rose by 23%. Growth in separations in the over 75 age group accounted for the entire growth in separation of people aged over 65, with multi-day separations increasing by 42%.⁴⁶

These figures strongly suggest that demand for hospital care from people aged over 65 has been delayed or deferred for 10 years or so until people reach 75 and beyond. The ‘deferred illness’ and ‘delayed demand’ for hospital care started appearing in public hospitals in the late-1990s, contributing to the emergence of serious overcrowding as increasing numbers of ‘very old’ patients requiring care in emergency departments.

Public health and community health lobbyists claim the problems in hospitals are due to government policy focusing too much on hospitals rather than prevention.⁴⁷ Even hard-headed commentators have been seduced by the wellness model of health care to promote health, reduce health costs and—in the words of the federal health minister—‘keep people well and out of hospital.’⁴⁸

Average life spans have increased dramatically in the last 40 years due to better prevention. Healthier lifestyles and more effective medications have resulted in significant falls in rates of heart attacks and strokes.⁴⁹ People who once would have entered hospitals and died while in their 50s and 60s now live longer and eventually become users of emergency departments and consumers of acute public hospital beds when they are older and sicker. These frail and ‘very old’ patients aged 75 years and over suffer from chronic conditions in association with other co-morbidities and experience multi-system failures that are complex and time-consuming to diagnose and treat. They are ‘frequent flyers’ in emergency departments and often require unplanned admission to inpatient beds.⁵⁰

Struggling public hospitals are already bearing the brunt of the inexorable ageing of the population. Between 2004 and 2007, the number of patients presenting at emergency departments with medical problems requiring unplanned admission increased by 15%.⁵¹ Total public acute beds per 1,000 now number roughly the same as in 1996. Public hospital activity—measured by total patient days—has increased by over 10% in a decade. Putting this another way, while bed numbers increased by less than 0.02% since 1997, between 1998–99 and 2007, public hospital admissions increased faster than population growth by nearly 16%, and there has been a ‘strong upward trend nationally since 2000–01.’ The rise in admissions is ‘mainly accounted for by an increase in acute medical care admissions,’ which increased by 23% since 1998, and by 7% alone since 2004–05.⁵²

The growth in admissions reflects the increase in demand among ‘very old’ patients. In the last five years, separations in public hospitals by patients aged 75–84 and 85 and over have increased by 25%.⁵³ Patients in these age groups accounted for 20% of separations in 2007–08.⁵⁴ Patients aged 75 and over accounted for 14% of separations in 1996–97. A decade ago, the over 85 demographic was not even separately distinguished in the statistics.⁵⁵

The reality is that better prevention, combined with improved medical treatment of elderly patients with complex conditions, is enabling increasing numbers of Australians to live to older and sicker ages. The illnesses these patients experience, and their need for hospital treatment, is being deferred to later stages of life—adding to the pressure on overcrowded public hospitals. In an ageing Australia, an increasing proportion of the population will be aged over 75. Increasing numbers of ‘very old’ patients are inevitably going to fall acutely ill and require admission to hospital. This patient group will be *the hospital patients of the twenty-first century*.

Hospitals are facing an unprecedented tsunami of (delayed) demand for unplanned admission and bed-based medical and nursing care from ‘very old’ patients. The problem is not that there has been too much focus on hospitals and not enough on prevention. Higher spending on supposed ‘wellness’ promoting preventive health measures is the wrong priority for an ageing Australia. Overcrowded public hospitals need more beds to provide timely care for increasing numbers of older and sicker patients who require hospital care *due to the success of prevention*.

The myth of GP-style patients

State Labor governments blame the hospital crisis on the idea that public hospitals are swamped by GP-style patients⁵⁶ and the (Howard) federal government’s alleged failure to provide sufficient Commonwealth-funded GP services, particularly after-hours care.⁵⁷

The conventional policy wisdom that hospital overcrowding is caused by patients seeking primary care at emergency departments is a myth. So is the ‘fact’ that public hospitals are swamped by patients classified ATS 4 semi-urgent and ATS 5 non-urgent under the Australasian Triage Scale, who, in the words of federal Health Minister Nicola Roxon, are a ‘proxy of primary care patients.’⁵⁸

The Minister has also stated that ‘a significant issue when we talk about blocks’ is so-called elderly, chronic disease patients: emergency staff are forced to spend time with too many elderly patients suffering complex illness, who are classified ATS 4 and ATS 5, and who could be seen and have their conditions better managed in primary care settings.⁵⁹

The reasoning is that rising numbers of high-risk, frail and elderly patients with complex, chronic illnesses are being admitted to hospitals because of gaps in the primary care system. Inadequate management of their multiple conditions at home or in the community is failing to prevent the onset of acute illness and the need for hospitalisation. The policy implication—endorsed at the highest levels inside the health bureaucracies—is that ‘more beds’ are not only (allegedly) unaffordable but also unnecessary (an ‘inappropriate investment’⁶⁰) and will lock in inappropriate and unsustainable traditional modes of hospital-based services. Alternative or new models of community-based care—hospitals at home and coordinated care schemes—can

be substituted for beds for the growing group of ‘very old’ patients who allegedly would be better treated outside hospitals rather than in a hospital bed.⁶¹

These claims are highly problematic. There is no stand-alone data showing how many true primary care patients are treated in emergency departments. The claim that elderly chronic disease patients who could be treated by GPs are using emergency departments to access primary care for ongoing conditions is based on anecdotal reports.⁶²

Despite the lack of evidence, these claims have created much confusion about the causes and cures of the hospital crisis.⁶³ John Menadue, an experienced ex-Commonwealth bureaucrat and prominent advocate for boosting primary care and community health, claims that ‘*unplanned admissions* pouring in through emergency departments ... is caused by a major problem in another part of the “system”—the collapse of practice at night, weekends, in outer suburban and rural areas.’⁶⁴ Bulk-billing after-hours GP clinics near or co-located with public hospitals, or primary care or medical assessment units, are therefore recommended to solve the hospital crisis. The claim is that GP clinics will ease overcrowding and reduce so-called unnecessary emergency presentations by GP-style ATS 4 and ATS 5 and elderly chronic disease patients who allegedly do not require specialist assessment in an emergency department.⁶⁵

These policy prescriptions require close scrutiny because they are refuted by the evidence readily available in the Australian and international literature on access block. When an expert panel was convened to examine overcrowding in Canadian public hospitals, access to primary care services was the first cause eliminated. This was because the ‘types of ED patients leading to overcrowding are those who would be referred to the ED even if alternate sources of primary care are available (e.g. those with chest pain).’⁶⁶

A number of studies have also revealed that GP-style (or low acuity) patients, who have a cold or a headache or a sore toe, are cheaply and quickly treated once they are seen by emergency staff or diverted to appropriate services as per established protocols. Low acuity patients have been found to constitute between 10 and 15% of emergency presentations. These patients also account for only a fraction, 2% to 3%, of the emergency workload, and for less than 10% of emergency costs. Because GP-style patients are few and far between—around 10 patients per day and no more than one per hour—the provision of costly alternative GP services is estimated to reduce total emergency presentations and costs by no more than 2%.⁶⁷ Where co-locating extended hours and bulk-billing GP clinics have been trialled, the effect at best has been ‘an average reduction in attendances of one patient every two hours while the clinics are open.’⁶⁸

It stands to reason that streaming GP patients away from emergency to alternative primary care services does not alleviate overcrowding. ‘Vertical’ patients—who can sit or stand in a waiting room, who are not so sick they need to lie down, and who

attend emergency departments although they could be seen by a GP—do not cause overcrowding by definition. This is because a GP-style patient (contra John Menadue) is never an unplanned admission. It is ‘horizontal’ patients—those who are so sick they need to lie down in a treatment cubicle, on trolleys in corridors, or in ambulances queued up or circling outside, and need to be admitted to a hospital bed—who cause (or rather contribute to) overcrowding.

It is impossible to treat ‘horizontal’ patients in a GP clinic. There are no alternative care settings for patients who need to be admitted, are acutely ill, and require the specialised assessment, equipment, and facilities that are only available in acute hospitals.⁶⁹ In other words, overcrowding is caused by a genuine demand for emergency admission by patients who cannot be treated anywhere other than in a hospital.

Yet according to the federal health minister, public hospitals are overcrowded because over 40% of emergency presentations are by proxy primary care patients in triage categories ATS 4 and ATS 5.⁷⁰ The basis for this claim is a flawed study of the key drivers of emergency demand in NSW hospitals, which was prepared for NSW Health in collaboration with other state health departments. The report found that the root cause of overcrowding was that ATS 4 and ATS 5 primary care type patients consistently made up 44% of emergency presentations. Highly inaccurate criteria were used to identify proxy GP patients who could ‘potentially be treated in a primary care environment.’[‡]

By contrast, the leading and unrefuted Australian study used far more robust and accurate criteria to identify true GP patients and accurately measure so-called demand transfer from primary care:

- ATS 4 or ATS 5; AND self-referred; AND
- Did not arrive by ambulance; AND
- Presented between 0800 and 2400; AND

[‡] The extremely broad and flawed criteria to identify potential GP patients even included patients referred by a GP to the emergency department. The other criteria were:

- patients who were classified as triage categories T4 (semi-urgent: within 60 minutes) or T5 (non-urgent: within 120 minutes) under the Australasian Triage Scale.
- who did not arrive by emergency vehicle.
- who were not admitted to the wards.

The report also failed to specify whether the patients identified were actually GP patients. It also predetermined the report’s conclusion by identifying as potential GP patients those who made repeat presentations for the same conditions based on anecdotal reports that these were ‘chronic disease’ patients who could be treated by GPs and were using emergency departments to access primary care for ongoing conditions.

- Treatment time (time seen by doctor to time ready for discharge) less than 60 minutes; AND
- Subsequently discharged from the emergency department.

This study by the NSW Faculty of the Australasian College for Emergency Medicine forensically analysed the patient data generated by the NSW Health Emergency Department Information System (EDIS).⁷¹ Just 10% of presentations were identified as potential GP-style patients.⁷² Most ATS 4 and ATS 5 patients were also found to have been referred to emergency departments by GPs. And most of these patients presented during business hours when GPs were available. Hospitals that were not located near after-hours GP clinics were also found to have similar numbers of ATS 4 and ATS 5 patients as hospitals located near such clinics. Most importantly, the complexities of these patients and the workload they generate were accurately assessed. The study found ATS 4 and ATS 5 patients consumed up to four and two times more clinician time respectively than the average GP encounter.

ATS 4 and ATS 5 patients were also found to be admitted at a rate of up to 20% and 10% respectively compared with an admission rate of just 1% in general practice. What the admission rate data demonstrates is that ATS categories rank emergency patients in order of urgency, which is not the same thing as the severity and complexity of illnesses. A lower ATS 4 and ATS 5 rank means it may be safe for patients to wait an hour or two while more urgent cases are attended. But it does not mean, and was never intended to mean, that less urgent patients could be seen by a GP. It does not mean that only ATS 1, 2 and 3 patients who need treatment within 30 minutes should be seen in emergency departments. Nor does it mean that 'if it is all right for you to wait for an hour or more to be seen in an emergency department then you probably didn't need to be seen by an emergency specialist.'⁷³ The condition of many ATS 4 and ATS 5 patients may be serious. A frail and elderly patient (a so-called chronic disease patient)—who is suffering an underlying condition that is difficult and time-consuming to diagnose and treat, who needs to be assessed by experienced and highly trained emergency specialists, and who needs to be admitted—would be coded ATS 4 and could never be treated in a GP clinic. For example:

A person who comes in as triage category four who has a slight temperature and is 80 years old and then ends up in the ICU because of what seemed like an insignificant illness is actually quite seriously ill and dies two days later ... Anyone who's been a director of an emergency department knows that [this] group of people are the ones [at] the greatest risk for misdiagnosis, and although they are a low triage category does not mean they don't have serious problems that require an expert to review them.⁷⁴

Why beds, rather than the alternatives, matter

The notion the hospital crisis is caused by gaps in the federal primary care system, and can be fixed by improving the quantity and quality of the Commonwealth-funded community-based services, has gained policy traction at the national level. The centrepiece of the Labor federal government's plan to take pressure off public hospitals and create a 'less hospital-focused' health system is a 300-strong national network of GP Super Clinics. These Super Clinics are designed to provide all-hours GP services for GP-style patients and coordinated primary care for elderly chronic disease patients.⁷⁵ Unfortunately, the government's misguided and wrongheaded Super Clinics policy blames the hospital crisis on the wrong problems and ignores the evidence and everyday realities in public hospital emergency departments.

The Super Clinics policy is based on the alleged benefits of coordinated care (also called 'managed care' or 'chronic disease management'). Coordinated care involves a GP or a nurse practitioner monitoring the condition and managing the care of chronically ill and elderly patients. The highly questionable assumption of the proponents of coordinated care is that ensuring patients receive all available care from a wide variety of allied health providers will prevent conditions from deteriorating to the point these patients require urgent, unplanned, and potentially avoidable admission into hospitals.⁷⁶

The evidence that alternative models of community-based coordinated primary care can substitute for hospital beds and hospital care, especially for elderly patients, and will alleviate the pressure on emergency departments is 'weak at best.'⁷⁷ Some studies indicate that schemes designed as substitutes in practice ended up complementing hospital care. They have resulted in increased hospital activity in the context of rising overall demand and bed cuts.⁷⁸

Survey articles suggest 'good evidence' that coordinated care of chronic disease patients reduces risk of emergency admission.⁷⁹ But this conclusion is primarily based on a trial in the early 1980s in the United States, which found that coordinating the primary care of patients aged over 65 resulted in a static hospital admission rate.⁸⁰ On this slender evidentiary basis rests the grand claim that large numbers of 'horizontal' acutely ill elderly patients can be more appropriately treated in alternative community-based settings.⁸¹

The results of the second round of the Australian Coordinated Care Trial suggest we should be sceptical about the effectiveness of alternative models of care in reducing hospital usage by 'very old' patients. One of the coordinated care programs studied as part of the trial, which was conducted in the northern suburbs of Melbourne, targeted the key demographic—frail and elderly patients aged 75 and over. Coordinating the care of a trial group of patients appears to have produced no significant reduction in hospital use compared to a control group who continued

to receive their usual level of care from their GP. Overall inpatient cost trends for intervention and control groups did not differ significantly once hospital admission data were adjusted for the much larger number of patients in the control group admitted for kidney dialysis compared to the intervention group. Intervention patients also had significantly higher hospital usage early in the trial. In fact, except for a three-month period, between nine and 12 months, during the 15-month trial, intervention patients had significantly higher use of inpatient hospital services at the beginning, the end, and throughout the trial on average than the control group.⁸²

The Final Report of the National Health and Hospital Reform Commission claimed that major government investment in alternative primary care services is justified because:

Almost 10 per cent of hospital stays are potentially preventable if timely and adequate non-hospital health care had been provided to patients with chronic conditions.⁸³

Yet a discussion paper by Leonie Segal prepared to inform the work of the commission found that ‘the evidence here is equivocal’:

Some success in small scale intervention trials is observed, but this is not necessarily translated into larger population based interventions. While reasons can be posited as to why the ‘expected reduction’ in hospital admission did not occur, it is plausible that high quality primary care may be additive to, rather than a replacement for hospital care.⁸⁴

One of the well-demonstrated effects of coordinated care is to uncover unmet needs and bring forward demand for hospital services. This is no bad thing and hardly an argument against coordinated care. But it does mean that rather than take the pressure off hospitals, coordinated care may well add to the pressure.⁸⁵

Other studies hint at other explanations for this outcome. Studies that have examined the use of emergency departments by elderly patients have, as expected, established that the elderly are frequent users of emergency departments. But they have also found that very few visits were avoidable since the vast majority were for high-intensity reasons. In other words, very few patients were found who could be diverted to allegedly more appropriate primary care.⁸⁶

On top of the high quality Commonwealth-funded GP services, a multiplicity of federal and state programs already exist in the community health sector to care for older patients with complex and chronic conditions. Medicare-funded GP Super Clinics will only add to the duplication.⁸⁷ Crucially, existing programs appear to be working well. As a result of the community-based care the elderly are already receiving, ‘patients are entering high dependency residential aged care facilities later than

previously.’ However, residents are entering these facilities sicker than in the past. They are, therefore, more likely to need referrals to hospitals, and are almost always true emergency cases requiring admission to a ward bed.⁸⁸

The problem is not that elderly chronic disease patients are not receiving appropriate primary care but that more effective community-based care is leading to greater demand for hospital care for reasons that ‘seem unavoidable.’⁸⁹ This identifies a major flaw in the alternative models of care approach. It is simply not possible to endlessly prevent the need for ‘very old’ patients to be admitted to hospitals.⁹⁰ As people live longer due to more effective prevention, they develop conditions the onset of which are linked to genetic and hereditary factors, which tend to deteriorate with age until inpatient admission becomes inevitable.⁹¹ Put another way, ‘morbidity of chronic illness occurring later in life will still mean the patient requires hospital care, though at a later stage in life.’⁹²

This is supported by experienced emergency staff, who report rarely treating elderly patients whose admission could have been prevented by better primary care.⁹³ A new situation is developing in hospitals. Older patients are no longer being admitted solely for ‘end of life’ care. Instead, they are frequent and repeat visitors. They fall ill, are admitted, and receive acute medical treatment plus traditional overnight bed-based care. They recover, leave and come back again when their conditions decline.⁹⁴ It is complex older and sicker patients who now generate the greatest and most complex emergency workload, consume the bulk of staff attention, and slow the assessment of new patients.⁹⁵ Various studies show that access block is highly associated with acuity of condition, with patients who arrive by ambulance, and with increases in the age of patients.⁹⁶ Not surprisingly, older patients are disproportionately represented in emergency presentations. They are admitted at double the rate compared to younger patients, and have more frequent and longer stays in beds.⁹⁷

The key policy point is that trying to provide alternative care to contain rather than meet the growing need for hospital care generated by elderly patients is a futile strategy. At some point, older and sicker people need to go hospitals to access the acute care—specialist assessment, modern diagnostic, therapeutic, and procedural equipment, *and* bed-based medical and nursing care—that is only available in a hospital. If this is correct, then greater government spending on alternatives to hospital care for very old patients is no short- or long-term alternative. The quality of hospital care Australians of all ages will receive will depend on whether Australia has a hospital sector equipped to meet the demand for the bed-based care that its ageing population will inevitably require. Based on the experience of the last 25 years, there is good reason to think this will not happen unless public hospitals are rid of the systemic problems that have created the crisis.

Funding, structural and administrative reform

The comprehensive funding, structural and administrative reforms outlined in the Introduction to this book are the only cure for the systemic problem in public hospitals. Market-based reform is overdue to force autonomous service providers to respond appropriately to market signals and efficiently expand the supply of hospital care to meet demand. The demand and supply side of public hospital care must be liberalised so the means by which publicly funded hospital services are produced resembles a normal market as closely as possible.

Transforming public hospitals into the price and quality conscious, customer-oriented service providers requires a nationwide activity-based payment system that ties funding to patients. It also requires decentralising control of hospitals by re-establishing local hospital boards. Waste on bureaucracy that reduces productivity and leads to rationing and shortages must also be ended by abolishing the superfluous 'area' bureaucracies and downsizing the parasitic state health departments.

Direct funding on a case-by-case basis, in combination with the reestablishment of hospitals boards, will enable hospitals to regain their independence and respond appropriately to the health needs of the community. This will encourage not only technical efficiency (the delivery of hospital services for lower cost) but also enhance allocative efficiency. Doing away with population-based block funding and centralised control will realign the organisational and financial incentive structures. Local hospitals will have the operational freedom and authority to align resources with patient demand and end bed shortages.

Funding methods have been found to help direct health care services towards patient needs if the care delivered is appropriately remunerated. Existing funding arrangements (including case-mix funding) are biased towards elective procedures. Procedures are easier to cost and measure. Emergency and acute medical care are not only more labour and capital intensive but more costly, complex, time-consuming, and difficult to measure.⁹⁸ Case-mix funding therefore gives hospitals an incentive to operate at maximum capacity to maximise turnover of simpler elective patients at the expense of the emergency department rather than manage complex acute patients.⁹⁹ In Victoria, case-mix funding has resulted in the highest bed occupancy levels in the nation, while its access block is perhaps more serious than in other jurisdictions.¹⁰⁰

A central feature of market-based reform must be a transparent and rigorous case-mix voucher system that properly prices acute medical care to minimise the procedural bias in existing funding arrangements and remedy the underfunding of non-procedural services. Hospitals must be remunerated for each occasion of emergency care provided, and the case-mix cost of the acute care provided to sicker, more complex patients must be properly priced, including the full capital and labour costs. To directly address overcrowding and access block, hospitals providing emergency care will also be able to submit bids twice a year (to adjust for changes in 'winter' and

‘summer’ demand) for extra ‘bed vouchers.’ These extra ‘bed vouchers’ will pay for the fixed costs of an adequate supply of beds and appropriate levels of staff in specific regions to admit emergency patients.¹⁰¹ This system will be overseen by a national hospital funding authority, whose role will be to express demand for beds pegged and adjusted according to a demonstrated need for unplanned admission on a hospital-by-hospital basis. This will enable hospitals to have emergency and bed capacity on call during periods of low demand, operate at 85% occupancy, and secure the prompt unplanned admission of patients.¹⁰² The allocation of beds and the determination of bed numbers will be transformed into an open and accountable process and bypass the vested interests of bed-phobic central plan-bureaucracies. Local boards will also be responsible for their emergency department, and will have the operational authority and economic incentive to increase bed numbers.

A reasonable objection to market-based reform is that liberating the supply and demand for hospital care may prove enormously expensive. Governments will have to pay for all the demand that is currently unmet due to rationing. The goal is to reallocate the resources saved by slashing the bureaucracy and to pay for the frontline hospital services and hospital bed capacity. If, after the waste on bureaucracy is eliminated, the cost proves too expensive, then the nation will have to have a serious debate about cost sharing and the future of the fiction that is a ‘free’ health system. This is necessary anyway given the unsustainable inter-generational impact on future taxpayers and government budgets of the rising cost of medical technology and paying for the health care of an ageing population.¹⁰³

The overriding point, however, is that we cannot afford to continue with the status quo.

Centralist means for federalist ends

A further likely objection is the offence to strict federalism. States own and operate public hospitals, so state governments should be responsible for raising the revenue to fund them.

Over the last 25 years, public hospitals have been predominantly funded from taxes collected by the federal government and distributed to the states on a promise to provide ‘free’ hospital care. The states are not organic communities. Their borders represent the arbitrary lines drawn on the map by colonial officials in the nineteenth century. It makes no more sense to run hospitals in Broken Hill and Broome from Sydney and Perth than from Canberra.

It would be pointless for the federal government to take over the public hospital system and continue to employ the failed bureaucratic model of running and funding hospitals. Under the reforms proposed in this book, public hospitals will not remain the same old government monolith except run by a centralised command-and-control authority out of Canberra. The funding of public hospitals and other health

services would be centralised by the federal government, *but in order to achieve market-based reform of the way hospital services are produced*. In practice, federal principles will be satisfied but by centralist means, as control over hospitals will be restored to autonomous community boards, while health providers on the ground will have the incentives to deliver care in an efficient and consumer-centred manner.

This isn't a perfect constitutional arrangement. But it will deliver an outcome far superior to the status quo. We could wait and hope the state governments get around to reforming public hospitals. However, the public sector health unions are a powerful brake on reform, and entrenched institutional obstacles within the state health bureaucracies are equally difficult to overcome. At the November 2008 Council of Australian Governments (COAG) meeting, the states received a huge boost in Commonwealth funding from the Rudd government. In return, the Premiers agreed in principal to introduce a national system of activity-based hospital payment. However, the implementation of case-mix funding was put off until the never-never of 2013–14, despite the fact that the case-mix system was introduced in just five months in Victoria in the 1990s.¹⁰⁴ In April 2010, the Rudd government heralded the states signing up to its 'landmark' National Health and Hospitals Network Plan: in return for billions more in additional funding, the Premiers agreed to national activity-based funding!¹⁰⁵ This must be a record even for Australia's dysfunctional federation, with states twice being bribed by the Commonwealth to 'achieve' a sensible reform.

The states' intransigence over case-mix reinforces the need for real national leadership. The only alternative to throwing good money after bad and propping up poorly performing public hospitals is for the Commonwealth to use its financial muscle to leverage real reform.¹⁰⁶

Federalism demands that some issues be treated as properly federal. One dollar out of every 10 in the national economy is being spent on health services, and approximately 70% of all health expenditure is funded by taxpayers and controlled by government. The share of GDP spent on medical and hospital care will rise significantly as the impact of the ageing tsunami hits. The nation can no longer afford to allow one-third of its health dollars—more than \$30 billion per annum—to be locked up and wasted in the unproductive public hospital sector. Cost containment is important, but it should go without saying that scarce health funding must be spent optimally. There is a need beyond the normal public policy reasons for eliminating the systemic dysfunctions that cloud the future of our high cost and poor performing public hospital system. The most important issue is the quality of care that hospitals will be able to provide for all Australians. Comprehensive funding, structural and administrative reform will improve quality, increase efficiency, and enable Australians to receive more and better health care for each health dollar spent.

The politics of planning and market-based reform

The systemic problems at the heart of the hospital crisis highlight the high price the community pays for the so-called ‘free’ hospital care that government taxes us heavily to pay fund. Far less of the health care we all wish to access to lengthen and improve our lives is provided than is warranted by the billions of taxpayer dollars poured into the public hospital system—a poor return measured by the growth in bureaucracy against the spiralling expenditure and ever-lengthening waiting times for treatment. Every health dollar wasted on excessive bureaucracy is a dollar of health care the community forgoes—literally on a bed forgone for a sick patient to lie in.

Policymakers must address the hospital crisis in the same way they address all policy areas that involve costly and inefficient provision of government services. It is no revelation that government bureaucracies fail to efficiently allocate resources and are the least efficient way to provide public services, and the impact on the delivery of hospital services is especially dire. Nevertheless, far-reaching health reform is difficult to accomplish. The majority of voters remain attracted to the idea of ‘free’ hospital care irrespective of the litany of problems in public hospitals. This has politically quarantined public hospitals from structural reforms. The case for taxpayer-funded vouchers is well established in the field of education as a way to improve efficiency, quality and access to publicly funded services.¹⁰⁷ Less politically challenging policy options that instead tinker with clinical or bureaucratic structures at state and federal levels will not solve the hospital crisis. Ultimately, the ability of the Australian hospital system to cope with the impact of an ageing population depends on whether policymakers have the courage to undertake genuine reform.

We are going to need more beds to provide more bed-based medical care for an ageing population. A 50% increase in patients presenting at emergency aged over 85 is predicted over the next five years alone.¹⁰⁸ Policymakers must ensure that flexible financing and responsive administration arrangements are in place to significantly increase bed numbers and cope with rising demand.¹⁰⁹ Reforms that tie hospital funding to clinical need and patient demand, in combination with decentralised management by local hospital boards, will allow demand for hospital services to dictate the supply of hospital services according to the actual health needs of the community. Market-based reform will eliminate waste on excessive bureaucracy, promote productivity and, most importantly, enable money to follow patients to staffed beds at the frontlines. This is imperative considering how difficult it is for governments to get it right when they attempt to centrally plan for future demand. The assumptions employed to plan hospital services—by cutting beds as demand increased—have proved flawed and created the hospital crisis. The national health reform agenda is dominated by subterranean public sector interest group politics and new central planning assumptions that assume based on weak evidence that alternative community-based primary care can make up for bed shortages in the long run in an

ageing Australia. If top-down approaches are adopted (based on the presumption that governments know what mix of health services are required and can plan the circumstances in which they should be delivered), then politicians will ultimately have to bear the blame for continued shortages in the provision of hospital services. If hospitals remain in crisis, Members of Parliament can expect to receive a lot of complaints from a lot of angry relatives about the poor treatment received by grandparents and great-grandparents forced to wait for hours in emergency departments.

Conclusion

In the wake of the global financial crisis, there has been a reaction against market-based reform led by the committed enemies of the free-market. Most Australians, including politicians, are non-ideological. For better but usually worse, the vast majority of politicians see their job as using taxpayer dollars to provide the services that the community wants. Most Australians, like the people they elect to represent, are empirically minded. They are interested in what works and what doesn't. The average citizen, and perhaps most policymakers, may consider the systemic problems in public hospitals an abstract issue. Yet in their bones, both politicians and the people know that bureaucracies cannot deliver public services properly, even if they don't know how else to provide these services.

The hospital crisis illustrates this policy impasse. Public hospitals have been mismanaged on an epic scale. Taxpayer dollars have been channelled into useless bureaucracy at the expense of patient care. Critics of vouchers have already protested that this would 'unleash' the market on public hospitals.¹¹⁰ And so we should. The genius of markets is that they efficiently allocate resources to enable the most productive and efficient providers to deliver goods and services that consumers demand at the lowest cost and highest quality. Market-based reform will mean that if in the future there is greater demand for beds and bed-based care—based on clinical need as diagnosed by doctors—hospitals will be able to adjust to meet it. By dispensing with central planning and improving the responsiveness of the hospital system, far-reaching reform can improve access in the long run. If the demand is there, hospital vouchers will pay for beds and not for bureaucracies.

Hospitals provide essential services that the community is going to need more and more in coming decades. So essential are these services that government bureaucracies cannot continue to be allowed to run and ruin hospitals. To equip the hospital system to cope with an ageing population and provide quality care to all age groups, the tried and failed methods of running and ruining public hospitals must be abandoned and replaced by:

- Flexible voucher-based funding arrangements that allow money to follow patients according to clinical need.

- Localised administrative arrangements responsive to patient demand.
- An end to central planning and ‘command and control’ bureaucracy, and the closing down of the bureaucracies to open more beds.



Endnotes

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- ¹⁸ John Graham, 'Turning back the tide of errors,' *The Australian* (4 October 2007).
- ¹⁹ 'Statistical information on these services is not as highly developed as that on other services (such as hospitals) and there is no nationally agreed basis for describing the nature of the services or for measuring the amounts of service provided.' Australian Institute of Health and Welfare, *Australia's Health 2008*, Cat. No. AUS 99 (Canberra: AIHW, 2008), 342.
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- ²¹ Australian Institute of Health and Welfare, *Health Expenditure Australia 2006–07*, Health Expenditure Series No. 35 Cat. No. HWE 42 (Canberra: AIHW, 2008), 45–48.
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- ³³ Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals (Garling report), Final Report (27 November 2008), 2.

- ³⁴ AIHW, *Australian Hospital Statistics 2007–08*, Health services Series No. 33 Cat. No. HSE 71 (Canberra: AIHW, 2009), 13.
- ³⁵ As above, Table 2.2, Table 3.3. The other factor is that bed cuts have not been evenly distributed. Major urban hospitals have been targeted for bigger reductions, while under-utilised beds in country hospitals, which have low occupancy rates, have been retained for political reasons. For example, in Western Australia, 1,200 overnight beds are located in country hospitals with an average occupancy of around 50%, compared to average 90% occupancy for beds in metropolitan regions. Ross Fox, *Talking the Pulse: Reform Initiatives for the WA Health System* (Melbourne: Institute of Public Affairs and Mannkal Economic Education Foundation Project, Western Australia, 2008), 7.
- ³⁶ Department of Health and Ageing, *State of our Public Hospitals June 2007 Report* (Canberra: Government of Australia, 2007), 23. This information and analysis is partly based on an unpublished paper provided the author by Dr Paul Cunningham.
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- ⁴³ AIHW, *Australian Hospital Statistics 2006–07*, as above, xv.
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- ⁴⁷ For the flavour of these arguments and a critical discussion, see Jeremy Sammut, *The False Promise of GP Super Clinics Part 1*, Papers in Health and Ageing (3), CIS Policy Monograph No. 84 (Sydney: The Centre for Independent Studies, 2008).
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- ⁵⁴ AIHW, *Australian Hospital Statistics 2007–08*, as above, 191.
- ⁵⁵ AIHW, *Australian Hospital Statistics 1996–97*, as above, 61
- ⁵⁶ This has also been described as having always in part been a squabble over which tier of government should pay for the GP-style care rather than where GP-style care is best delivered. Australasian College of Emergency Medicine, *Access Block and Overcrowding in Emergency Departments* (Melbourne: ACEM, 2004), 11.
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- ⁶⁰ *Beyond the Blame Game: Accountability and Performance Benchmarks for the next Australian Health Care Agreements* (Canberra: NHHRC, April 2008), 46. For example, this report alludes to the problems in public hospital emergency departments, but not a single mention is made in the entire report about bed numbers or the only real solution, which is more beds.
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- ⁶⁵ TGF International, *Report in the Operation and Future of the Australian Health Care Agreements and the Funding of Public Hospitals* (Melbourne: Australian Centre for Health Research, 2008), 454–456; See recommendations of the Garling report, particularly concerning Medical Assessment Units, outlined in Natasha Wallace and Alexandra Smith, ‘Public hospitals on “brink of collapse,”’ *The Sydney Morning Herald* (28 November 2008). Medical Assessment Units were established at 17 hospitals in metropolitan Sydney in 2008. In the Garling report, they have inexplicably been linked to the issue of ATS 4 and ATS 5 patients and diverting ‘non-emergency’ and GP-style patients away from emergency departments. Despite their name, patients are not assessed in the units. Patients first attend emergency and are referred *after they receive specialist assessment* to the medical assessment units. The units, in truth, are short-stay hospital wards. Patients can remain for up to two days before being sent home or admitted to a general ward. They are specially designed to cater for the needs of elderly patients over 75 and suffering complex, chronic and acute illnesses. They have added 235 extra hospital beds across the system. In other words, medical assessment units are hospital wards by another name. They are proof that more beds *are* needed for an ageing population and to relieve the pressure on overcrowded hospital departments. ‘Medical Assessment Units provide specialist treatment for elderly patients,’ NSW Health, media release (9 April 2008); ‘Elderly Patients Medical Assessment Units,’ *New South Wales Hansard* (9 April 2008).
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Coordinated Care, Papers in Health and Ageing (4) CIS Policy Monograph No. 85 (Sydney: The Centre for Independent Studies, 2008).

- ⁷⁶ Jeremy Sammut, *The False Promise of GP Super Clinics Part 2*, as above.
- ⁷⁷ By the mid-1990s in the United Kingdom, bed reductions and the drive to operate hospitals at above 90% occupancy began to seriously affect the ability of overcrowded NHS hospitals to admit emergency patients without undue delay. (Martin McKee, 'Reducing hospital beds: What are the lessons to be learned?' *European Observatory on Health Systems and Policies* 6 (2004), 5.) This led to the formation in 1998 of the National Bed Inquiry, which reported in 2000 that acute bed closures had gone too far, and that the prevailing view that continued efficiency gains made further bed closer possible was flawed. Given that two-thirds of acute beds were used by elderly patients, there may be a need for greater investment in additional bed capacity. The report also speculated that in the absence of bed increases, some of the slack might be taken up by providing the elderly with 'community-based alternatives to hospital care.' (*Shaping the Future NHS*, 12, see endnote 50.) But as Allyson Pollack and Matthew Dunnigan were quick to point out, papers commissioned by the inquiry itself revealed 'the evidence is weak at best that hospital at home and other early discharge schemes reduce overall hospitalisations and the need for acute hospital beds.' (Allyson M. Pollock and Matthew G. Dunnigan, 'Beds in the NHS: The national bed inquiry exposes contradictions in government policy,' *British Medical Journal* 320:7233 (February 2000), 461–462.
- ⁷⁸ Martin Hensher, et al., 'Better out than in?' Alternatives to hospitals—such as hospital in the home—complement rather than replace hospital care because the more intensive the care the elderly receive, the more their utilisation of hospital care increases. McKee, 'Reducing Hospital Beds,' as above, 7. In a similar vein, studies of hospital in the home schemes 'have not looked directly at the effect on the emergency department.' It is a 'presumption that decreasing length of stay will decrease bed occupancy and in turn improve emergency care patient flows.' Nor has hospital in the home been found to be a cheaper option over inpatient care, and early discharge schemes can also prove a false efficiency by leading to higher readmission rates. Matthew Cooke, et al., *Reducing Attendances and Waits in Emergency Departments: A Systematic Review of Present Innovations*, Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (London: NCCSDO, 2004). It might also be the case that sending elderly patients to sub-acute facilities is self-defeating because early discharge leads to higher rates of re-admission as patients come back 'sicker and quicker.'
- ⁷⁹ 'Towards faster treatment: reducing attendance and waits at emergency departments,' A Briefing Paper from the UK National Coordinating Centre for NHS Service Delivery and Organization Research and Development, *Longwoods Review* 4:1 (2006), 9. However, the full study was more equivocal about the 'lack of high quality evidence.' It concluded: 'Attendance by the elderly, those with chronic disease and those with multiple attendances may be reduced by various interventions. Trials are needed in this area.' Cooke, et al., *Reducing Attendances*, as above, 95, 187, 192.
- ⁸⁰ Cooke, et al., *Reducing Attendances*, as above, 89
- ⁸¹ For example, the Australian General Practice Network has claimed that coordinating the care of patients reduced hospital admissions by 25% compared to a control group of patients whose care was not coordinated. This measured the difference in average rates of growth in hospital use in the trial compared to the pre-trial period. And if you plough through the Commonwealth Department of Health and Ageing report on the trials, you find that when the initial difference in pre-trial rates of hospital use between the two groups was adjusted for, the so-called substitution effect—coordinated care leading to

- reduced use of hospitals—disappeared. There was no real reduction in hospital use because patients who received coordinated care also received ‘significantly’ more hospital services than the control group. What this seems to demonstrate is that coordinated care enhances primary care’s traditional roles of timely detection and referral to necessary treatment. See Jeremy Sammut, *False Promise of GP Super Clinics Part 2*, as above.
- ⁸² Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials*, Department of Health and Ageing (Canberra: Government of Australia, 2007), Part 3, 595, 621–622, 627, 630–631.
- ⁸³ National Health and Hospital Reform Commission, *A Healthier Future for all Australians: Final Report, June 2009* (Government of Australia, Canberra, 2009) (*Final Report*), 56.
- ⁸⁴ Leonie Segal, *A Vision for Primary Care: Funding and other System Factors for Optimising the Primary Care Contribution to the Community’s Health* (August 2008), 2.
- ⁸⁵ For a longer discussion of these issues, see Jeremy Sammut, *The False Promise of GP Super Clinics Part 2*, as above.
- ⁸⁶ Fredric D. Wolinsky, et al., ‘Emergency department utilisation patterns among older adults,’ *The Journals of Gerontology Series 63a:2* (2008), 204–209.
- ⁸⁷ The way to clean up these structural problems is to repeat the dose of radical surgery in community health; end block funding of community health; and pay for services from community health providers and non-government providers using case-mix vouchers, with GPs and hospital physicians and specialists fulfilling a gate-keeping role and referring patients to community-based chronic disease and hospital-in-the-home programs based on clinical need. This issue is taken up in Jeremy Sammut, *Like The Curate’s Egg: On the Bennett Report*, Papers in Health and Ageing (10), CIS Policy Monograph No. 104 (Sydney: The Centre for Independent Studies, 2009).
- ⁸⁸ Booz Allen Hamilton, *Key Drivers of Emergency Demand*, 72, 115. See this report (at 20–41) for the full list of Commonwealth and state programs providing community-based care for the elderly and chronic disease sufferers, combined with other hospital diversion schemes, which covered 21 A4 pages.
- ⁸⁹ This is consistent with the findings of a 2006 Australian study, which found that the vast majority (nine out of 10) emergency department presentations by residents of aged-care facilities were appropriate and, in the words of the authors, the vast majority ‘seem unavoidable’ because ‘the therapeutic and/or diagnostic requirements of the patients acute condition preclude the patient being managed outside the ED.’ Though, as the authors pointed out, this wasn’t to say some presentations could not have been avoided if residential aged care facilities had the capacity to provide alternative sub-acute care on-site. ‘However, even with improved skill levels and communication between acute care and residential care facilities, the vast majority of presentations to the ED seem unavoidable.’ Judith C. Finn, ‘Interface between residential aged care facilities and a teacher hospital emergency department in Western Australia,’ *Medical Journal of Australia* 184:9 (May 2006), 432–435.
- ⁹⁰ A sense of the demand for hospital care this creates is gained from the fact that surveys of aged care providers indicate that on average 63% of residents are sent to emergency departments each year. Booz A. Hamilton, *Key Drivers of Emergency Demand*, as above, 72.
- ⁹¹ George Braitburg, ‘Emergency department overcrowding: Dying to get in?’ *Medical Journal of Australia* 187:11/12 (December 2007), 624–625, 624.
- ⁹² Statement of Dr Brian Morton, Annexure B to the submission of the Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers’ Federation (28 March 2008), quoted in the Garling report, as above, 752.

- ⁹³ This is contrary to the claim that ‘seventy per cent of the hospital admissions of older Australians who are in very poor condition could be avoided if there was effective community intervention.’ Mike Stekette, ‘Situation is no accident,’ *The Australian* (6 October 2007).
- ⁹⁴ An out-of-date assumption is that population ageing has a minor impact on demand for hospital care because the demand generated by very old patients is fixed. The idea is that because need for acute care is highly associated with proximity to death, demand is more or less limited to the care of dying patients. Martin McKee, ‘Reducing hospital beds,’ as above, 7.
- ⁹⁵ ACEM, *Access Block and Overcrowding in Emergency Departments*, 8. See also the following emergency department staff interview quotes, in Booz Allan Hamilton, *Key Drivers of Emergency Demand*, 109–110:
- ‘The ageing of the population is a key driver on overall ED demand ...
 - The numbers of elderly patients going to ED is on a wave—if we don’t solve this problem we’ll be in gridlock ...
 - We are seeing more complex patients, often with multi-system failures.
 - We are keeping people alive longer and treating more complex conditions.’
- ⁹⁶ Roberto Forero, et al., ‘Access block in NSW hospitals, 1999–2001: Does the definition matter?’ *Medical Journal of Australia* 180:2 (January 2004), 67–70.
- ⁹⁷ Analysis of NSW emergency admission data revealed that patients aged 65 and over accounted for 33, 30 and 25% of ED patients in ATS 1, 2, and 3 categories respectively. Patients aged 75 plus accounted for 22, 18, and 15% of the demand in each of these categories. This analysis also revealed the highest growth in attendances and admissions was among patients aged over 75. ‘Very old’ patients spent longer than other patients in emergency departments (8.8 hours) and were admitted at higher rates (55%) than any other patient group. Booz Allan Hamilton, *Key Drivers of Emergency Demand*, as above, 11–12.
- ⁹⁸ Roberto Forero and Ken Hillman, *Access Block and Overcrowding: A literature review. Report Commissioned by the Australasian College for Emergency Medicine*, Access Block Solutions Summit (Melbourne, 12 September 2008), 6–7, 12. Peter A. Cameron and Donald A. Campbell, ‘Access block: Problems and progress,’ *Medical Journal of Australia* 178:3 (February 2003), 99–100.
- ⁹⁹ Peter A. Cameron, et al., ‘Access block can be managed,’ *Medical Journal of Australia* 190:7 (April 2009), 364–368.
- ¹⁰⁰ Tom Keating attributes the increase in hospital productivity and the rise of access block in the post case-mix era to this factor: ‘Why would you leave a bed vacant for a possible emergency admission when you could fill it with a patient who generated a payment.’ Tom Keating, ‘Gaming the health system is a rational response to bad policy,’ *Crikey* (25 June 2009).
- ¹⁰¹ This is similar to the regime recently proposed by the National Health and Hospitals Reform Commission that hospitals be funded primarily by activity based case-mix payments combined with fixed grants to maintain bed and staffing capacity for hospitals with major emergency load. *A Healthier Future for all Australians: Interim Report December 2008* (Canberra: NHHRC, 2009), 10, 137.
- ¹⁰² This is a necessary safeguard against ‘market failure.’ The temptation for hospitals will always be to use spare bed capacity to treat ‘cheap and easy’ procedural patients at the expense

of emergency departments and more complex and costly acute patients. Hence, private hospitals in the United States encounter the same access block problems as do public hospitals in Australia, the United Kingdom, and Canada. ‘Bed vouchers’ can be thought of as an ‘essential service guarantee’ to ensure the provision of safe and timely emergency care.

- ¹⁰³ See Jeremy Sammut, *The Coming Crisis of Medicare*, Papers in Health and Ageing (2), CIS Policy Monograph No. 79, (Sydney: The Centre for Independent Studies, 2007).
- ¹⁰⁴ Jeremy Sammut, ‘Federal government gets hospitals casemix wrong,’ *The Weekend Australian* (19 September 2009).
- ¹⁰⁵ With the transition to ‘occur over some time,’ *Council of Australian Governments Meeting Communiqué* (Canberra: 19 and 20 April 2010), 5.
- ¹⁰⁶ Despite the lack of accurate financial data on the cost of public hospital care, analysis by the Productivity Commission reveals a 20 to 25% productivity gap between least efficient public hospital systems and the relative best practice states, and 35% difference in the average of cost of treating patients between jurisdictions. See Australian Institute of Health Studies, *Revitalising Health Reform—Time to Act*, Discussion Paper (September 2007), 10–11.
- ¹⁰⁷ Jennifer Buckingham, *Families, Freedom, and Education: Why School Choice Makes Sense*, CIS Policy Monograph No. 52 (Sydney: The Centre for Independent Studies, 2001).
- ¹⁰⁸ Garling report, as above, 55.
- ¹⁰⁹ As above, 1004.
- ¹¹⁰ See NSW Health Minister, John Della Bosca, quoted in Siohbain Ryan and Imre Salusinszky, ‘NSW healthcare “a victim of Soviet system,”’ *The Australian* (29 January 2009).



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