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The Past is the Future for Public Hospitals:

An Insider's Perspective on Hospital Administration

John R Graham

Papers in Health and Ageing (9)

THE CENTRE FOR INDEPENDENT STUDIES

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Foreword

There is no bigger issue facing the Australian health system than what to do about public hospitals.

Public hospitals provide 60% of the hospital care needed in Australia each year and treat the majority of the oldest, sickest and most complex patients.[1] They also consumed $28 billion in 2007–08.[2] This represents approximately 40% of federal and state health spending, or just under one-third of the total amount spent on health care in Australia.

Despite the ever-increasing sums that Australian governments pour into public hospitals each year, waiting times for elective surgery grow even longer. Emergency departments continue to be clogged with patients forced to endure long waits on trolleys in overcrowded corridors before being admitted to a hospital bed.

Until there is major structural reform of the governance, funding, and delivery of taxpayer-funded hospital services, the public hospital system will continue to monopolise and lock up billions of valuable health dollars in the least productive segment of the health sector.

But despite the scale of the so-called 'hospital crisis,' governments throughout Australia remain in denial about the poor performance of public hospitals. When yet another disaster hits the headlines, the standard response of health ministers is to blame red herrings such as 'under-funding.'[3] The real problem, which politicians are understandably reluctant to admit, is the way they have chosen to run public hospitals.

How public hospitals should be administered is the subject of Dr John Graham's monograph. It provides an insider account—from the perspective of a medical practitioner with more than 40 years of experience in NSW hospitals—of what the author describes as the 'disastrous reorganisation of public hospital administration of the last 25 years.'

Dr Graham's policy advice is straightforward, but he presents more than the case for why each public hospital should once again be run by an independent board of directors with full responsibility for the entire hospital budget. He also provides a telling account of the health policy upheavals of the last 25 years and the deleterious impact the establishment of Medicare by the Hawke federal government has had on the quality and quantity of the hospital care received by Australians.

As Dr Graham explains, only the less well-off received treatment in a public hospital without charge prior to 1984, while those who could provide for themselves were expected to get private health insurance to cover their hospital bills. Once the era of 'free' hospital care began, many formerly self-reliant people dropped their private cover 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 and ration the services that public hospitals delivered by closing large numbers of hospital beds. But before beds could be cut, the tried and tested administrative structure that had ensured the good governance of public hospitals had to be dismantled. Local hospital boards were summarily abolished around the country in the 1980s and 1990s and replaced with the Area Health Services, which continue to administer numerous hospitals within a geographic region.

Once public hospitals had lost their financial and administrative independence, the rot set in. Dr Graham amply demonstrates this by detailing the resulting waste and inefficiency. Huge amounts of taxpayer's money have been misallocated to pay for massive and unnecessary growth of the health bureaucracy. Funding is no longer spent effectively in hospitals because there is nobody in a position of authority on the ground anymore.

The massive government expansion into the health sector has resulted in fewer and fewer health dollars out of ever-increasing hospital budgets reaching the frontline. Dr Graham shows just how high has been the price of 'free' hospital treatment. The real bottom-line cost incurred by the community is the significant amount of timely and beneficial hospital care that has been forgone.

Dr Graham's monograph makes the important point that prior to the mid-1980s, public hospitals were *of government*—their governing boards were constituted by an Act of parliament—but they were not part of *the government*. Instead of being dependent on government and the funding allocated by health departments as they currently are, public hospitals were strongly

connected to the community and were a vibrant part of civil society. These connections started with the broad membership of their governing boards, extended to the generous citizens who made donations to support their work, and flowed right down to the numerous volunteers who donated their time and effort in service of the local hospital.

The ranges of issues Dr Graham discusses pertain to the impact of big government growing ever bigger. But what makes this a unique and perhaps unusual publication is the first-hand experience brought to the topic. Most importantly, we told what it was like when hospitals were not mismanaged from remote and centralised bureaucracies. 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 become subject to the dead hand of statist domination and bureaucratic command-and-control.

Dr Graham also recounts the history of his medical home—Sydney Hospital. The story of Sydney Hospital over the last four decades is a case-study of the way hospitals once functioned under autonomous boards. Graham argues that one of the key advantages was the way problems were quickly and effectively solved. As he shows, these highly accountable governance arrangements are a world away from the highly bureaucratic arrangements of today. Micro-managing hospitals from afar has only ensured that decisions take forever to be handed down and are frequently flawed in conception or implementation or both.

This monograph is a timely intervention into the health policy debate. A government policy wonk recently told me that he could understand why market-based or 'demand-side' hospital reform (such as a competitive system of voucher-style hospital funding[4]) would improve public hospital efficiency. But he just could not get his head around the need for 'supply-side' reform to achieve better outcomes. He was puzzled why anyone would think it is better to go back to the future and re-establish the local hospital boards abolished two decades ago. His questions have now been answered.

Drawing on his vast experience, Dr Graham explains why the only future for public hospitals is to reclaim the best features of their past and reclaim their freedom from the clutches of the bureaucracies that have stifled them to the detriment of the health and welfare of the community.

October 2009
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Endnotes

1 *Australian Hospital Statistics 2007–08,* Health services Series No. 33 Cat. No. HSE 71 (Canberra: AIHW, 2009), vii-viii.
2 As above, 13.
3 Jeremy Sammut, *Why Public Hospitals are Overcrowded: 10 Points for Policy Makers,* CIS Policy Monograph No. 99, Papers in Health and Ageing (8) (Sydney: The Centre for Independent Studies, 2009).
4 Wolfgang Kasper, *Radical Surgery: The Only Cure for NSW Hospitals,* CIS Policy Monograph No. 91, Papers in Health and Ageing (7) (Sydney: The Centre for Independent Studies, 2008).

Dr John R Graham is Chairman, Department of Medicine, Sydney Hospital and Sydney Eye Hospital. The views expressed in this paper are entirely his own and do not necessarily reflect the views of any other person or persons.

The Past is the Future for Public Hospitals: An Insider's Perspective on Hospital Administration

John R Graham

Executive Summary

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.

Policymakers need to understand the causes and the consequences of the major problems in our public hospitals and take appropriate action to fix the administrative dysfunction that has severely restricted ordinary Australians' access to basic hospital services.

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' Area Health Services. This obliterated the tried-and-tested governance structure that had essentially allowed hospitals to manage their own affairs unfettered by outside interference.

Under the independent control of local boards, decision-making in public hospitals was quick and effective and problems were speedily resolved, based on good communication between frontline clinicians and the managers responsible for the day-to-day operation of the hospital.

The stubborn, cumbersome, and remote Area Health Services have seriously compromised the efficiency of our public hospital system. Funding is not spent optimally, and trust, cooperation, morale and institutional loyalty has been sapped. Resource misallocation involving extraordinary growth in the size and cost of the bureaucracy has led to a massive waste of taxpayer's money.

All Area Health Services should therefore be immediately abolished and autonomous pro-bono Boards of Directors should be put back in charge at 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. Every hospital budget should also principally be based on clinical throughput, allowing for local demand as well as referred cases, whilst making appropriate use of casemix payments to ensure efficiency and equity.

This paper is an insider's account (and mini-history) of hospital administration in NSW. These policy recommendations are based on my experiences of more than 40 years of practice at Sydney Hospital. The story 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.

Introduction

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 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 New South Wales, with lengthy appointments at five public hospitals (two major teaching hospitals and three district hospitals).

This reasonably extensive experience hopefully qualifies me to comment on a very important subject: how hospitals should and shouldn't be run. There are only a handful of similarly placed senior specialists still in active clinical practice in Australia today whose career began in the public hospital system of the 1960s or before. Such a lengthy and intimate experience with public hospitals obviously permits a perspective that is both broad-based and well-grounded in factual observation.

Though 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,' one recent product of the system wrote earlier this year, 'less interested in motivating and developing its workers than the workplace of the public hospital.'[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, during my early career especially, 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. As the ensuing insider's account (and mini-history) of the disastrous reorganisation of public hospital administration of the last 25 years explains, 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 the chaos, tragedy, and sometimes even downright farce into which public hospitals have descended (which I have been unfortunate to witness at close quarters) has only intensified my commitment to the principles that Sydney Hospital once exemplified with respect to the administration of public hospitals.

Ensuring that our hospitals are governed efficiently and effectively is critical to the future of the health system.

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 health system—both in NSW and throughout Australia.

If public hospitals are to be restored to what they once were—some of the most trusted and well-run institutions in the country—I firmly believe that governments, bureaucrats, and all health experts and stakeholders must learn from the lessons of the past. Immediate action must be taken to reverse the mistakes that have robbed hospitals like Sydney Hospital of their autonomy and seriously compromised their ability to properly serve the community.

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.

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.

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 the clinical and the 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 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 colo-rectal 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 of their degree 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 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 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.

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 provides the public with Australia's best clinical and research centres for eye and hand surgery. This work is supported by a virtually unique Department of Medicine, which comprises 10 general physicians with a vast array and unique mix of skills. Sydney Hospital also operates the world-renowned Kirketon Road Clinic at Kings Cross and the Macquarie Street campus has Sydney's leading Department of Sexual Health.

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 own 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 budget (as was then the case for all public hospitals in NSW) was essentially based on actual clinical throughput—that is the number of patients the hospital managed to treat each year—allowing also for the complexity of their management.

The membership of the Board of Directors was broadly representative of the community. This included 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 to superior planning for the future. The fact that the Board was singularly devoted to advancing the interests of the hospital also helped to 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 public service to the hospital and the community. Volunteer lay services included 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 all their services to public patients, to medical students, and to trainee nurses 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 the diagnostic and research facilities.) The resident medical officers lived on-site and worked long hours with no overtime payments. (Their reward was a superior education.)[3]

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.

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 can 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 support they once enjoyed. Donors are (understandably) reluctant to give money to hospitals that are now terribly mismanaged by gigantic government bureaucracies. Sydney Hospital still manages to do great work against the odds (despite dangerously reduced bed and service capacities) to the enormous credit of 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 how dysfunctional the administration

of our public hospitals has become. The department's time is mainly occupied in dealing with centralised directives issued by the South Eastern Sydney and Illawarra Area Health Service (SESIAHS) and NSW Health. Some of the protocols 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, though, the (ever-changing) initiatives that are being mandated, and that each hospital department across an Area or across NSW is expected to implement, involve an inappropriate one-size-fits-all approach. The uniqueness, the skills-base, and the diversity of each hospital 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 far removed hospitals (about which they know so little), they feel pressured to dream up 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.

The uniqueness, the skills-base, and the diversity of each hospital are being completely ignored.

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 in conjunction 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 a 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 some rapid advances in the science of hospital care.

In the 1960s, it was commonplace for patients to be admitted to public hospitals for periods of at least a month, and rarely less than about 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 the advent of coronary artery stenting, brought huge benefits to the patients but added greatly to the overall health costs. 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 improved the speed and accuracy of diagnosis, while further adding to 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. 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.

The ideologically-driven decision to allow all comers to be treated for free regardless of means fundamentally changed the dynamic that underpinned the successful operation of the public hospital system.

Following the introduction of Medicare and the abolition of a means test, doctors gradually accepted 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 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 a 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 could now achieve outcomes in two days that formerly took two weeks. The Australian community would have spent more on health care, but in return would have received more, better and faster hospital care. 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.

The only strength of the Area Health Services was that it enabled bed cuts to be imposed on hospitals at arm's length from 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 Area Health Services 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 Area Health Services 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 Area Health Services 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 rese arch. 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. 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 Area Health Services 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 managerial 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.

The amazing outcomes achieved at St Vincent's special units illustrate the obvious superiority of the board-led hospital model.

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 the 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, top 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—an entirely new centralised agency is to be 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 Area Health Services should be immediately abolished and (pro bono) Boards of Directors[6] 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.

All Area Health Services should be immediately abolished and (pro bono) Boards of Directors restored at each and every public hospital.

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]

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.

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 through 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 in NSW in the mid-1980s 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 Area Health Services 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.

NSW Health has stubbornly denied the truth of the appalling situation. It has 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 that political leaders in NSW wake up and impose some serious cuts on NSW Health. 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* that 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.

About the Author

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