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Like the Curate's Egg:

A Market-based Response and Alternative to the Bennett Report

Jeremy Sammut

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THE CENTRE FOR INDEPENDENT STUDIES

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Like the Curate's Egg: a Market-based Response and Alternative to the Bennett Report

Jeremy Sammut

Executive Summary

The final report of the National Health and Hospital Reform Commission (NHHRC or the Commission), *A Healthier Future for All Australians* (the Bennett Report), is like the curate's egg—only good in part and therefore spoiled overall.

The NHHRC has acknowledged the need to ensure health services are responsive to the needs of patients, and has recommended some very limited market-based reforms to improve the efficiency of public hospitals. But, overall, the Commission's long-term health reform blueprint will not put consumers in charge and 'develop a person-centred health system.'

The major recommendations contained in the Bennett Report concern:

(1) Expanding the role of the Commonwealth in the primary care sector of the health system;

(2) Ending the 'blame game' by clarifying the complex and overlapping governance responsibilities of the federal and state governments; and

(3) Modifying the way the public hospital system is run and funded.

The three major problems with the reforms recommended by the Commission are:

Ineffective primary care centred strategy. Spending billions of taxpayers' dollars on a Commonwealth-financed GP Super Clinics network will not fix the problems in Australia's public hospital system.

Tinkering with governance arrangements at the national level. Recasting federal and state responsibilities to establish clearer policy, funding, and performance accountabilities for problems in the health system will not achieve structural reform of the way public hospital and other taxpayer-funded health services are produced.

Market-based hospital reform doesn't go far enough. Requiring all public hospitals to be 100% funded on an activity-based casemix basis is an overdue reform, but casemix funding alone will not end the wasteful and inefficient administration of public hospitals by state government health bureaucracies.

The chair of the NHHRC, Dr Christine Bennett, has claimed that the most important reforms in the Bennett Report will make the health system 'person-centred,' because the proposed primary care reforms will allow 'health consumers to have access to the services they need' instead of only having access to current mix of 'hospital-centric' health services that governments 'want to offer.'

Developing a truly person-centred health system requires market-based structural reform of the governance, funding, and delivery of taxpayer-funded health services. Instead of health departments allocating the taxpayer subsidy to government-owned public hospitals and community health services, a new set of flexible and responsive arrangements are required. The taxpayer subsidy should be tied directly to the delivery of patient care by either public or private providers, and demand for health services should be allowed to set the supply of health services according to the clinical needs of individual patients.

Unfortunately, the NHHRC has adopted a highly contradictory, top down approach to the so-called person-centred health reform. The federal government has been advised that the best way to take pressure off public hospitals is to fill the service gaps in the primary care sector that allegedly cause overuse of hospital services.

According to the Commission, improved access to Medicare-funded multidisciplinary 'coordinated' primary and allied health care services will prevent avoidable admissions and keep the elderly and chronically ill well and out of overcrowded hospitals. The evidence, including expert discussion papers prepared for the NHHRC, shows that these community-based so-called 'alternative models of care' are no substitute for hospital care.

The NHHRC's plan to provide more primary care and less hospital services is therefore a characteristically flawed example of 'command-and-control' central planning:

- The primary care reforms designed to create a less 'hospital-centric' health system oriented around stronger community-based services will not improve access to hospital services in the long run.

- The recommended governance reforms do not address the root causes of the hospital crisis, which are the systemic problems in public hospitals that severely restrict access to basic hospital services.

- The proposed hospital reforms do not adequately address the real cause of dangerous overcrowding, which is the critical nationwide shortage of acute public hospital beds.

- Higher spending on supposed 'wellness' promoting preventive health measures is the wrong priority for an ageing Australia, given the urgent need to open more beds to provide timely hospital treatment for an older and sicker population in the coming decades.

Due to the serious problem with the Bennett Report's flawed prescription for a better health system, it is important to carefully scrutinise the recommendations and establish the alternative set of principles, priorities and policies that should guide sustainable, long-term health and hospital reform.

To cope with the health challenges of the twenty-first century, this monograph recommends the federal government implement the following market-based structural reforms of the financing and administration of the health system:

A. A federally-funded hospital voucher scheme covering the casemix cost of treatment in either public or private hospitals, in conjunction with the re-establishment of local public hospital boards; and

B. An extended health voucher scheme for chronic disease management and other community-based services (including sub-acute and hospital-in-the-home care) provided by either public or private providers.

The national hospital and health voucher scheme will allow consumer choice, provider competition, and clinical need as diagnosed by doctors to determine the appropriate supply of health services in coming decades. A voucher-based health system would be truly person-centred, and provide all Australians with better access to the right care at the right time and right place, especially when health needs are greatest and hospital treatment is essential.

Perhaps most importantly, the report puts forward real options for health consumers to have access to the services they need, rather than the services the health system wants to offer.

—*Dr Christine Bennett* [1]

Many of the problems besetting hospitals arise from other health care services. They affect hospital performance but are outside the direct control of hospitals, such as lack of timely access to primary health care ... We need to change how much, and where, we spend to improve outcomes from health spending and to contain the upward pressure on health budgets. We contend that this is possible through evidence-based investment in strengthened primary health care services and health promotion and prevention to keep people healthy.

—*A Healthier Future for all Australians: Interim Report* [2]

Our fifth priority is to take action now to improve timely access to quality care in public hospitals, particularly care in emergency departments and access to planned surgical and medical care.

—*A Healthier Future for all Australians: Final Report* [3]

Introduction

Before the 2007 federal election, the then leader of the opposition, Kevin Rudd, promised to end the 'blame game' between the states and the Commonwealth over the problems in the Australian health system. Responding to rising concerns about ever-longer waiting times for elective and emergency care in Australia's dangerously overcrowded public hospitals, Mr Rudd promised that if elected prime minister, his government would provide national leadership on health and undertake 'root and branch' reform. The buck for fixing the problems in the health system would stop with him.

In February 2008, Prime Minister Rudd appointed the 10-member National Health and Hospital Reform Commission (NHHRC or the Commission) to review the health system and advise his government on the long-term reforms needed to address the major health challenges of the twenty-first century, including the ageing of the population, the growing burden of chronic disease, and the problems attributed to different tiers of state and federal governments running different parts of the health system.

After conducting extensive consultations with health care providers and members of the general public, and receiving hundreds of submissions from stakeholders, the 15-month NHHRC review culminated with the release of its final report, *A Healthier Future for All Australians* (the Bennett Report), in July 2009.* The 300-page report makes more than 100 recommendations on a range of aspects of the health system. This paper examines the most important recommendations the Commission has devised to end the blame game, to take pressure off public hospitals, and to develop a so-called 'person-centred' health system that gives all Australians access to the 'right care in the right time and at the right place.'

Healthy Australia Accord

The Bennett Report's most important recommendations concern the following three aspects of the health system:

1. Expanding the role of the Commonwealth in the primary health care sector;

2. Clarifying the governance responsibilities and accountabilities of federal and state governments; and

3. Modifying the way public hospitals are run and funded.

The governance of the health system in Australia is, to say the least, complex, overlapping and fragmented. The federal government partly funds 'free' public hospital care through grants to the states under the five-yearly Australian Health Care Agreements (AHCA). The Commonwealth also funds GP and other community-based services through Medicare and other federal health programs. State governments run and partially fund public hospitals. The states also fund and run community health services, which provide salaried general practice, allied health care, and other community-based services.

To clarify health responsibilities, the Commission has recommended the federal and state governments agree to the Healthy Australia Accord. The proposed Accord, which is an inter-governmental agreement that encompasses governance, primary care, and hospital reform, is designed to establish clearer policy, performance, and funding accountabilities at the national level.

To clarify health responsibilities, the Commission has recommended the federal and state governments agree to the Healthy Australia Accord … which is an inter-governmental agreement that encompasses governance, primary care, and hospital reform.

* Note, as the Commission has pointed out, that the final Bennett Report needs to be considered in conjunction with the NHHRC's interim report of February 2009.

Under the Accord, the federal government would:

- Assume full responsibility for primary care policy and funding, including hospital outpatient services (with appropriate adjustments made to the federal grants and allocation of GST revenue to the states), to allow the Commonwealth to 'join up' and expand the disconnected state and federal community-based programs;

- Recast the realigned federal and state responsibilities and improve accountability by creating a comprehensive National Access Target (NAT) performance reporting system covering both hospital-based and non-hospital services, with clear benchmarks for quality, safety, and access to care, plus an incentive payments scheme to reward states that achieve national benchmarks for timely public hospital emergency and elective care;

- Pay the states a hospital benefit capped at 40% of the efficient casemix cost (see p. 13) for each occasion of inpatient and emergency care in public hospitals, with the states responsible for determining overall levels of expenditure and services, and all public hospitals 100% funded by activity-based casemix payments.

Primary care centred strategy

According to the Bennett Report, the 'single most important strategy for improving our health, and making the system sustainable' is creating strong primary health care services for everyone.

The Commission maintains that long waits for treatment in public hospitals stem from service gaps, waste and duplication in Australia's fragmented primary care system.[4] Lack of access to multidisciplinary 'coordinated'† primary and allied health care services is leading to the overuse of under-pressure hospitals by elderly and chronically ill patients. The Bennett Report therefore claims that solving the hospital crisis requires evidence-based investment by the federal government in more and better primary care. Improving access to coordinated primary health care services will improve access to hospital services because 'a sound working system of primary health care means avoidable hospitalisations' and 'lower rates of hospitalisation.'[5]

To take the pressure off public hospitals, the NHHRC further recommends that the Commonwealth:

- roll out by 2015 a 300-strong national network of federal government-financed 'comprehensive' primary care health care 'Super Clinics,' which will bring GPs and allied health services together under one roof;

- expand the range of community-based health services funded by the Commonwealth under Medicare to facilitate higher government spending on coordinated primary care, which the NHHRC claims would reduce avoidable admissions by keeping people well and out of overcrowded public hospitals.

Rudd's response

The Rudd government will discuss the Bennett Report with the state governments at the Council of Australian Governments (COAG) meeting in the first week of December 2009. The federal government's detailed response, which will be finalised in early 2010, is expected to endorse a number of the Commission's recommendations, especially those relating to existing government policy, the GP Super Clinic network, and primary care reform in general.

† Coordinated primary care (which is sometimes referred to as 'care planning' or 'chronic disease management') involves either a GP or a practice nurse monitoring the condition and managing the care of elderly and chronically ill patients to ensure they receive all appropriate care from a wide variety of allied health providers. Coordinated care also involves better educating patients about their disease so they can better self-manage their condition and maintain their health, with particular regard to the secondary prevention of lifestyle related co-morbidities (additional chronic conditions—diabetes, for instance, can lead to heart disease and stroke) that can cause complications and more frequent, longer and expensive hospital stays.

Recent newspaper reports suggest the Prime Minister is considering possible alternatives to the NHHRC strategy.[6] If, as he claims, Mr Rudd is really not interested in band-aid solutions, then his government should reject the Bennett Report. The Commission's recommendations are no band-aid—they are the equivalent of prescribing a Panadol and a lie-down for the gaping wound that is the hospital crisis. The federal government should proceed much more boldly down the path of 'root and branch,' true person-centred health and hospital reform, and implement the national hospital and health voucher scheme this monograph proposes.

Vision and contradiction

> Our vision for a future health system involves revitalising and strengthening primary health care services. While Galileo was excommunicated for suggesting that the Earth revolved around the sun, we don't think it is too heretical to suggest that primary health care services should be the axis or pivot around which we seek to develop a person-centred health system. Indeed, we heard broad support throughout our consultations for expanding the role of primary health care services to take on this role.
>
> —*A Healthier Future for all Australians: Final Report* [7]

Person-centred health system

There is no question that the NHHRC has enthusiastically embraced its brief and adopted 'a visionary approach in identifying what the health system should look like over the next twenty years.'[8] The aim of the 'fundamental redesign of our health system arrangements,'[9] as outlined in the Bennett Report, is to engineer a 'fundamental paradigm shift' away from a 'hospital-centric' and 'overloaded sickness' system towards a primary care oriented system that promotes 'wellness.'[10]

According to the NHHRC, the proposed primary care reforms will enable Australians to keep well and out of hospital by accessing the right community-based health care at the right time and place. The chair of the NHHRC, Dr Christine Bennett, has therefore claimed that the most important recommendations in the Bennett Report will make the health system person-centred rather than government-centred, because reorienting the system around stronger primary care will allow health consumers to have access to the services they need rather than only have access to the current mix of 'hospital-centric' health services that governments want to offer.

According to the NHHRC, the proposed primary care reforms will enable Australians to keep well and out of hospital by accessing the right community-based health care at the right time and place.

To assess the merits of the NNHRC's blueprint for a so-called 'person-centred health system,' the Commission's approach to health reform and the rationale behind the most important recommendations in the Bennett Report must be carefully scrutinised.

Consumer-directed health care

Making sure the health services funded by taxpayers are person-centred and meet the health needs of patients is the holy grail of health reform throughout the world. The Commission has borrowed the idea of a person-centred health system from the market-based principles associated internationally with the consumer-directed health care movement. But (and this is a huge but) it has failed to appreciate that developing a truly person-centred health system requires market-based *structural reform* of the way taxpayer-funded health services are produced.

In the Australian context, consumer-directed health care aims to reform the old-fashioned 'command-and-control' arrangements that limit choice and prevent competition in the government sector of the health system. The threefold goal of consumer-directed health reform is to transform the way public health services are governed, funded and delivered; ensure the correct allocation of resources; and maintain the correct equilibrium between the supply and demand for health services according to the clinical needs of individual patients as diagnosed by doctors.

Right now, the type, amount and mix of taxpayer-funded public hospital and community-based services that are or are not provided to Australians are determined by federal and state governments,[11] whose crucial yet often imperfect and highly-politicised policy and planning decisions frequently overlook the actual needs of patients.[12] Health departments allocate taxpayer subsidies in the form of population-based capped global budgets to public hospitals and community health services, which are expected to deliver an unquantified and indeterminate amount of health services to the community. For consumers, this system is well described as a 'take what you're given' arrangement. Patients who wish to receive 'free' services cannot choose where they are treated. Government health services enjoy a monopoly over taxpayer funding and cannot go bankrupt regardless of how poorly they perform.

These 'command-and-control' arrangements account for the systemic problems in Australia's public hospitals and community health services. The absence of consumer choice and provider competition means public hospitals have no real incentive to attract customers, innovate and increase productivity, or to maximise the quantity and quality of the services provided at the lowest possible cost. Nor do they have an incentive to allocate resources efficiently to meet the health needs of patients. In fact, they have a financial disincentive to deliver care to patients. Patients become a burden, and services are rationed by closing beds or limiting elective surgeries to stay within budget because the normal market incentives (which improve quality and lower cost) do not apply.

Vast sums of taxpayer dollars are also wasted and misallocated away from frontline services to pay for the huge growth in the size, cost and complexity of the area health services—the centralised bureaucracies that have run several public hospitals in designated regions since local hospital boards were abolished by state governments in the 1980s and 1990s.[13] Service delivery is 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 and endure longer queues for essential hospital care.[14]

These systemic factors have directly contributed to the crisis in the public hospital system. The technical cause of the hospital crisis is the rising demand for bed-based hospital care from an ageing population, and the 60% fall in the number of acute public hospital beds per 1,000 head of population since the establishment of Medicare in 1984. So critical is the nationwide shortage of beds that over one-third of emergency patients requiring admission are not admitted to a hospital bed within eight hours, and are forced to queue and suffer on trolleys in hospital corridors. Overcrowding (or 'access block') occurs when hospitals operate beyond the internationally recognised safe level of 85% bed occupancy, and is caused by a genuine demand for emergency admission to a bed by patients who cannot be treated anywhere other than in a hospital.[15]

Structural reform

Consumer-directed health care addresses all these problems by the application of quasi-market mechanisms to the government health sector. Governments would still be responsible for funding health care, but service provision would not be determined from the top-down. Instead, funding would be flexible, responsive, and far more accountable. The taxpayer subsidy would be tied directly to the delivery of services and only be paid at the point at which each occasion of care is provided. Funding would follow patients by means of a taxpayer-funded voucher, and patients, subject to clinical referral, would purchase appropriate hospital and other health services from competing public or private providers.

Consumer-directed health care addresses all these problems by the application of quasi-market mechanisms to the government health sector.

In the long run, empowering consumers and tying funding to patients based on clinical need and choice of competing providers would reduce costs and bureaucracy, while increasing access, quality, productivity, and allocative efficiency. Most importantly, governments would no longer centrally plan the type, amount and mix of health services as the supply would be set by the actual health needs of individual patients. Market-based structural reforms that promote the efficient use of scarce resources would therefore establish a truly person-centred health system.

Visible fist, not invisible hand

Despite the person-centred rhetoric, and despite advocating limited support for select market-based reforms (such as casemix funding for public hospitals), the Bennett Report pays only lip service to the principles of consumer-directed health reform by adopting a highly contradictory approach.

The Commission's 'long term reform plan'[16] encourages the federal government to 'redesign health services around people'[17] and direct the future of Australian health care from the top down. The NHHRC claims to know the 'right' mix of primary care rather than hospital-based care that an ageing population is going to require in 10 and 20 years, and the circumstances in which the federal government should deliver these so-called more efficient and effective 'alternative' community-based health services.[18]

Examined in detail in the proceeding sections of this monograph are the huge question marks that hang over the appropriateness and effectiveness of the Commission's proposals:

- A national network of Commonwealth-financed GP Super Clinics delivering Medicare-funded coordinated care will not reduce the pressure on overcrowded hospital or improve access to hospital services as promised by the Commission.

- Tinkering with governance, funding and clinical structures at the national level, as proposed under the Healthy Australia Accord, will not fix the systemic problems in the public hospital system that create waste and inefficiency, and restrict access to hospital care, nor transform public hospitals into consumer-oriented, cost-and-quality conscious service providers.

- Reforms designed to reorient the health system around services that promote 'wellness' will not address the most important challenge facing the health system in an ageing Australia—the nationwide shortage of acute public hospital beds and the urgent need to open more beds to properly care for an older and sicker population.

These problems mean the reforms proposed by the Commission will not ensure that all Australians receive the right care in the right time and place, especially when health needs are greatest and hospital care is required. The Bennett blueprint therefore falls far short of a blueprint for a true person-centred health system because the Commission has failed to recommend the market-based structural reforms that are required to reorient the hospital and other health services around consumers. In reality, the Bennett Report's plan to create a less 'hospital-centric' health system that delivers stronger primary care services and less hospital-based care is a characteristically flawed example of 'command-and-control' central planning—of the imperfect knowledge and political distortions that always defeat attempts by politicians and bureaucrats to micro-manage complex systems to achieve the best outcomes for citizens.

The Commission has failed to recommend the market-based structural reforms that are required to reorient the hospital and other health services around consumers.

Primary care

Fragmentation and gaps

As the Bennett Report details, Australia's fragmented primary care system currently encompasses:

- general practice, which is largely Commonwealth funded, and multidisciplinary teams funded predominantly by states;

- private allied health professionals, who are mainly funded directly by households and private health insurers;

- community health services, which may be supported by either local or visiting salaried GPs, medical specialists, and specialist consultants or stand-alone nursing services;

- community health programs funded by the Commonwealth and state governments that are aimed at population groups with high needs, including low income earners, people with a mental illness, people with new babies, the frail elderly, people with disabilities, and people living in rural and remote areas.[19]

In recent years, the states have piloted community-based 'hospital avoidance' strategies to manage the conditions of chronic disease patients. At the same time, the federal government has expanded Medicare beyond the traditional fee-for-service GP consultations and rolled out the Enhanced Primary Care and Chronic Disease Management MBS Items covering care coordination and multidisciplinary allied health services for patients with chronic illnesses.[20]

Some patients with ongoing and complex needs—whether due to lifestyle-related chronic conditions or due to injury, ageing or genetic conditions—are reported to encounter difficulties navigating the different services run by different governments. The lack of integration between Medicare-funded private general practice, state government run and funded community health services, and other federal and state community-based programs is blamed for creating barriers that limit access to care.

The Bennett Report recommends a federal takeover of primary care funding and policy to end the waste, duplication and barriers that the Commission claims is the cause of problems in the public hospital system.[21] GP Super Clinics are supposed to fill the service gaps for non-hospital care that allegedly lead to overuse of hospitals. Each Super Clinic is intended to operate as a one-stop shop providing the full range of Medicare-funded community-based services.[22]

Inefficiency and more duplication

Yet research cited by the Commission reveals that only three in 10 Australians with a chronic condition complain of poor coordination, conflicting advice, and duplication of tests. It appears that the majority of patients are satisfied with the quality of existing primary care services, and problems are experienced mainly by socio-economically disadvantaged people.

The state-run community health services are supposed to cater for low socio-economic status patients and provide access to multidisciplinary primary health care and other community-based services such as hospital-in-the-home. Annual expenditure on the community health sector is approaching $4 billion a year. However, the complete absence of performance data means we have no way of knowing what we are getting for the money spent.[23]

What we do know is that the community health services are plagued by the same systemic problems as public hospitals, and that budget limits are enforced by rationing care, often by making services as difficult to access as possible. (Unlike public hospitals, community health services are not subject to the same demand pressures as public hospitals and are able to hide their services because they don't have big signs on the roads directing the general public to make free use of their services.) Hence, despite the duplicate federal and state primary care systems, there remain 'significant levels of unmet need and inequities of access across geographic areas and population groups.'[24]

It is important to note that the Commission has failed to set out in detail how the federal government should integrate community health services with GP Super Clinics, other than to propose that locally-controlled regional 'Primary Health Care Organisations' be established (based on existing Divisions of General Practices) to 'incorporate' government services with private practices. The community health services are staffed by union-dominated workforces and protected by the Labor Party. There is no guarantee they can be rationalised or that the states will agree to a federal takeover of primary care funding and policy. In fact, there is a real risk that the GP Super Clinics network could further waste resources by simply duplicating existing state and federal funded primary care programs.

The NHHRC has chosen to ignore these issues and not focus on removing the inefficiencies in the community health sector that cause waste and gaps.

Medicare Next Generation

The NHHRC has chosen to ignore these issues and not focus on removing the inefficiencies in the community health sector that cause waste and gaps.

Instead, the Bennett Report has recommended that 'Medicare needs to be further expanded beyond medical care to support access to a wider range of health professionals in primary health care, using funding approaches that are better suited to care over an extended time.'[25] The proposed expansion of the community-based health services funded by the Commonwealth is titled Medicare Next Generation. The inclusion of services such as physiotherapy and podiatry would represent the biggest single expansion of the system in Medicare's 25-year history.

A further recommendation is that people with long-term complex and chronic conditions, especially the elderly, be encouraged to enrol with a primary care 'home.' For each enrolled patient, primary care providers would receive additional capitation funding from Medicare to support the delivery of coordinated primary care and multidisciplinary allied health services, and assist people to better self-manage their conditions and stay well and out overcrowded public hospitals.[26] The recommendation that Super Clinics receive capitation payments for collecting autographs (enrolling patients) is a throwback 'command-and-control' policy which would entrench rather than address the systemic inefficiencies in the community health sector (see Box 1).

Box 1. Throwback I: capitation funding

Capitation funding is designed to cap funding for primary care services rather than allow health budgets to be driven by demand for uncapped fee-for-service programs. It is another form of population-based 'block funding,' which allocates funding to a specific institution instead of tying the money to patients and directly to the delivery of services. The primary care health providers receiving capitation funding would decide the kind and amount of services people receive or don't receive. Capitation funding would embed in Super Clinics the systemic problems, the barriers to access, and the excessive rationing of care that already plague under-performing public hospitals and community health services.[27]

Significantly, the interim Bennett Report admitted that capitation funding skews incentives and that 'necessary health services may not be provided.' The Commission has therefore recommended that clear national benchmarks for patient access and outcomes, linked to performance payments, will be essential to ensure that care is provided.[28] In other words, the system will be bureaucratically controlled rather than consumer-oriented.

The warning signs from across the Tasman should be heeded. In New Zealand, Primary Health Organisations (PHOs) channel capitation payments to GPs and allied health professionals based on patient lists. A recent OCED economic survey concluded that while the intention of the primary care reforms implemented in the late 1990s were to engineer 'a major structural shift in the primary care services towards innovative, co-ordinated, multidisciplinary and efficient forms,' they had 'failed by and large to deliver on its promise of more effective outpatient care for chronic conditions' as capitation funding had encouraged providers to deny care to patients.[29]

Blaming the wrong problem—Howard and the Labor states

To appreciate the flaws in the Commission's primary care centred health reform strategy, the political background to the NHHRC needs to be understood, starting with the deleterious impact of the blame game between the states and the Commonwealth.

The Labor state governments, who have been in office in most states for most of the past decade, routinely claim that the problems experienced in public hospitals are the fault of Prime Minister John Howard's Coalition government. According to the states, public hospitals have not only been underfunded by the Commonwealth under the AHCA but emergency departments have also been overwhelmed by an influx of 'GP-style' patients who cannot access Commonwealth-funded general practice and other primary care services.

The claims are a political contrivance and a myth. Public hospitals are overcrowded not due to lack of access to adequate primary care services.

The claims are a political contrivance and a myth. Public hospitals are overcrowded not due to lack of access to adequate primary care services.[30] They are overcrowded due to the rising demand for unplanned admission generated by an ageing population, the nationwide shortage of acute hospital beds caused by 25 years of cuts to bed numbers, and the raft of systemic problems that cause waste, inefficiency, and severely restrict the access of ordinary Australians to basic elective and emergency services.[31]

Roxon and Rudd's Super Clinics

Regardless of the truth, the claim that 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 become conventional wisdom and gained policy traction at the national level.

Before the 2007 election, the federal Labor Party jumped on the same bandwagon as their state colleagues and shifted the blame for the problems in public hospitals on to the Howard government's supposed neglect of the primary care system. The centrepiece of the pre-election health policy announced by the Prime Minister and Health Minister Nicola Roxon was a national network of federal government-financed GP Super Clinics. Under the Rudd government's $275 million plan, an initial 36 Super Clinics have been approved to provide local communities with enhanced access to general practice care, preventive health care, and coordinated primary care services.[32]

The Labor Party's existing health policy has been rubber stamped, and the Rudd government has been given a warrant to proceed with the rollout of GP Super Clinics.

Unfortunately, the NHHRC has failed to rise above partisan politics. The Bennett Report has strongly backed greater federal government spending on primary care infrastructure and services. The Commission has basically done what governments always expect the inquiries they establish to do. The Labor Party's existing health policy has been rubber stamped, and the Rudd government has been given a warrant to proceed with the rollout of GP Super Clinics.[33] It has also ignored the evidence that directly contradicts both the government's policy and its own recommendations. (See Box 2)

Box 2. Stronger primary care—the international evidence

According to the Bennett Report, international evidence shows that strengthening the primary health care system will produce better health outcomes, contain growth in overall health costs and, most importantly, reduce the use of public hospital services.[34]

In fact, international evidence does not support the claim that compared to higher-cost hospital care, lower cost primary care achieves better health outcomes for less. A 2002 cross-country analysis of 13 OECD countries revealed that countries with comparatively weaker primary care systems—including Australia—achieved better health outcomes than those with stronger primary care.[35]

In other words, more spending on higher cost hospital care, rather than less spending on lower cost 'preventive' primary care, appears to produce better health outcomes. International comparisons do not show that countries with stronger primary care and 'less focus on specialist/hospital care' achieve better health outcomes at lower cost.[36]

These findings have also been confirmed by the NHHRC discussion paper by Hurley, et al.:

> those [countries] with the best primary health care systems may be underspending on appropriate referred care which may, in part, account for the poor performances of these countries' populations later in life. Therefore, evidence may suggest that a disproportionate focus on primary health care at the expense of other sectors may be detrimental to health outcomes.[37]

Coordinated care—the non-solution for the hospital crisis

Influential stakeholders, including state health bureaucracies and the politically-influential community health sector, claim that coordinated primary care is an effective alternative model of care or substitute for hospital care, and dismiss any need to open more hospital beds.[38] The NHHRC's deliberations have been strongly influenced by this school of thought—to the extent that the Commission has described opening more beds as an 'inappropriate investment.'[39]

The Bennett Report claims that 10% of hospital admissions are potentially preventable if high-risk patients (chronically ill and frail elderly patients with complex conditions) were provided with so-called alternative community-based care 'at the right time.'[40] The theory is that avoiding preventable hospital admissions requires coordinated primary care from multidisciplinary teams of health professionals in a Super Clinic, not 'six-minute' fee-for-service medicine from a GP.[41]

Yet as I have argued elsewhere at length, the overwhelming bulk of research into the topic suggests that strengthening the primary care system will not take the pressure off hospitals in an ageing Australia.[42] The evidence is summarised in a discussion paper by Segal, which the NHHRC commissioned to inform its work, and deserves to be quoted in full:

> Whilst it has also been postulated that high quality primary care will reduce the use and cost of hospital services by substituting for less appropriate or more expensive tertiary in-patient or emergency department care and improving the quality of chronic disease management and lowering rates of disease progression and complications 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. In any case, 'ambulatory care sensitive' admissions (potentially avoidable through high quality primary care), for diabetes complications, COPD etc. have been estimated to account for only 10% of hospital admissions. Reform of primary care should be justified in terms of its impact on health and wellbeing and equity, rather than presumed 'cost savings.'[43]

The significance of these devastating findings cannot be understated. The evidence is not just equivocal. It shows that despite the provision of the 'right care in the right setting,' the expected reductions of 'only 10%' in hospital admissions 'did not happen.' In other words, the rationale for greater government investment in coordinated care has been debunked by an overwhelming amount of evidence. Community-based services have proven to be no substitute for hospital care, and will not make up for hospital bed shortages in the short or long term.

Without acknowledgment, comment or explanation, these findings have been completely ignored by the Bennett Report. The Commission has also ignored the results of the federal government's multi-million-dollar Australian Coordinated Care trials, which showed that coordinating the care of a trial group of elderly and chronically ill patients aged 75 and over produced no significant reduction in hospital use, compared to a control group who continued to receive their usual level of care from their GP.[44]

The evidence is not just equivocal. It shows that despite the provision of the 'right care in the right setting,' the expected reductions of 'only 10%' in hospital admissions 'did not happen.'

Of equal significance are the studies that suggest lack of coordination acts as a 'rationing' device. These studies indicate that the main effect of coordinated care is to uncover unmet need and ensure patients receive all beneficial hospital care.[45] This is hardly an argument against coordinated care. There is a case for the efficient provision of coordinated care in terms of improved well-being and social equity. (See Box 3) But the overriding point, which all policymakers and stakeholders need to understand, is that coordinated care may well increase demand for hospital care and add to the pressure on public hospitals. The bottom-line is that stronger primary care is no solution for the crisis confronting Australia's overcrowded hospitals.

Box 3. The truth about coordination

Coordinating the care of chronic disease patients from lower socio-economic groups is one way to try to reduce 'unacceptable inequities in health outcomes and access to services.'[46]
In this context, coordinated care is a form of medico-social work for unmotivated and high risk patients:

> John is a patient in his late 40s who has presented to the local hospital emergency department with asthma on three occasions over the past 12 months. He continues to smoke (although he has tried to cut down). He has been given preventer and reliever medications but does not take these regularly. He sees one of 2 or 3 GPs when he has an attack but has not presented for the 3+ visits suggested by his GP. He has a management plan (which he shows to his pharmacist) but does not really follow this. He attended for a health check visit after being invited by one of his GPs and had his BP and lipids checked (which were within normal limits) but has not changed his lifestyle.[47]

The first objective is to supplement and 'connect up' care of those with complex needs who are most likely to fall through the gaps and fail to utilise all appropriate and beneficial services. The second objective is to try to make up for the poor knowledge and skills of the patients who are more likely not to follow recommended treatments and are more likely to fail to modify lifestyle risk factors associated with long-term chronic diseases. The ultimate goal is to reduce the number of people who fail to self-manage their conditions properly, and ensure, for example, that Type 2 diabetes sufferers receive regular blood pressure, vision, and pathology checks.[48]

The difficulties involved in changing the entrenched behaviours of unmotivated patients may explain the small prospects for the success of coordinated care in terms of reducing the use of hospitals. But granted the high health stakes—that failure to manage their condition will result in a diabetic patient losing a foot—there is a case for government funding of coordinated care 'in terms of its impact on health and wellbeing and equity,' so long as these services are provided in the most economically efficient, consumer-directed, and person-centred way possible. (See p. 19)

Governance

The Canberra option

Health commentators who believe governance problems are at the root of all the problems in the Australian health system maintain that the federal government should assume complete control of all health responsibilities, including taking direct control of all public hospitals. A full federal takeover, the argument goes, will solve the cost-shifting, service gaps, and duplication caused by the current ad hoc division of federal and state responsibilities, and put an end to the constant bickering between the Commonwealth and the states over problems in the health system. Commentators sharing this opinion have expressed disappointment at Prime Minister Rudd's decision to backtrack on his pre-election commitment to take over the public hospital system if the states failed to 'fix up the public hospitals in twelve months' pending the results of the NHHRC review of the health system.

The NHHRC has rightly rejected the option of a unitary health system run entirely out of Canberra as too risky and politically complex.

The NHHRC has rightly rejected the option of a unitary health system run entirely out of Canberra as too risky and politically complex. Instead, it has proposed the Healthy Australia Accord, a less ambitious proposal to clarify complex and overlapping governance responsibilities and establish clearer policy, funding and performance accountabilities at the national level.

Micro-management (instead of micro-reform)

The Commission maintains that if the state and federal governments agree to the Healthy Australia Accord, it will lead to improved service delivery. The theory behind the Accord is that the electorate will know who is to blame for problems. Clearer financial and policy responsibilities for different parts of the health system will be allocated to the state and federal governments, who will be held politically accountable for service failures by voters.

There are a number of problems with both the detail and philosophy of the Commission's proposed governance reforms. The Healthy Australia Accord would leave plenty of scope for the blame game to continue. Even if state governments sign up, they can continue to blame the hospital crisis on the federal government's supposed failures to provide adequate primary care services. Moreover, the Healthy Australia Accord is likely to create new perverse incentives and encourage the states to cost-shift patients to federally-funded outpatient and community-based services.

The biggest problem is the overall theory. According to the Commission, the (weak) political and budgetary incentives created by clarifying governance responsibilities will inspire state and federal governments to be better micro-managers and somehow fix the problems that impede the performance of the parts of the health system they run.[49] Since the Accord would require the Commonwealth to share the financial risk in relation to hospital costs, the federal government would have a financial incentive to invest in primary care services. The Commonwealth, the Commission predicts, will therefore seek to make these services as effective as possible to reduce the use of hospitals and avoid having to pay 40% of the cost of 'avoidable' hospital admissions.[50]

The Healthy Australia Accord is indicative of the contradictions in the Commission's top-down approach to developing a so-called patient-centred health system.

This plan to incentivise governments to micro-manage the health system is the antithesis of consumer-directed health reform. It overlooks the systemic and administrative problems that plague the health sector and ignores the urgent need for consumer choice and provider competition to improve the cost and quality of health care.

The Healthy Australia Accord is indicative of the contradictions in the Commission's top-down approach to developing a so-called patient-centred health system. The NAT system perfectly illustrates these contradictions because, in policy terms, it is a throwback to the era of central planning, which will pile another layer of bureaucratic control on top of the health system, rather than put consumers in charge. (See Box 4) If the Commission was serious about structural reform of taxpayer-funded health care, ending the public hospital monopoly, and optimising the use of private providers to deliver taxpayer-funded care, it would never have recommended the creation of government-owned stand-alone elective hospitals. (See Box 5)

Box 4. Throwback II: performance targets

As a mechanism for keeping service providers accountable for the public funding they receive, performance targets are the ultimate micro-management technique employed by command-and-control bureaucracies. In practice, reporting requirements distort priorities and lead to the 'only what's measured, gets done' syndrome. Staff time and effort are diverted into bureaucratic tasks, and resources are channelled into administrative positions at the expense of patient care.

The Bennett Report ignores how politically mandated performance targets have been a costly disaster in the United Kingdom, having failed to turn hospitals into cost-and-quality conscious providers. Report after report has established that the 70% real increase in National Health Service funding since 2000 hasn't produced a commensurate increase in productivity. The systemic problems, and bureaucratic cost and complexity, of the NHS have been multiplied at a much higher cost to taxpayers.[51] By the time the additional funding was funnelled through the bureaucracy or turned into higher staff pay, only a fraction of the extra money reached the frontline.

The Commission's enthusiasm for performance targets and bonus payments is based on the apparent success of a similar system in Victoria. In combination with casemix funding, these arrangements are credited with transforming the Victorian public hospital system into the most efficient in the nation. However, confidence in the performance of Victorian hospitals has been seriously undermined by recent revelations that hospital data have been systematically falsified ('gamed') to appear to meet targets and trigger incentive payments.[52]

'Gaming' is a problem innate to all performance reporting regimes and symptomatic of the systemic problems and administrative dysfunction in public hospitals. Public hospitals run by centralised Area Health Services do not have the managerial autonomy at the local level to pursue efficiencies by making changes to staffing and other arrangements such as cleaning, catering and laundry services. Funding is not used optimally because the long and diffuse chain of command means that hospitals are unable to efficiently reallocate resources and undertake innovations that increase productivity and achieve real improvements in access to services. Most importantly, hospitals do not have the financial capacity and flexibility in their capped budgets, nor the operational authority over their own facilities, to increase bed numbers to admit and treat emergency and elective patients in a timely fashion.

Box 5. Throwback III: public procedural hospitals

The interim Bennett Report recommended greater contracting out of elective surgery for public patients to private hospitals in order to cut waiting lists, relieve some of the pressures on public hospitals with heavy demand for emergency admission, and 'optimise the provision and use of public and private hospital services.'[53] The final Bennett Report has recommended the establishment of stand-alone elective hospitals.

This recommendation sums up the Commission's contradictory approach to health reform.

Sixty percent of surgery in Australia is currently preformed in private hospitals. In some states (Queensland, in particular[54]), taxpayer-funded procedural care is already delivered in private hospitals. In 2008, the Rudd government established a $150 million a year national program to purchase private hospital services to try to clear public elective waiting lists.

When the alternative policy is for governments to pay for elective care for public patients in private hospitals, the rationale for the Commission's expensive and outdated proposal to create a duplicate public procedural system is difficult to fathom. At best, this is a throwback to the discredited idea that the proper role for government is to directly provide (as opposed to fund) the health services the community requires. At worst, this is an example of the 'public is best' mentality, which continues to skew the perspective of stakeholders in the health debate who remain ideologically opposed to the private health sector.

Hospitals

A funding reform in the right direction

Public hospitals are not 'under-funded.' Spending on the public hospital system (funded overwhelmingly by federal and state taxes) has increased in the last decade by 64% in real terms (adjusted for inflation) from $17 billion in 1996–07 to $27 billion in 2007–08. The best aspect of the Healthy Australia Accord is that the NHHRC has realised that lack of funding is not the cause of the hospital crisis.

The Commission appreciates that spending billions of health dollars on public hospitals to inefficiently expand their services[55] cannot be justified unless the community receives more and better services.

> We need to ensure that funding approaches achieve our objectives for health services that improve patient outcomes and are efficient, and that additional investment by government converts into real improvements in access and quality.[56]

Casemix

At present, public hospitals are principally funded by global budgets, adjusted for population, and calculated largely on a historical basis, except in Victoria where casemix funding was introduced in the 1990s. The Commission agrees that public hospitals must be taken off the drip feed of annual budget allocations from state health departments and supports a partial shift away from the existing command-and-control method of running and funding the system. The Bennett Report has therefore recommended, as part of the Healthy Australia Accord, that public hospitals nationwide must be funded by activity-based casemix payments for inpatient and emergency care. The NHHRC's qualified support for limited market-based reform (though the Bennett Report does not use this term) to tie funding directly to the delivery of patient care is welcome.

Casemix funding is a transparent system in which hospitals earn their funding based on the work they do and the number, type and complexity of patients treated. This pay-for-performance arrangement is based on the efficient cost of providing each occasion of care averaged across both public and private hospitals. Casemix funding requires hospitals to use resources optimally and rewards greater technical efficiency. It gives hospitals a powerful incentive to innovate, increase productivity, maximise services, reduce waiting times, and promote allocative efficiency. Activity-based payments are 'information rich' and require producers to understand how much of what kind of services patients require.[57]

Greater choice, more competition

The introduction of 100% casemix funding under the Healthy Australia Accord is an overdue reform in the right consumer-orientated direction. It would improve the way public hospitals are funded, increase productivity, and improve value for taxpayers' money. But even under 100% casemix funding, state health departments and area health services will still be in charge of spending with the same incentives to cap casemix hospital budgets, cut beds, and ration services to sustain and expand the size of the bureaucracy.[58]

Furthermore, the Commission has not found a comprehensive solution to the waste and inefficiency caused by the 'high administrative cost' (misallocation of resources to pay for excessive bureaucracy) and the 'rift between corporate and clinical accountabilities' (the breakdown in the working relationship between remote area health bureaucrats and frontline doctors and nurses that means funding for patient care is not spent optimally).[59] Casemix funding alone cannot remedy the systemic problems and the resulting administrative dysfunction that stems from the absence of consumer choice and provider competition in the bureaucratically-run public hospital monopoly. Public hospitals need market-based structural and administrative reform, including the re-establishment of local hospital boards to transform them into consumer-oriented, cost and quality conscious service providers.

The right priorities for an ageing Australia

Wellness promotion

The Commission, like many health commentators, has called for higher government spending on preventive health, including coordinated primary care services, on the grounds that 'if we continue with business as usual, the fastest growing areas of spending will be acute services such as hospitals.'[60]

The argument, based on very thin evidence of the effectiveness of health promotion measures, is that more needs to be done to address the predominantly class-based lifestyle-related risk factors associated with chronic illness, keep people healthy, and alleviate the pressure on hospitals. (See Box 6)

Box 6. The golden thread: a policy looking for an evidence-base

The interim Bennett Report described greater funding for 'health promotion and prevention capacity at the national level' as 'the "golden thread" that connects our report.'[61] The final Bennett Report described higher federal government spending on 'evidence-based' prevention measures as a 'no-brainer.'[62] It claims that improved access to so-called preventive primary care services would reduce obesity, leading to reductions in related diseases and, ultimately, reductions in the use of more expensive acute hospital care services.[63]

The Commission maintains that the preventive care delivered in Super Clinics will facilitate lifestyle modification and address the 'ticking time-bomb' of obesity. The Bennett Report points to the poor quality of preventive care by GPs. It highlights reports that only one in five lifestyle problems (smoking, weight loss, alcohol abuse, and exercise counselling) are treated using non-pharmacological interventions.[64] The plan is for Super Clinics to deliver high-intensity, multidisciplinary lifestyle interventions to patients at higher risk of chronic disease.

One might presume that evidence therefore exists to guide the rollout of preventive health measures and bring about a real reduction in lifestyle-related chronic disease and demand for hospital services. Unfortunately, the Commission admits that it has no evidence to show what interventions work and are effective in addressing lifestyle-related issues such as poor diet and lack of exercise.[65]

The reality is that so 'limited' and 'scarce'[66] is the evidence that calls for greater government spending on prevention is a 'policy looking for an evidence base.'[67] The evidence actually indicates that greater spending on prevention is unlikely to be effective. Major reports on public health policy in Australia and the United Kingdom reached identical conclusions. Both found that despite millions of taxpayers' dollars being spent on health promotion, the levels of physical activity had not changed much and obesity levels had risen.[68]

In addition, the Wanless Review in the United Kingdom commented on the 'very poor information base' and 'lack of conclusive evidence for action,' as well as noting that there was 'generally little evidence about the cost-effectiveness of public health and preventive policies or their practical implementation.' It also commented on the singular failure of public health policies to promote the health of lower-income people and concluded that 'there is little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities.'[69]

Studies have also shown that even high-intensity lifestyle interventions have had a low impact on behaviour, particularly with regard to the key challenge: ensuring the long-term retention of lifestyle changes.[70] The evidence, therefore, suggests that many recipients of Medicare-funded preventive health services will fail to change their unhealthy lifestyle, and future governments will have to fund the recurring costs of ineffective preventive care that yields negligible health and cost benefits.[71]

The NHHRC discussion paper by Young, et al. was commissioned by the NHHHRC to challenge these findings. Yet the authors also found the evidence concerning the best way to 'meet preventive health care policy objectives is scant and inconclusive,' and raised alarm bells about the national rollout of policy ahead of the evidence because:

> There is little empirical evidence to support any particular mix of payment system in meeting health policy objectives. Nor do we know whether particular payments systems are effective in reducing cost, nor do we understand how they might actually work to produce behaviour change.[72]

Longevity and chronic disease

The Commission cites what seems to be compelling evidence for making greater expenditure on preventive health the 'golden thread' or chief policy priority. The Bennett Report highlights the strain the 'shifting disease patterns' and the 'rising tide of chronic disease and frailty in the future' will continue to place on the health system. One in four Australians already has two or more chronic conditions. Eighty-three percent of elderly patients have multiple conditions, and four in 10 GP patients are chronically ill. Over half of GP consultations concern chronic conditions. By 2030, Type 2 diabetes is expected to increase by 520%, dementia by 369%, and respiratory conditions by 205%.[73]

Yet the Bennett Report does not answer the crucial question—whether demographic or lifestyle factors are the cause of the rising chronic disease burden? One of the expert discussion papers commissioned by the NHHRC maintained that the 'meteoric rise in the prevalence of chronic disease in Australia owes as much to our lifestyle as the ageing phenomenon.'[74] But a different discussion paper pointed out that over 55% of elderly people have five or more long-term conditions and that the 'demographic shift towards an older population ... has contributed not only to the change in prevalence in chronic disease but also an increased demand on health services.'[75]

The final Bennett Report hedges its bet: 'In the future, as the population grows and ages, more people will suffer from chronic disease, some as a consequence of unhealthy behaviour.'[76] The proportion of the rising tide of chronic disease that is caused by lifestyle and may be preventable compared to the amount that is caused by ageing and is unpreventable has vital policy implications that suggest the Commission has got its priorities wrong.

Limits of prevention and demand for hospital care

Due to the lifestyle changes and medical advances of the last 40 years (which include reductions in smoking and healthier diets in some sections of the community, improved medications, falling rates of stroke, and higher cancer survival rates), Australia already has the second highest average life expectancy in the world next to Japan.[77] The crucial point that has been overlooked, not only by the NHHRC but in the health debate in general, is that lengthening life-spans mean that more people are and will continue to live to older ages, at which the onset and deterioration of age-related chronic disease occurs. There is very limited scope to maintain the health of elderly patients who will inevitably fall acutely ill and require admission to hospitals for basic, bed-based medical and nursing care.[78]

Increasing numbers of frail older and sicker patients aged 75 and over are already putting the greatest pressure on public hospitals by presenting at emergency departments and requiring admission to scarce hospital beds. In the last five years, separations in public hospitals by 'very old' patients aged 75–84 and 85 and over have increased by 25%, while bed numbers have remained steady at around 2.5 beds per 1,000.[79] The result is dangerous overcrowding in public hospitals that do not have enough beds to provide the traditional bed-based medical and nursing care that increasing numbers of patients require.

There is an urgent need to get the policy settings right and make sure that all Australians can have timely access to a hospital bed when health needs are greatest.

The assumptions behind the Bennett Report's plan to fundamentally redesign the health system around 'wellness' promoting primary care services are therefore faulty. The implications of the push to make the health system less 'hospital-centric' are deeply concerning. Higher government spending on prevention is the wrong policy priority for an ageing Australia. Investing in coordinated primary care services will not equip the health system to cope with the unprecedented and inexorable impact of population ageing, which will inevitably increase the demands on

‡ I am committed to none of the details set down here of the proposed national voucher scheme. What follows is an exercise in thinking our way out of the current mess and is intended to stimulate discussion. The author is happy to be made aware of likely problems, potential pitfalls, and possible improvements.

hospitals required to care for larger numbers of older and sicker patients in coming decades. Due to record longevity, many more acute hospital beds than are currently available are going to have to be opened to provide the hospital care that Australia's ageing population will require.[80]

Reforms that will allow the acute hospital bed base in Australian hospitals to be rebuilt should be the number one reform priority. There is an urgent need to get the policy settings right and make sure that all Australians can have timely access to a hospital bed when health needs are greatest.

National Hospital and Health Voucher Scheme‡

Market-based hospital reform

To ensure that the health system is equipped to cope with the pressures created by an ageing population, a market-based transformation of the way taxpayer-funded hospital and other health services are produced is required. This transformation can be achieved by the federal government implementing the following structural changes to the financing and administration of the health system:

A. **A federally-funded national hospital voucher scheme** covering the casemix cost of treatment in either public or private hospitals, in conjunction with the re-establishment of local public hospital boards to run public hospitals and the abolition of superfluous area health services; and

B. **An extended national health voucher scheme** for chronic disease management and other community-based services (including sub-acute and hospital-in-the-home care) provided by either government or private providers.

The national hospital and health voucher scheme would create a set of truly person-centred and consumer-driven governance, funding and delivery arrangements.

The national hospital and health voucher scheme would create a set of truly person-centred and consumer-driven governance, funding and delivery arrangements. Clinical need, patient choice, and provider competition would set the supply of hospital and other community-based health services needed by our ageing population in the coming decades. All Australians would have access to the right care they need in the right place at the right time, without having to rely on the imperfect decisions of politicians and their advisors who (as the Bennett Report demonstrates) frequently get policy and planning decisions terribly wrong.

Issue vouchers—demand-side reform

Under the national hospital voucher scheme, all existing government funding for hospitals and community health would be converted into taxpayer-funded hospital and health vouchers.

Hospital vouchers would be issued by Medicare, subject to clinical referral, and set at the 'efficient' casemix cost of emergency and inpatient hospital services. Vouchers would cover the full cost of whole episodes of emergency and inpatient care, include the cost of capital, and be properly adjusted for the complexity of acute patients requiring bed-based medical and nursing care. All citizens would continue to have voucher-funded access to necessary acute and procedural care irrespective of their capacity to pay out of private income, thereby preserving the equity that underpins political support for the 'free' Medicare system. However, the way taxpayer-funded hospital services are produced would be transformed and resemble the operation of normal market conditions as closely as possible. Hospital budgets would be principally based on clinical throughput and the vouchers earned for providing each occasion of service to the community.

A voucher scheme would liberalise the demand side of hospital care. Funding would be tied to patients and empower consumers with choice of both public and private providers. The economic incentives in the voucher system would be genuinely consumer-oriented. Each hospital would have to compete for revenue and, therefore, be required to focus its efforts on providing services of the highest quality at the lowest cost. The best, most innovative, and most efficient hospitals would thrive and expand their capacity to deliver more and better care to the community. Because

all payments to hospitals would be principally in the form of a casemix voucher calculated on a defined length of stay for each episode of hospital care, the voucher scheme would not only encourage efficiency and cost containment but also create an incentive to improve quality and avoid complications, such as hospital infections, which lengthen stays and may cause unnecessary readmission.

Re-establish hospital boards—supply-side reform

Transforming public hospitals into cost-and-quality conscious, customer-oriented service providers would also require supply-side reform. The administration of hospitals must be decentralised by re-establishing autonomous (pro-bono) Boards of Directors at each public hospital in Australia. Boards with a mix of clinical representation and citizens with business, legal and accounting expertise would resemble non-profit corporations. They would have autonomous control over the hospital's budget and full responsibility for the financial management of the facility. The standard requirements of corporate governance would apply. The board would need to calculate the cost of their services, be cost-conscious to ensure long-term viability, and be required to publish annual reports detailing the hospital's financial performance.

Boards would be responsible for strategic planning in conjunction with the professional administrators employed to oversee the day-to-day running of the hospital. Each hospital would appoint a chief executive officer answerable to the board and accountable for managing the hospital's budget. The administrative team would have full operational control, and clinical governance would also be restored. The board and the chief executive would rapidly resolve problems as they arise and improve performance in partnership with frontline clinicians.

Once freed from external bureaucratic interference and the endless paperwork staff are forced to complete to comply with centralised health department and area health directives, hospitals would be able to concentrate on their core responsibilities: improving the quality of patient care, optimising service delivery, and undertaking judicious capital investment based on informed and sustainable planning of services. Centrally determined staffing and wage agreements should also be abandoned. Each hospital would negotiate flexible arrangements and end restrictive practices that currently lower productivity and restrict access to care.

Networking 'from below'

Decentralised administrative autonomy combined with the financial realities of the voucher system would encourage the networking of hospital services 'from below.' Hospitals (subject to a minimum community service obligation) would be encouraged to specialise and integrate their services with nearby facilities, and not attempt to offer an unsustainable range of services.

The development of city-country hospital networks would also be encouraged. Small rural hospitals would be keen to establish links with major urban hospitals that offer all specialities. City hospitals would have an incentive to access new patient bases in the bush. To allay concerns about the impact on access to care, patients in rural areas forced to travel for major planned procedures would also receive extra vouchers covering travel expenses.

Allocative efficiency

The national voucher scheme would not only encourage technical efficiency (the delivery of hospital services for lower cost) but also allocative efficiency. The need to earn vouchers would require hospitals to react to market signals and efficiently expand the supply of hospital care to meet demand. Decentralised administration would give local boards the authority to make effective management decisions and give hospitals the freedom to respond appropriately to the health needs of the community. Vouchers—direct funding on a case-by-case basis—in combination with the re-establishment of local hospital boards would transform hospitals into consumer-oriented providers. Doing away with the present system of population-based block funding and centralised bureaucratic control would realign governance structures and financial incentives, and give local hospitals the freedom and authority to align resources with patient demand, cut waiting times, and end bed shortages.

A voucher scheme in conjunction with the re-establishment of local boards and the abolition of area health services would also end the waste on bureaucracy that lowers productivity and leads to excessive rationing of care and service shortages. The health dollars saved by closing down redundant bureaucracies would be reallocated to fund vouchers and pay for frontline hospital services.

Swift action would also be required on reform of medical and specialist training in Australia to free up the supply of doctors.[81] In-hospital nurse training (proposed in the dying days of the Howard government) should also 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 and deliver traditional bed-based nursing care.

Public and private

A national voucher scheme would remove the artificial barriers that give public hospitals their monopoly over taxpayer-funded care and prevent taxpayer-funding from following patients to private hospitals. By permitting choice and competition, vouchers would enable more procedural care to be delivered in private facilities as a matter of course. Efficient use of private hospitals would increase access to services and reduce waiting times.

The National Hospital Date Collection complied by the Commonwealth Department of Health and Ageing shows that private hospitals perform the 20 most common surgical procedures at between 5 and 7% lower cost than public hospitals.[82] Exposing public hospitals to direct competition with more efficient private hospitals would enhance the drive for public sector productivity gains and help reduce the total cost of the voucher scheme.

The national voucher scheme will also create a level playing field and ensure fair competition between public and private hospitals.

The national voucher scheme would also create a level playing field and ensure fair competition between public and private hospitals. The financial disciplines created by voucher-based funding would require public hospitals to properly cost their services. Current practices (which discourage private investment in essential health services) that permit globally-budgeted and financially unaccountable public hospitals to 'double dip'—to use medical infrastructure and hospital capacity funded by taxpayers to undercut private hospitals by providing 'cut price' services to private patients—would no longer be affordable.

Beds

To address public hospital overcrowding, the interim Bennett Report recommended that major public hospitals with large emergency workloads receive separate fixed-based grants to ensure they have bed capacity on call to ensure prompt, unplanned admission of patients. The final Bennett Report recommends the federal government finance a 15% boost in bed numbers to allow major urban hospitals with large demand for emergency admission to operate at the safe level of 85% bed occupancy. This expensive proposal amounts to throwing more money at public hospitals. It is not a long-term solution for the national bed shortage.

A national voucher scheme, combined with the re-establishment of autonomous local boards, would give hospitals the financial incentive and operational authority to adjust their services and open and staff more beds. Because hospital funding would follow patients based on clinical need, funding would be available to meet the looming rise in demand for acute hospital care from older and sicker patients. Because the voucher system would be consumer-driven, demand for hospital services would set the appropriate supply of hospital beds and services according to the health needs of an ageing Australia.

The voucher system would be overseen by the national voucher agency, a new authority that the federal government would establish to authorise hospital vouchers. One of the first tasks for the national voucher agency would be to remove the bias in favour of procedural care in casemix system, which leads to the underfunding of non-procedural care. The bias is a product of procedures being easier to cost and measure, compared to the more costly, complex and time-consuming emergency and acute care that is far more labour and capital intensive. To ensure that non-procedural hospital care is properly priced, the agency would be required to accurately

measure the average cost (including full capital and labour costs) of providing emergency and acute medical and nursing care for the acutely ill patients, who currently account for 67% of admissions to public hospitals in Australia.[83]

To directly address overcrowding, hospitals providing emergency services would also submit bids twice a year (to adjust for changes in peak winter and lower summer demand) for extra 'bed vouchers' to pay for the fixed costs of the bed supply and appropriate levels of staff required to maintain adequate capacity to admit patients from emergency.[84] This would minimise the incentive that hospitals have to use the spare bed capacity needed to manage unplanned admissions and instead treat procedural patients. The extra bed vouchers would also be issued by the national voucher agency, the responsibilities of which would include expressing demand for acute beds, pegged and adjusted according to demonstrated need for unplanned admission, on a hospital-by-hospital basis.

Consumer-driven community-based services

Competitive care coordination

The best way to address the waste, duplication and gaps in the primary care system is to double the dose of structural reform. The national voucher scheme should be extended to cover coordinated chronic disease care. These vouchers would finance (based on robust evidence-based practice guidelines for chronic disease management) the casemix cost of care planning and the purchase by the care coordinator of a package of allied health services for at-risk patients with serious chronic conditions, subject to clinical need as diagnosed and referred by gate-keeping GPs who would retain overall control of patients' medical care.

Private health insurance funds (which already run similar programs for their members) and non-government charitable and philanthropic organisations would be eligible to provide voucher-funded care coordination. These organisations would compete for customers based on the quality of the multidisciplinary services they purchase on behalf of patients from either private, allied health care providers, or government community health services. The voucher system would address the concerns about equity, barriers and lack of integration behind calls for greater government investment in coordinated care. It would ensure that the chronically ill receive all beneficial care but in the most economically efficient and consumer-driven way, with local agencies empowered to deliver services that are responsive to patients needs. The incentives would be correct—to provide the highest quality of care to patients at the lowest possible cost. Patients, together with their GPs, would have free choice of competing care coordinators, and have the power to take their voucher to an organisation that offers the best service.[85]

The voucher system … will ensure the chronically ill receive all beneficial care but in the most economically efficient and consumer-driven way.

Sub-acute services

The voucher system should fund other non-hospital and community-based home services, such as 'hospital in the home' and other social care for the elderly, and sub-acute and rehabilitation care.

Properly resourcing an alternative step-down level of care for elderly patients transitioning into aged-care facilities, and for all patients well enough to leave hospital but not yet well enough to go home, would help free up higher cost acute beds and further alleviate the pressure on overcrowded public hospitals. Because all payments to hospitals would be in the form of a casemix voucher calculated on a defined length of stay, the scheme would encourage acute and sub-acute care providers to improve the interface and patient journey between the two levels of care, and ensure seamless transition for those moving from hospital to home.

Voucher-based funding would also ensure the sub-acute sector is open to competition from a wide range of providers, including private and not-for-profit hospitals and nursing home facilities. A guaranteed voucher-based funding stream would encourage rapid private investment in sub-acute services and relieve the federal government of the onerous financial burden of providing the capital required to build government owned-and-operated facilities.[86]

Implementation

Interim, staged, and staggered

Implementing the national voucher scheme would require the federal government to assume full responsibility for *funding* taxpayer-funded health services.

As an interim measure, 100% casemix funding should be immediately introduced for public hospitals, with appropriate changes made to the terms of the Australian Health Care Agreement.

While the national vouchers system will require the federal government to become the single national funder of the health system, the Commonwealth will not take over or run either public hospitals or community health services.

While the national voucher system would require the federal government to become the single national funder of the health system (with appropriate adjustment to grants to the states and allocation of GST revenue), the Commonwealth would not take over or run either public hospitals or community health services. A federal funding package (along the lines of the National Competition policy of the 1990s) should be offered covering the transition costs and cost of redundancies in health departments and area health services in states that agree to pass legislation re-establishing local hospital boards. The devolution of operational authority to local hospital boards would be the trigger for introducing Medicare-issued hospital vouchers on a state-by-state basis. A staged and staggered introduction would enable problems to be identified and remedied as the national rollout proceeds.

Vouchers for elective care would be issued to members of the general public by Medicare Australia upon presentation of their hospital invoice. Patients requiring emergency treatment would be 'bulk billed' to Medicare by each hospital, thereby making the funding arrangements as close to market-based as possible, given the obvious lack of scope for choice and competition when emergency treatment is urgently required. Medicare is a trusted brand and its involvement in the new system would build public confidence in the reforms.

The federal government would also be required to develop a robust national health reporting system covering both hospitals and community-based care. To assist consumers make informed choices, to enhance competition, and to promote quality and safety, all providers would be obliged to collect key clinical outcomes for patients (such as medication errors, infections, complication, re-admission, and case-specific mortality rates). This data—the collection and collation of which would be made possible when the national system of electronic health records is up and running—would be published quarterly on the website of the Commonwealth health department. Protections against gaming should include criminal sanctions for fraud.

National voucher agency

The national voucher agency should be established as a stand-alone semi-government authority, separate from Medicare Australia, detached from the federal health department, and located outside of Canberra.

The agency's responsibilities would include determining which hospital and others services should be covered by vouchers, based on the cost-effective impact on health outcomes. To fulfil this role, the agency would need to be tough-minded, evidence-based, and insulated from political influence and special pleading. The agency's charter would be to approve vouchers covering minimum hospital and community-based care requirements.

Transparency

The national voucher scheme would be financially transparent and enable the health services received by the community for taxpayers' money to be accurately measured.

Instead of rationing care and controlling costs by elective waiting lists and emergency queues as is the case now, decisions taken to restrict public funding for services considered voucher-worthy would be transparent rather than hidden, arbitrary and irrational. The national voucher agency would also be responsible for conducting cost-benefit assessments of new medical technologies.

Establishing a clear, objective and evidence-based assessment process is crucial in the context of demographic change, continuous medical advances, rising consumer expectations, and a shrinking base of taxpayers to fund the ever rising cost and sophistication of health care.[87] The voucher scheme would also permit the cost-effectiveness of medical interventions to be periodically evaluated. Medical technologies and interventions found not to provide value for money or enhance health outcomes would no longer be funded.

Financial transparency would also encourage greater public discussion of issues critical to the future of the health system, especially the cost of 'end of life care.' The national voucher agency would be required to publically report the (non-identified) patient and cost data generated by the voucher scheme each year. This data would also be audited by the national voucher agency to identify instances of over-servicing, as well as fraud, based on like-for-like population-based comparisons.

Copayments

A less bureaucratic way to protect against abuse and guarantee the integrity and financial sustainability of the voucher system would be a well-designed system of compulsory copayments, with limited exceptions for the disadvantaged and genuine emergency care.

Copayment should be extended to bulk-billed GP services as well to curb growth in government spending at the least acute end of the health spectrum. Since the establishment of Medicare in 1984, Australians have been entitled to receive bulk-billed GP consultations on demand, and the growth in the uncapped cost of the Medical Benefits Scheme (MBS) has encouraged governments to restrict spending on hospitals by capping hospital budgets and cutting bed numbers. An irrational 'inverse care law' applies in Australian health care, as those with the least serious health needs have relatively unlimited taxpayer-funded access to GP services, while those with more serious and acute illnesses wait in the queue for public hospital treatment.

A less bureaucratic way to protect against abuse and guarantee the integrity and financial sustainability of the voucher system would be a well-designed system of compulsory copayments

Introducing copayments and controlling continued growth in the cost of the MBS would encourage the Commonwealth to dispense with capped hospital budgets and embrace a voucher-based demand-driven funding system. This significant change to Medicare and the philosophy of 'free' medicine would require educating the community about benefits of becoming more informed and financially cautious consumers of health services. The trade off for greater personal responsibility for the least severe and financially onerous health needs would be enhanced access to the expensive hospital services required when personal health problems are greatest.

Minimum public package and PHI

A transparent voucher scheme would also promote rational debate about the treatments beyond a voucher-funded minimum package of care that should be considered foreseeable health expenditures (for example, knee and hip replacements or cataract surgery) for which people should be expected to privately insure and 'top up' their cover as they choose. This approach to establishing the limits on government responsibility for health care, and reinforcing the distinctively 'mixed' public and private character of the Australian health system, has been foreshadowed by the NHHRC as part of the Medicare Select model (see p. 23).

The long-term objective is to better integrate Medicare and the private health insurance system. The ability to use vouchers to pay for treatment in private hospitals would start the process by reducing the cost of choosing to take out private insurance. As the economist Joshua Gans has argued, making taxpayer-funded hospital coverage portable to private hospitals, and avoiding the need to 'pay twice' for hospital cover (once through the tax system and twice by paying premiums), would make health fund membership (and such advantages as a single room in a private facility and choice of doctor for elective procedures) more affordable for all Australians.[88]

Best practice

The national voucher scheme is not a plan to privatise the health system. It matches the ambitions of the left-of-centre proponents of market-design strategies that pursue both social and economic values in public policy areas blighted by failed government service provision.[89]

Permitting consumer choice and provider competition will take control over the decisions that determine availability and access to different health services out of the hands of governments

The principle that should govern health reform is that government purchase of health care may be acceptable (socialised payment using taxpayers' money to ensure universal coverage) but socialised production of health care is not. The national voucher scheme is consistent with the health system design-principles endorsed as best practice by the World Health Organization. Government involvement would retreat to the more appropriate role of funder of health care and regulator of safety and administrative standards, but no longer the monopoly provider of taxpayer-funded health services.[90] Permitting consumer choice and provider competition would take control over the decisions that determine availability and access to different health services out of the hands of governments and bureaucratically-run public providers. In the long run, a voucher-system would create a genuinely consumer-oriented health system, increase service capacities, and all Australians would secure more timely access to care.

Centralist means for federalist ends

A likely objection to the national voucher scheme is an 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 national voucher scheme, public hospitals would not remain the same old government monolith except run by a centralised command-and-control authority out of Canberra. It would mean the funding of public hospitals and other health services would be centralised by the federal government, *but in order to achieve consumer-oriented structural reform of the way hospital and community-based health services are produced*. In practice, federal principles would be satisfied, but by centralist means, as control over hospitals would be restored to autonomous community boards, while on-the-ground health providers would be incentivised to deliver care to patients in an efficient and person-centred manner.

State obstructionism

This isn't a perfect constitutional arrangement. But it would 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.

The tortuous path of 'cooperative' federal-state health reform since the election of the Rudd government in November 2007, amply demonstrates how large an impediment to change are the states. The introduction of 100% casemix funding of all public hospitals would require the least efficient jurisdictions to lift their game or bear the cost of their bloated health bureaucracies. Therefore, some states have already signalled that they would oppose this reform.[91] In fact, the states have already blocked the introduction of activity-based payments. At the November 2008 Council of Australian Governments (COAG) meeting, states received a huge boost in Commonwealth funding from the Rudd government. In return, the states agreed in principle to introduce a nationally consistent system of activity-based hospital payment. However, the implementation of

casemix funding was delayed until the never-never of 2013–14, despite the fact the casemix system was introduced in just five months in Victoria in the 1990s.[92]

Health is properly federal

The states' intransigence over casemix reinforces the need for 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 achieve real reform.

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 expenditures are funded by taxpayers and controlled by government. The share of GDP spent on medical and hospital care would rise significantly as the impact of the ageing tsunami hits. The nation can no longer afford to allow one-third of the nation's health dollars—over $30 billion per annum—to be locked up and wasted in the least productive public hospital and community health sectors.

The states' intransigence over casemix reinforces the need for national leadership.

The Bennett Report notes that a 20–25% productivity gap has been identified between the least and most efficient public hospital systems in the nation. The report also estimates the amount of timely and beneficial care the community is forgoing. It suggests that enhanced efficiency could deliver a 10 to 20% increase in the volume of health services provided to the community using the same resources. The Commission also says the health system has reached a 'tipping point,' and would be unaffordable in 25 years.

The total cost of the reforms recommended by the Commission is predicted to be between $18 billion and $36 billion over the next five years alone. The Bennett Report estimates that these expensive reforms would reduce health spending by a miniscule 0.2% of GDP in 2032–33 (12.4 to 12.2%). Cost containment is important, but it should go without saying that scarce health funding must be spent optimally. We must find the best way to ensure Australians receive more of the health services they need. The greater choice and competition that the national voucher scheme would permit will lower costs, improve quality, increase efficiency, and enable Australians to receive more and better health care for each health dollar spent.

Medicare Select

In the closing pages of the Bennett Report, the NHHRC basically concedes that its recommendations for transformative change do not go far enough:

> While we agree that there will be significant benefits from these governance reforms ... we also believe there is a real need to further improve the responsiveness and efficiency of the health system and its capacity for innovation. We agree that greater consumer choice and provider competition, and better use of public and private health resources, have the potential to achieve this ...[93]

Acknowledging the importance of choice and competition to drive innovation, efficiency, quality, responsiveness, and sustainability, the Commission sketched out for public discussion a new governance model—Medicare Select.

Under this model, all Australians would receive risk-adjusted taxpayer-funded vouchers to purchase insurance. They would choose from a range of competing government and private-run health and hospital plans that cover a minimum mandatory set of essential services. The health funds would then purchase services from hospitals and other providers on behalf of members, and coordinate the delivery of all appropriate care. Private insurance would remain optional to pay for extra services and add-ons that are not covered by vouchers. As the Commission notes, Medicare Select requires further development and a great deal of study—not to mention the lengthy national debate required to overcome the political challenges entailed in so seismic shift in the way Australians access health care.

Implementing the national hospital and health voucher scheme would represent an important first step. Voucher-based funding would prepare hospital and health providers for the age of even greater choice and competition in price, quality and patient-satisfaction, should a future

government decide to pursue the Medicare Select option. Voucher funding for coordinated primary care services would also introduce the principle of competitive purchasing into the health system, and private health insurers would build expertise in this area, a role they would significantly expand under the Medicare Select model.

Conclusion

Right reform, right now

The NHHRC maintains the reforms proposed in the Bennett Report are designed to ensure the services that the health system delivers are the services that people need, rather than the services that governments want to offer. Unfortunately, as this monograph has shown, the Commission's centrally planned approach to determining the 'right' mix of community-based and hospital-based services the community requires would not realise the important goal of creating a truly person-centred health system.

The Commission's centrally planned approach to determining the 'right' mix of community-based and hospital-based services the community requires will not realise the important goal of creating a truly person-centred health system.

Rather than take the Commission's advice and attempt to redesign health services from the top-down, the federal government should resist the temptation to micro-manage the health system and go much more boldly down the path of genuine consumer-directed health reform. The national voucher scheme would tie Australia's precious health dollars to patients and ensure our ageing population receives the right care at the right place and right time.

For the sake of the sustainability of the health system, and to improve the efficiency, quality and accessibility of the health care received by all Australians, a flexible and responsive voucher-based system of funding hospital and non-hospital services is the right reform needed right now.

Endnotes

1 Quoted in Siobhain Ryan, 'States and doctors uneasy,' *The Australian* (17 February 2009).

2 National Health and Hospital Reform Commission, *A Healthier Future for all Australians: Interim Report, December 2008* (Commonwealth of Australia, Canberra, 2009) (*Interim Report*), 10, 23.

3 National Health and Hospital Reform Commission, *A Healthier Future for all Australians: Final Report, June 2009* (Commonwealth of Australia, Canberra, 2009) (*Final Report*), 5.

4 *Interim Report*, 2, 81; *Final Report*, 10, 23, 111–113.

5 *Interim Report*, 10, 23, 81, 84. The *Interim Report* bases these claims on the discussion paper commissioned by the NHHRC. Mark Harris, Michael Kidd, and Teri Snowdon, 'New Models of Primary and Community Care to meet the challenges of chronic disease prevention and management: a discussion paper for NHHRC' (4 July 2008). Harris, et al. assume that strong primary care is more efficient and leads to lower hospitalisations, based on one study linking continuity of primary care with lower use of hospitals. Beres Wencks and Ian Watts, *Paper for the National Health and Hospital Reform Commission* (July 2008), 7. Wencks and Watts also assume stronger primary takes pressure off public hospitals by delivering high quality preventive care, but cite studies showing a link between primary care supply and the rate of detection of diseases such as breast, cervical and colorectal cancer for which there are sophisticated diagnostics. But they do not cite evidence of stronger primary care reducing lifestyle risk factors or the incidence of lifestyle diseases.

6 Misha Schubert, 'Rudd tests wind on hospitals takeover,' *The Age* (30 October 2009).

7 *Final Report*, as above, 102.

8 *Interim Report*, as above, 18.

9 As above, 6.

10 *Final Report*, as above, 5, 45, 51.

11 The best example of the way funding decisions determine service provision is that as part of the Medicare system, all Australians are entitled to unlimited access to bulk-billed general practice services on demand under the uncapped Medical Benefits Scheme, and 'free' access to hospital care at point of access in public hospitals with capped budgets and therefore limited capacity. Access to health services is therefore greatest when health needs are slightest, and access to required services most restricted when health needs are greatest and hospital treatment is required.

12 For example, as I have argued elsewhere, hospital planners continue to claim that hospital bed numbers are 'less important' due to falling lengths of stay. This is regardless of the reality that in recent years, the actual trend has been towards higher demand for inpatient beds and hospitals have experienced chronic overcrowding due to the shortage of available beds. See Jeremy Sammut, *Why Public Hospitals Are Overcrowded*, CIS Policy Monograph No. 99 *Papers in Health and Ageing (8)* (Sydney: The Centre for Independent Studies, 2009), 10. As I have also argued, federal government support for resourcing primary care rather than opening more beds is a product of health politics and the political influence of the most vocal and politically influential public health lobby and community-based provider groups. See Jeremy Sammut, as above, 5.

13 See John Graham, *The Past is the Future for Public Hospitals: An Insider's Perspective on Hospital Administration*, CIS Policy Monograph No. 102 *Papers in Health and Ageing (9)* (Sydney: The Centre for Independent Studies, 2009). The emerging consensus in the health debate is that the administrative upheavals of the last 25 years have been an expensive national disaster for taxpayers and public hospital staff and patients. See David Pennington, 'Cure for an ailing system,' *The Australian* (24 October, 2009).

14 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).

15 Jeremy Sammut, *Why Public Hospitals are Overcrowded*, as above. The total number of acute public hospital beds in Australia has been cut by one-third since 1984. In 1983, there were 74,000 beds in public hospitals and just 54,137 in 2007–08. Taking population growth into account, the real fall in bed numbers is even larger—a 60% fall from 4.8 public acute beds per 1,000 population in 1983 to around 2.5 per 1,000 population today, a level far below the OECD average of four beds per 1,000.

16 *Final Report*, 45, 68.

17 As above, 6.

18 As above, 102; *Interim Report*, 6.

19 *Final Report*, 82.
20 *Interim Report*, 88; Hal Swerissen, *Primary Care Reform Options*, 7.
21 *Final Report*, 114.
22 *Interim Report*, 45.
23 '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. Community health services are also notorious for providing a range of 'politically correct' public health programs (such as drug counselling and needle exchanges, women, and adolescent health) mixed in with some important (but often difficult to access) hospital avoidance programs, such as hospital- in-the-home schemes, as well as for administrative excesses, for over-staffing and creating work-avoidance havens for salaried public sector employees.
24 Hal Swerissen, as above, 3.
25 *Interim Report*, 79.
26 As above, 79, 117; *Final Report*, 7, 9, 84, 95, 136.
27 In addition, capitation funding could potentially create incentives for fund-holding primary care providers to cream-skim and cost-shift the sickest patients to emergency departments.
28 *Interim Report*, 309.
29 *OECD Economic Surveys: New Zealand 2009,* 126.
30 For the definitive rebuttal of these claims, see Australasian College of Emergency Medicine, *The Relationship Between Emergency Department Overcrowding and Alternative After Hours GP Services* (Melbourne: ACEM, 2004).
31 See Wolfgang Kasper, Jeremy Sammut, John Graham, as above.
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49 *Final Report*, 145.
50 *Interim Report*, 20; *Final Report*, 10, 146.
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