Policy Monographs

THE CENTRE FOR INDEPENDENT STUDIES

Radical Surgery:

The Only Cure for New South Wales Hospitals

Wolfgang Kasper

Papers in Health and Ageing (7)

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Executive Summary

NSW public hospitals are plagued by massive systemic failures, as diagnosed in the Garling report. At the same time, hospital costs are blowing out, and may yet bankrupt the NSW budget despite a massive federal bailout under the COAG agreement. The situation requires dramatic and fundamental changes to hospital management—not additional layers of bureaucratic control or more federal subsidies.

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

The underlying cause of the crisis is excessive, parasitic and superfluous bureaucratisation—something the health system shares with other areas of public sector service delivery in NSW, from transport and education to child protection.

The hospital malaise can only be remedied by removing the central, bureaucratic control of hospitals and creating opportunities for spontaneous, decentralised and customer-oriented supply of hospital care. Taking for granted that many Australians want heavy subsidies to cover the cost of hospital stays, this essay explores how to provide public hospital care with less bureaucracy. We argue for a separation of the provision of access to hospitals for those in need from the production of services in government-run hospitals. Specifically, we advocate a three-pronged reform:

1. *Revenue for services:* Medicare should issue 'patient vouchers' to needy patients, which empower them to choose their hospital whenever feasible. In addition, a government agency should express demand for hospital beds in specific regions by inviting annual bids from hospital managers for publicly funded 'bed vouchers.' Hospitals should be obliged to earn all their revenue from these two types of vouchers and other payments for services rendered. They must be weaned off direct budget allocations.
2. *Liberation from bureaucratic fiat:* The growing and costly health bureaucracy in NSW imposes often disruptive central planning concepts and inflicts frivolous costs on taxpayers and clinicians. The NSW experiment with area health services, therefore, needs to be abandoned.
3. *Hospital autonomy and diversity:* Public hospitals should be made independent of detailed, centralised management directives. The time-tested practice of local boards should be strengthened by giving boards genuine autonomy, as long as they adhere to certain clinical and administrative standards.

The purpose of these reforms is to move the NSW hospital system from a costly, initiative-stifling top-down command-and-control mode to independent, decentralised decision making. The interaction of buyers and sellers will generate useful information and, thus, improve the use of scarce resources.

Without such reforms, NSW citizens are bound to face a continuing deterioration in the quality of hospital care and will before long lose their traditional free access to hospitals.

'*Salus populi suprema lex esto*'

or The health of the people must be the overarching law!

—Marcus Tullius Cicero (Roman lawyer and orator, 106–43 B.C.)
and Peter Garling SC (NSW lawyer, 1952–)

'The community told us: We want more care in the community, we want it closer to our home, we want stronger primary care.'

—C. Bennett, Chair of the Australian Prime Minister's *National Health and Hospitals Reform Commission*, 2008

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

—Dr. Max Gammon (British physician who studied the British health system) as quoted by *Australian Doctors' Fund,* 2008

The NSW Hospital System is Acutely Ill

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

Over the past, economically prosperous decade, public spending on Australian hospitals has gone up by 64 percent. It is funded largely by Commonwealth and State taxes. Compared with the population growth of less than 14 percent over the same period, this increase in hospital spending appears disproportionate, even if one allows for the progressive ageing of the population, massive advances in medical and pharmaceutical sciences, and consequent increases in the availability and cost of cures. Of course, it is legitimate and quite usual that we use a bigger share of our growing income and wealth to buy more, and better, health services—economists call this a 'high income elasticity of health expenditure.' Nevertheless, it is now an acute concern for policy makers worldwide to reconcile rapid rises in health spending with other priorities.[1]

Spending on hospitals of course only indicates the cost of inputs, it is not a measure of their output. Citizens and taxpayers appear to have received little quality improvement for the expenditure, and doctors and nurses who deliver hospital services appear acutely dissatisfied. The Australian Medical Association tell us that hospitals are not safe. The press inform us that hospitals are dangerously overcrowded. Preventable deaths in Australian hospitals are reported to exceed road fatalities. Pervasive cutbacks in public hospital bed numbers and frontline nursing staff have produced shortages of beds and overcrowded emergency departments. Elderly patients and birthing mothers have to be kept in parked ambulances, corridors, and the storerooms of emergency departments because proper beds cannot be found for them. Emergency staff in Australian public hospitals spend 41 percent of their time caring for patients for whom no permanent hospital bed can be found. Psychiatry patients are being transported from hospital to hospital in the middle of the night because one overcrowded hospital has to accept patients of unassessed acuity but has no spare bed. The situation often seems reminiscent of Third World conditions, rather than what one would expect of one the most affluent countries on Earth.

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

The trend has been to cut costs by reducing facilities and services rather than searching for improvements in productivity.

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

The closure of rural hospitals throughout NSW, indeed throughout Australia, has contributed to creating the much-lamented rural doctor shortage. If one classifies those medical practitioners who are qualified to conduct procedures such as anaesthetics, obstetrics or surgery (which, in the city, are typically performed by specialists) according to their location, and adds up full-time doctor equivalents for rural towns and remote locations (categories RAMA 5, 6 and 7), one finds that the density of practitioners in rural and remote areas has indeed been declining considerably over recent years—and this despite targeted financial subsidies for rural proceduralists.[5] Experts have identified the closure of small non-metropolitan hospitals as a major cause for this problematic decline. This is not surprising because the typical private non-metropolitan medical practitioner earns about one-third of his income from services rendered in hospitals as a visiting medical officer (VMO). The worsening 'rural doctor shortage' therefore is another unintended and deleterious consequence of bureaucratically driven centralisation.

Another factor that contributes to the thinning out of rural doctors, in particular obstetricians, has been the steep rise in indemnity insurance (costing an estimated $30000 or more per annum). The explosion in insurance costs was the consequence of aggressive litigation and court decisions, which attributed long-term health problems to actions by obstetricians at birth, in one case even 21 years later! The NSW government now covers insurance costs for obstetricians in public hospitals. However, the services of the State-contracted insurer fall far short of the quality of insurance that private insurers normally offer doctors, causing many to abandon obstetrics. Likewise, litigation and insurance costs have forced many midwives to abandon their chosen profession.

Of Hotels and Hospitals

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

There are several obvious differences:

- One is of course that healthcare products are often not as clearly defined before the purchase as in the case of hotel accommodation. Moreover, clients tend to know more about hotels

than hospitals, as most of us book into hotels more often than into hospitals. The average customer is better informed about the quality of hotel services and can judge it better than the qualities that matter in the performance of hospitals. Moreover, not all dimensions of hospital treatment can be known before one enters a hospital, even for non-emergency treatment. Economists and marketing experts make a difference between 'experience goods' and 'search goods.' The latter are goods and services whose (variable) quality can be readily established by buyers at low information costs (example: fruit in a market stall). In contrast, experience goods can only be assessed by consuming the product (examples: assessing the quality of what is in a tin of fruit by eating the contents or undergoing a prostate operation). For experience goods, suppliers typically develop brand names, cultivate a good reputation, and rely on similar devices to inspire trust; moreover, independent middlemen and information providers, possibly including government agencies, assist intending buyers in making appropriate choices. In view of this, it is surprising that hospitals do not publish hard information, such as case-specific mortality rates and other data to demonstrate what share of promised outcomes they actually achieve. Indeed, such statistics, which are reputedly available internally, cannot be obtained by the public in NSW. The argument that members of the public would not be able to interpret such data properly seems vacuous. It is amazing how well patients and their kin are nowadays learning complicated medical details from the internet and from their chief advisors on such matters—their personal doctors.

It is surprising that hospitals do not publish hard information ... to demonstrate what share of promised outcomes they actually achieve.

- Another difference between hotels and hospitals is that the cost of hotel accommodation is much lower relative to one's income than that of most hospital services, so that the financial stability of individuals is less imperilled by recourse to the former than the latter. Ordinary Australians—and even medical practitioners—tend to have little idea of the total cost of standard operations, because the costs are disguised by government subsidies. For example, a standard hip operation in a private hospital is likely to cost the patient, the insurer and the taxpayer together around $30,000 as of 2009, and a standard prostate operation between $35,000 and $40,000. By contrast, hotels widely advertise their room rates, offer discounts, and reveal all supplementary charges.
- Patients normally turn to hospitals at times of great personal need and anxiety. This translates into what economists call 'price-inelastic demand.' People generally react to price differentials when booking hotels rather than staying at home. When you need hospital treatment because you are diagnosed with cancer, you and your loved ones are likely to buy the treatment, which your medical advisors tell you to buy, whatever the cost. Unscrupulous suppliers might exploit this inelasticity of demand to overcharge, demanding payment way above the cost of the service.
- A much greater share of the cost of accommodation in a hotel is paid by the clients than they would in hospitals. We know that people spend money most prudently when it is their own, and that money is spent most unwisely when third-party agents are making decisions on behalf of people they do not even know. In this context, it is worth noting that hospital costs are not only determined by governments, who may have all sorts of extraneous objectives, but are also in part borne by insurance companies, who may have objectives that differ from those of the patients. In short, hotels tend to be much more consumer directed than hospitals.
- Partly for the above reasons, the health and hospital industry is much more densely regulated than the hotel industry. Alas, we know that regulators easily become 'rent-seekers,' acting to gain material advantage and power from their role, even if it is at the expense of the professed ultimate objectives of the industry—the care and healing of patients in the most cost-effective ways. It is easy to lose sight of rational cost/risk-benefit analysis, which is normal in most other service industries. Instead, direct controls and compliance costs multiply.
- The majority of hospital admissions are emergency cases—some 60 percent of all admissions in public hospitals in Australia. In these instances, patients and their kin are, of course, not

in a position to evaluate the costs and benefits of alternatives before deciding whether to buy or not buy a particular service.

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

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

The escalation of hospital and health costs makes such a rational approach urgent.

However, since Australians seem to have taken a political decision to make health a matter of public, rather than private choice, the NSW hospital crisis should force us to think hard about how political and administrative arrangements can be reshaped to perform better in the citizens' best interest. After all, one of the widely endorsed objectives of public policy in this country is equity. Many would consider this an aspect of a civilised, affluent and cohesive society, of which we can be as proud as we are of our rule of law and our record of decent democracy. I accept for the present discussion that most Australians do not want their average fellow citizens to be massively out of pocket for the cost of births, surgery and hospital stays, although in practice, many of us still reveal our real preferences by opting for personal insurance for at least some hospital and medical outlays. This belief that hospital costs should not be borne by affected individuals underpins the political decision that the bulk of hospital costs should be borne by the community through taxes and subsidies. If we take this public choice as a given in our affluent and egalitarian society, it follows that every NSW citizen should have access to necessary hospital services irrespective of his or her financial condition.

The insistence that hospital and healthcare costs should be socialised at least in part does not, however, mean that the costs and the production methods should be immune from economic and commercial analysis. Nor does it mean that production should be run by bureaucratic coordination, top-down directives and in government-owned facilities. It is the decision to rely on socialised, centrally directed production that has brought about perverse, costly and unjust results: Hospital care is now plagued by cost escalation, pervasive dysfunction, infighting, disgruntlement, waiting lists, and poor-quality service. Normal checks and balances of decentralised competitive decision-making are suspended in public hospitals. The industry could therefore be captured by the insiders, most notably the bureaucrats, who form an 'iron triangle' with politicians and particular interest groups, such as public sector trade unions. 'Capture' means that those with insider knowledge and control over day-to-day management decisions serve their own purposes to the detriment of the clients. Initially, the agents just are after improving their own work conditions and emoluments, but over the long term, they dominate everything and hinder improvements in productivity and customer orientation. Powerful insider groups will also engage in political games to ensure that the elected representatives of the people do their bidding, rather than promote the public interest.

Campaign funding and support in election campaigns, combined with complacency in political parties, tend to entrench the power of the agents. The most frequently used (and accepted) argument to justify steps that pave the way for the capture of an industry is safety and security. When a risk is cited (even a remote one), people are intimidated into accepting regulations, even if their real purpose is the featherbedding of regulators and administrators. 'Safety first' can easily prejudice all other social objectives and can well be exploited with the end result that entire industries become dysfunctional. There is a paradox here: What is deemed important is organised in ways that create shortages and dysfunction, while what is deemed unimportant is allowed to be organised in effective, customer-oriented ways. Do the sick really deserve no better?

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

Administrative agents, who work in secure public sector jobs, thus tend to fall prey to 'agent opportunism' or 'moral hazard.' They exploit their insider knowledge to enhance their own benefits, including indexed pensions for retirement, work comfort, and on-the-job consumption: for example, meetings in comfortable surroundings, seminars, business travel with good per diems. Why shouldn't public hospitals cut their workloads by reducing available beds, as long as they are able to obtain revenue through political lobbying for direct funds from the centre? Why shouldn't they reduce their workload by providing less patient care? 'Work avoidance' is invariably an integral part of any centralised, top-down system of production. This was acknowledged in the Soviet economy and—unsurprisingly—is notorious in the NSW hospital system.

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

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

A related aspect of a public service delivery system, which has been captured by the agents, is that no one owns up to ultimate responsibility: ministers hide behind bureaucrats, bureaucrats hide behind political directives, and full-time spin doctors obfuscate matters to appease an angry public. In Australia, blame shifting is also common between the States and the Commonwealth. The costs of bureaucratic complications, and the creation of more committees and layers of administration to oversight and correct these, gradually crowd out service delivery. Fiscal constraints are then cited to justify cutbacks in services and closure of frontline delivery operations. In the case of the NSW hospital system, the growing bureaucratisation since the mid-1990s and fiscal constraints have led to the progressive closure of facilities, a concentration of specific services in some designated hospitals, and the much-lamented overall bed shortage.

Ministers hide behind bureaucrats, bureaucrats hide behind political directives, and full-time spin doctors obfuscate matters to appease an angry public.

From the point of view of the citizen and taxpayer, the administered bed shortage is of course nothing more than a 'work avoidance scheme'—people get less for their money, and even when they do, the services are often in inconvenient locations. The traditional notion that communities

had ownership of 'their' hospital is lost, and the citizens get angry about 'them'—an anonymous group of bureaucrats and politicians. As a result, respect for the rule of law and trust in democratic government decline. In the long run, growing reliance on government services has invariably been, and continues to be, the source of high costs and economic stagnation because people feel disenfranchised and withdraw their loyalty to the wider community.

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

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

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

Central Bureaucratic Control versus Self-Responsible Competition for Revenues

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

Economists who have studied systems management can point to differing incentives that are at work in independent, competitive systems and under collective, centrally-planned production. Above all, decentralised producers have to compete for their revenues. They respond to market signals—expanding what is in high demand and hence profitable, and ditching loss makers where demand is insufficient to justify the costs. The signal of profits and red ink also impels producers to search for innovations, which cut costs and introduce new products (process and product innovations). Major waves of innovation have reshaped entire economies and propelled material living standards to previously unimaginable levels. We had the agricultural revolution, the introduction of the steam engine, later combustion and electric engines, successive transport revolutions, and the current computer and telecom revolution. We are also experiencing a veritable revolution in the possibilities of healthcare, which competing entrepreneurs will exploit, 'as if directed by an invisible hand.' In most historic cases, innovations have driven economic growth forward and reduced the costs—food, transport and communication have all become cheaper. Yet, the medical revolution has failed to lower unit-costs. This uncharacteristic failure to realise productivity gains and translate them into cost reductions can only be attributed to the fact that the medical and pharmaceutical revolution has largely been taken from the hands of competing enterprises and has been controlled or directly operated by government-run monopolies, which are largely shielded from the usual competitive disciplines. In Australia, nearly three quarters of per-capita health expenditures are funded by taxpayers (the share has been rising) and controlled by government. A large proportion of production is run under bureaucratic control.

One revealing study about the differences between decentralised management of competing hospitals and central planning was published in New Zealand in 2005. NZ Treasury reported that the productivity in hospitals run by decentralised, autonomous boards, who decided how best to use government-supplied budgets, had increased by 1.1 percent from 1998 to 2001. However, between 2000–01 and 2003–04, when central planners and administrators replaced this system

of governance, hospital productivity dropped by 7.7 percent.[7] The critical factor in the drop in value-for-tax-dollars was that many more administrators and controllers were employed under the centralised system, which the NZ Labour government had introduced. It is reported that the centralised administration increased the amount of paperwork, detracting nurses and doctors from their main job of caring for patients. The NZ report offers numerous valuable insights to those in NSW who may be interested in learning the basic lessons of central *versus* decentralised governance and who are prepared to go beyond marginal administrative tinkering.

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

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

All too often, the production of a service under direct political control is distorted by extraneous political objectives.

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

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

In discussing the public hospital crisis in NSW, it cannot be overlooked that power brokers in the political and administrative system see the involvement of private doctors in public hospitals as an affront to their collectivist–socialist ideology. Yet, doctors with private practices, who contract with the Department of Health to do service as visiting medical officers (VMOs) in

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

> The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design.[11]

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

Efficient Production and Equitable Access Require a Three-Pronged Approach

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

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

(a) Hospital revenue only for service: Non-emergency patients can decide where they wish to be treated and to pay hospitals with 'hospital vouchers,' which they obtain by presenting their hospital invoice to Medicare. Such a voucher scheme will protect Australians from at least the financial consequences of medical calamities. Patients may decide to augment what they pay hospitals from their own savings or their private insurance in the form of '$ vouchers' (aka cash), for example, when they opt for a more expensive, better-quality hospital or request additional procedures. Hospital admission requires that doctors and specialists assess what specific hospital procedures a specific patient requires. As is the case now, they will have to function as 'gatekeepers.' To that extent, the present system of referrals by general practitioners and specialists should stay in place. Approximately 60 percent of hospital admissions are emergency cases, which means that public hospitals must also be able to earn government vouchers of a different type: Each

year, they should be able to bid for 'bed vouchers,' in return for which they maintain an appropriate number of hospital beds and corresponding staff. These two types of vouchers will constitute the revenue of hospitals. Such vouchers for service expose hospital managements to demand signals and ensure that they earn revenue only for services they provide.

(b) *Hospital autonomy:* Hospitals need to be governed by individual independent, self-responsible boards. They must calculate their costs and charge rates, and should have to get these periodically approved by independent assessors acting for the Department of Health. Hospitals will invoice patients for the various procedures either at Department-approved charge rates or at their own higher prices, which they then must advertise and quote to intending patients, as far as is feasible.[12] Hospital boards are autonomous and have the right to discontinue loss-making services, or may charge more than the centrally approved prices.

(c) *Saving administration and compliance costs:* The area health services and a large segment of the central administration in the Department of Health, which directs them, become superfluous and are abolished.

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

Let us discuss important aspects of the proposed reform package in more detail.

Demand to Drive Supply

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

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

When patients and their GP advisors become more aware of hospital cost, the now prevalent pernicious and socially corrosive 'claims mentality' will be contained. In this context, a major American study on behaviour in using health services is worth noting: A large number of families

were randomly assigned to various co-insurance and deductible health cost plans. Those who received 100 percent tax-financed reimbursement for all health expenditures proposed to use 67 percent more health-care services than those who had to foot virtually their entire bills.[13]

Some citizens may well be apprehensive about a voucher scheme because they fear that it offers less assurance of a reliable, dependable service than present-day government hospitals. The changes, therefore, need to be well explained in advance of any reform, and much will depend on the smooth and reliable implementation immediately after the reform. Citizens will then soon discover that they have wider choices and, most importantly, will see themselves as buyers of hospital services, not supplicants in a queue! For a wealthy, educated population like Australia's, this is a more worthy way of providing public access to hospitals. Such a fundamental change could therefore become extremely attractive to the electorate and would signal that the sponsoring political party is prepared to think creatively. Familiarity with this method of paying for hospital care will anchor the reformed system in the public mind, making it much less likely that particular interests can get the next government to turn back the clock and re-centralise hospital management on behalf of their rent-seeking cronies.

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

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

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

Although it appears that independent local hospital boards would be generally welcomed, the wider public will probably need more convincing to subscribe to the notion of vouchers. In reality, administrative devices that resemble vouchers are already in place in Australia. In 1998, the Australian Refined Diagnosis Related Group (AR-DRG) scheme was introduced. It was based on

payment for a case mix of 668 types of acute-care episodes. Victoria introduced a similar method of hospital funding in 1993–94, followed by South Australia. Although the implementation of case-mix based voucher payment led to significant cuts in hospital budgets, it was responsible for significant gains in hospital productivity. This is not surprising: After all, anyone who gets funded according to output will try to enhance productivity. Nor is it surprising that public sector unions intensely disliked the reform. It is also worth noting that a quasi-voucher system of the case mix kind has been tried in Queensland and Western Australia, but was abandoned, only to be reintroduced now. NSW has always opposed this rational funding approach.[17]

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

Management by Autonomous Hospital Boards

Almost all management and governance decisions in hospitals under a reformed system can be made by independent hospital boards. These should be composed of a mix of medical and nursing professionals with local knowledge, and citizens with commercial and financial expertise. The tenure of a board member should be six years, with half of the members stepping down after the first three years in the first instance, so that, in the long run, there is an overlap of tenure, continuity, and maintenance of 'institutional memory.' The boards, assisted by an executive hospital director and a chief nurse, will have to be cost-conscious and maximise the value of the vouchers they earn. They will not have to apply and lobby for direct government grants (a huge cost saving), because their revenues are derived from what the clients pay. Nor will they have to engage in bureaucratic infighting with Health Department officials, since they lose their ultimate decision-making powers over what happens at specific hospitals. This promises to attract people with an entrepreneurial frame of mind.

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

- rent out unused facilities to private doctors; for example, unused operating-theatre capacity could be sold to private surgeons who pay for the use of the facility,[18]
- buy or lease equipment as they see fit,
- charge 'congestion prices' if certain services exceed what they and their staff can handle at certain times, which would divert some elective demand to other hospitals or into other time slots, and
- offer new, or close down existing, specialities—structural changes, which may in specific circumstances have to be negotiated with the Health Department.

Ultimately, hospital boards' decisions will be determined by whether or not their costs can be covered by vouchers and other revenues. In many locations, hospital boards will discover that 'small is beautiful' and why mega hospitals are so difficult and costly to administer. Hospital boards should, of course, be made accountable through an obligation to publish annual reports; they might report more frequently to local councils and chambers of commerce.

Last not least, hospital boards will need to calculate their prices and costs with a view to their long-term viability. According to experts in the United States (where fundamental economic

conditions do not vary all that much from those in Australia), a hospital will need to calculate around 3 percent of all revenue as an operating margin, plus 6–7 percent of revenue to meet overhead expenses, such as depreciation of capital, replacement of plant and equipment, and maintenance of facilities.[19]

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

There is nothing wrong with rural communities enhancing the quality of life by exploiting synergies and making their local hospital a central part of the effort.

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

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

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

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

Saving Central Administration Costs

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

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

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

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

The NSW health administration was given *de facto* monopoly control by the NSW Labor government after the ALP's election win in 1995. It has burgeoned ever since and only its abolition will excise the intractable cause of the NSW hospital crisis. The key problem has been that frontline hospital services—the number of hospital beds and the workforce, who actually care for patients—have been cut back steadily while the administration has grown. Many a nurse and doctor have been pushed from patient care and the ward into administration by pay relativities and career opportunities, which make frontline service unattractive. For others in the system, mere menial nursing and clinical work have become no more than a stepping stone to the higher realms of hospital management. This attitudinal shift has to do, in part, with the transformation of nursing education from practical training of useful skills to tertiary level education ('professionalisation'). Nursing graduates now frequently appear to deem duty in hospital wards as below their standing. The reform package proposed here would open the way for returning clinical work to where it used to be—and would save the health system from bankruptcy.

Many a nurse and doctor have been pushed from patient care and the ward into administration.

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

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

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

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

Use of Knowledge

In the modern knowledge economy, the creation and exploitation of knowledge is the decisive factor in productivity and quality of services. Much relevant knowledge and knowhow is local and keeps changing all the time. This is why dispersed, self-responsible units are more agile in discovering and using new information and reacting constructively to changing circumstances. By contrast, large top-down plan-and-command systems depend on averages and abstract statistics, which become available only after a time lag. The management of small local hospitals will, for example, know of the availability of part-time support staff and make arrangements to draw on them, if necessary. They will be able to negotiate contracts for cheap local supply of, say, laundry and meal services, which a centralised system does not know about or finds too cumbersome to administer. It is a well-known fact that companies in socialist economies tried to do everything needed for their operation in-house, although that was costly—the challenge of sub-contracting was just too great in a centrally planned mega system. Nor was there any incentive to economise and risk innovations, as discussed above.

The incentives in centrally planned systems, like the NSW 'area health services,' work with the 'sticks' of command and coercion rather than the economic 'carrots' of material reward. Because relevant information has to be digested and implemented centrally, there is always an incentive to lie with statistics. Central planners, therefore, often do not even get the correct statistical information. This was a major problem in the socialist system of economic coordination. It is not surprising that, according to a recent press report, some NSW hospitals (Ryde and Gosford) also falsified performance figures,[23] or that nursing staff at western Sydney public hospitals are speaking openly about 'the political corrections' of hospital waiting lists for elective surgery before State elections. Friedrich Hayek got a Nobel Prize in Economic Science primarily for highlighting this fundamental problem endemic in all top-down centralised systems.[24]

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

Openness

A single State government could, if necessary, go it alone to introduce such a decentralised decision regime, as the variety of styles of hospital administration by various Australian State governments shows. Besides, healthcare vouchers are a concept, which Commonwealth Health Minister Nicola Roxon recently floated.[25] Therefore, NSW-based Medicare offices could be given the funds that now go directly to the Department of Health to pay for NSW hospitals and use them as vouchers for NSW residents.

Neither is there anything wrong with a degree of international competition: Many Australians

already shop around to have elective surgery performed in private hospitals overseas, often by Australian surgeons. Contrary to what is often alleged, these operations go far beyond plastic surgery. The option of using Australian vouchers to pay overseas health providers would recognise the reality that hospitals, too, now work in an open, globalised market. More openness will enhance the competitive discipline imposed on local hospitals.

Similar reform concepts are now again making waves in the education debate in numerous Western countries. In Britain, Holland, Sweden, and New Zealand, politicians are implementing education voucher schemes or are discussing advanced plans to do so. Funding then follows the student, not the other way round anymore. The recently elected New Zealand government has announced that such a free, more competitive school system will be introduced there to improve performance, choice and flexibility. Even Australia's Commonwealth government has confounded some of its traditional supporters, especially in the teachers' union, that it, too, will promote choice, performance pay for teachers, and accountability of school management. Why not apply such a basic concept to the healthcare sector?

The option of using Australian vouchers to pay overseas health providers would recognise the reality that hospitals, too, now work in an open, globalised market.

Conclusion: Avoid Bankruptcy Now!

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

Improvements in efficiency are sorely needed to stem the seemingly inexorable growth of health costs, which is, of course, not exclusive to NSW. Nor is the deterioration in the quality of public services confined to the hospital industry. NSW public transport, public education and Australian child protection services are justifiably criticised. As long as a bureaucratic monopoly displaces the time-tested mechanisms for cost discipline and productivity increase on the part of the producers (the hospitals) and a degree of self-responsibility on the part of the buyers (the public), the hospital crisis will continue. Eventually, it will cause a crisis of State and federal budgets. Over the past decade, the annual rate of increase in Australian hospital spending has been 5.1 percent. At that rate, public hospital spending would be ten times what it is now by 2055. At present, health spending already takes up 27 percent of the NSW budget, which is close to $1 billion in deficit. Throwing more Commonwealth money at the problem through politically convenient COAG deals remedies some symptoms of the present crisis, but it does not cure the underlying causes—to the contrary!

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

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

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

Endnotes

1. On average of all OECD countries (except USA), the income elasticity of health spending was 1.7 during the early 2000s [OECD, *OECD Health Data 2004*, 1st ed. (Paris: OECD, 2004)].
2. Peter Richard Garling, SC conducted an inquiry into and reported on the state of acute care services in NSW public hospitals in 2008. The three-volume report was commissioned by the governor of NSW—Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals (Garling report), *Final Report* (27 November 2008). www.lawlink.nsw.gov.acsinquiry.
3. An internet search yielded only one website that carried positive news about public hospitals in NSW, announcing that 'NSW hospitals [are] performing above national benchmarks.' When I clicked to read the good news in full, I was however told—'*Oops!'* to quote the website—'this article is only accessible to members of the Labor Party,' inviting me to join!
   The sound bite from the Leader of the NSW Opposition was that he welcomed the Garling report, but blamed Labor mismanagement for the shortcomings. To date, there is no indication of a constructive alternative strategy on how to cope with the costly hospital crisis at a time when the NSW budget deficit has climbed up to $1 billion.
4. 'Pregnant Pause,' *The Sunday Telegraph*, 12 October 2008, 29.
5. This information is based on a private communication from someone familiar with the 'Minimum Data Set (MDS) survey' conducted by the *Queensland Workforce Agency*—see: www.heathworkforce.com.au/main.asp?NodeID=27677
6. F.A. Hayek, *The Road to Serfdom* (Chicago: Chicago University Press, 1944), chapter 10.
7. An updated analysis of the NZ experience was published in 2008: *Productivity Performance of New Zealand Public Hospitals 1998/99 to 2005/06*, available on www.nzbr.org.nz. This report, written by the former chairman of the NZ Health Funding Authority, Dr. Graham Scott, was influential in the outcome of the 2008 NZ election.
8. D. Leonhardt reports that, in the United States, efficiency and customer orientation rank very poorly in local government decisions. D. Leonhardt, 'Piling Up Monuments of Waste,' *The New York Times,* 19 November 2008. Is there any proof that things are any better here—better, that is, from the standpoint of the citizen–taxpayer?
9. Anyone who doubts that a major driving force in NSW health policy is collectivist ideology should look at the NSW government's plans to charge private hospitals for blood and blood products that have been donated by Australians through the Red Cross and other organisations. The proposed 'blood tax' will be to the detriment of private hospital patients, who have insured themselves and who have thereby taken pressure off the overloaded public health system.
10. See for example W. Kasper–M.E. Streit, *Institutional Economics—Social Order and Public Policy* (Cheltenham, UK–Manchester, US: E. Elgar, 1998), chapter 10. Readers who wish to familiarise themselves with the basics of health economics might wish to turn to D.R. Henderson (ed.), *The Concise Encyclopedia of Economics* (Indianapolis, IN: Liberty Fund, 2007), in particular the articles 'Health Care' (M.E. Morrisey, 235–241), 'Health Insurance' (J.C. Goodman, 241–245), and 'Competition' (W. Kasper, 73–76).
11. F.A. Hayek, 'The Pretense of Knowledge,' reprinted in C. Nishiyama and K.R. Leube (ed.), *The Essence of Hayek* (Stanford: Hoover Institution, 1984), 266–280.
12. There is nothing wrong with different producers quoting and charging different prices for similar or the same product. I may be content with buying a Hyundai car, but you may prefer to pay for a Merc. I may want a $50 razor hair cut; you may opt for the $8, Wednesday morning pensioner special. People differ, and saving to buy quality healthcare must remain one of the most respectable motives to save. An exception is emergency admission to hospital, when circumstances dictate immediate treatment and preclude price comparisons and shopping around for the most preferred deal. These conditions can be handled by special administrative arrangements.
13. J.P. Newhouse *et al., Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).
14. W. Kasper *et al.*, *Australia at the Crossroads* (Sydney: Harcourt Brace, 1980), and W. Kasper, 'The Market Approach to Social Welfare,' in R. Mendelsohn (ed.), *Australian Social Welfare Finance* (Melbourne: Allen & Unwin, 1982), 80–93. These Australian applications were inspired by the pioneering work of Milton Friedman, 'The Role of Government in Education,' first published in 1955, www.schoolschoices.org/roo/ried1.htm.

15. H. Ergas, 'Why We Need to Revive Federalism,' *Quadrant* LII:12, 48. During the early Howard years (1997–2002), public health spending in Australia was pushed up by 4.6 % p.a., compared to 2.5% p.a. on average of all OECD countries—the most recent time span, for which internationally comparable data are available. (OECD, 'Health Spending in Most OECD Countries Rises' and 'OECD Health Data 2004, Table 1).
16. M. Friedman, 'How to Cure Healthcare,' *Hoover Digest*, 2001, no. 3, www.hoover.org/publications/digest/3459466.html; and Cato Institute, *Cato Handbook for Congress: Healthcare* (Washington, DC: 1996), www.cato.org/pubs/handbook/hb105-24.html.
17. I am indebted for this information to David Gadiel, an independent economist with an extensive work experience in Australia's health system (personal communication). Overseas, for example in the Netherlands, government-subsidised health provision is delivered by giving individual citizens age/sex specific vouchers, which they can use to pay for a health insurance contract of their choice.
18. It could be argued that, under the current VMO system, a kind of barter deal takes place: the visiting practitioner uses hospital facilities and provides teaching and nurse supervision. Outright commercial contracts would be more transparent and efficient.
19. S. Lipstein, 'Lipstein on Hospitals—hosted by Russ Roberts,' in *EconTalk—Library of Economics and Liberty*, December 2008, www.econtalk.org/archives/2008/12/lipstein–on–hos.html. Steven Lipstein is CEO of BJC Healthcare, a billion-dollar hospital system in St. Louis that covers a diverse array of non-profit hospitals.
20. D. Gadiel and L. Ridoutt, *Towards a Rural Allied Health Strategy—A Workforce and Economic Analysis of Allied Health in New South Wales* (North Sydney: [NSW] Department of Health, 1993), and *The Specialist Medical Workforce and Specialist Service Provision in Rural Areas* (Canberra: AGPS, 1995).
21. M. Gammon, 'Gammon's Law of Bureaucratic Displacement,' note on a teleconference of the *Australian Doctors' Fund*, 24–25 January 2005. www.adf.com.au/archive.php?doc_id=113.
22. Table 8.21 in *Australia's Health Report 2008*, www.ajhw.gov.au/publications/aus/ah08/ah08.pdf.
23. N. Wallace and L Hall, 'Revealed: How Hospitals Lied about Records,' *The Sydney Morning Herald*, 27 Nov. 2008.
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