

7 Health

Introduction: The Problems in Context

For nearly twenty years now, health has been the most difficult public policy problem facing Australian governments, both State and Federal. Demand is apparently boundless; vested interests proliferate; problems of inefficiency and unaccountability afflict supply; irrational considerations of ideology make rational policy discussion almost unattainable.

The problem, moreover, will get worse. While it is comforting to know that many treatments, surgical or otherwise, get shorter and safer, the necessary technology tends to get more expensive. And health care, like income security, involves generational considerations: expenditure on each citizen grows dramatically as the citizen gets older, a considerable problem as our population ages.

Looking at overseas experiences gives little cause for encouragement. No comparable country has a long-established total health system which comes anywhere near perfection, or which offers a ready-made model for transplanting to Australia. And looking at other countries offers us, in fact, a hypothesis that would make any self-respecting treasury official despair: expenditure on health tends to increase as nations and their citizens get wealthier—health spending becomes a 'positional good', like spending on leisure or any other 'quality of life' good.

None of this should discourage us from defining and pursuing the basic policy task, which is, in essence, to deliver in the most efficient manner possible the combination of quality and quantity of service decided on by some properly accountable means within the funds decided on by the political process.

Even by that broad essential definition, Australian health policy is not to be judged a notable success.

Expenditure, both as a proportion of the Commonwealth Budget and as a percentage of national product has steadily increased over the last twenty years: from 10.5 per cent of the Budget in 1972 to 13.4 per cent in 1992, and from 5.9 per cent of GDP in 1972 to 7.7 per cent in 1992. Evidence of apparent unmet demand is everywhere in the form of patient queues. There is at the same time considerable spare capacity in many public and private hospitals. Accountability is poor: good and current information on both costs and quality is not easily accessible to the general public or to professional enquirers. From what is available, however, it is clear that efficiency and quality vary greatly across the country.

The Federal government's policy responses to continuing difficulties include price control, and controlling the number of providers. The private hospital sector is implicitly discouraged from major new initiatives, although it may be permitted a peripheral, even 'last resort', role. The potential role of private health insurance in relieving pressures has so far been explicitly rejected. Public debate about the problems has been acrimonious; over the last year the Federal government has countered State requests for more money for the public hospital system with arguments that efficiency improvements within State hospitals would release hundreds of millions of dollars.

This last matter brings us to the starting point of our own study of health services in Western Australia. The State government—*any* State government—operates within the constraints—ideological and financial—imposed by the Federal government. The price of accepting Commonwealth funding for the State hospital system is free treatment for Medicare patients in public hospitals. Since the 1992 Federal Budget, the strings attached to the Medicare funding have become tighter, and now, for instance, include a requirement that the States pass legislation which entrenches the principles of Medicare. At the time of writing, the outcome of the protracted post-Budget negotiations was still far from clear; it seemed likely that a shift in the overall political balance among the State governments might force a result more rational than was the case in August.

These constraints severely limit the ability of the State government to find better ways of running a more efficient and accountable hospital system. Fully-fledged privatisation, for instance, would seem to be ruled out. A very courageous government might try going it alone on public hospitals, and indeed one health economist has

suggested a method of doing just that.⁸⁷ It is something that should be considered by a new State government; in this chapter we will concentrate on approaches more clearly within the limits of political possibility.

A complicating factor is that, with a change in government possible at the next Federal election, there may be a fundamental change in overriding health policy; at least to the extent that a new Federal Minister for Health might be willing to contemplate new arrangements within individual States. We believe that our suggested approaches will fit in with any likely policy changes in Canberra, and that the principal model suggested will deliver a better hospital system under any likely Federal regime. A first recommendation, however, should be made here: the new State government should seek, together with its counterparts in other States, a more rational funding arrangement with the Commonwealth.

The focus of this chapter is very much on hospitals. The maintenance of the public hospital system is, of course, only one of the Department's functions. It also provides the normal policy, monitoring and administrative functions; community health facilities; nursing homes; psychiatric facilities; alcohol and drug services; school dental services; and a good deal of public health propaganda. Some of these will be the subject of comment at a later stage. But since hospitals account for over 85 per cent of the State's health budget, it is sensible to focus on them.

Health, indeed, is the second biggest item in the State Budget. At \$1271 million, it represented 16.5 per cent per cent of outlays in the most recent State Budget. This in itself makes it an obvious candidate for scrutiny. Experience and theory suggests other more compelling reasons. Most of the State's hospital care is provided at no immediate cost to the consumer by organisations with near-monopoly status controlled, directly or indirectly, by bureaucrats and providers. We would reasonably expect the system to display certain characteristics common to such arrangements, including:

- indiscriminate overprovision;
- severe problems with resource allocation;
- lack of control over costs;
- poor product information for consumers;
- defective quality control;

⁸⁷ See J. Logan, 'Public Hospital Funding: An Exercise in Political Monopolisation', Health & Welfare Policy Programs, Working Papers Series No. 2, Centre for Independent Studies, Sydney, December 1988.

Reform and Recovery

- lack of accountability;
- openness to pressures from politics and vested interest;
- bureaucratic expansionism; and
- credentialism.

All of these appear to be present, although they may not have been officially diagnosed as such.

Many can be identified as implicit in the numerous publications of the National Health Strategy Unit over the last two years. The Federal Minister has certainly established to his satisfaction the existence of unspecified 'inefficiencies' in the State systems. The last State government itself commissioned, in January 1991, the Metropolitan Health Services Review, whose terms of reference explicitly asked for better efficiency and effectiveness, including considerations of accountability, resource allocation, and management. Anecdotal evidence, of course, abounds.

The difficulty for the outsider—a very considerable difficulty—lies in trying to locate the inefficiencies, given the very poor quality of the available data. (Since the publication of the Royal Commission's two reports, accountability has been brought to the fore in political debate. This might be a good place to suggest that one useful subsidiary definition of accountability is the publication of enough data to enable the construction of satisfactory policy alternatives.)

An initial, broad, judgement can be made on the basis of the comparative material published annually by the Commonwealth Grants Commission. The following table compares the State's actual expenditure, per capita and in constant dollars, on general medical services with the all-State average, adjusted for Western Australia's peculiar social and geographic circumstances.

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Standardised	314	317	319	424	433	451	472	471	471	478
Actual	379	374	389	472	477	487	488	503	505	519
% over-spend	21%	18%	22%	11%	10%	8%	3%	7%	7%	8%

Source: CGC data *Note:* Years refer to fiscal years (e.g., '1982' refers to 1981/82)

The table shows that, using the reasonable index established by the Grants Commission, Western Australia has for some time now been spending somewhat more on its public health system than it need. The next table is perhaps even more useful: it shows the same comparison, actual against standardised, for Queensland.

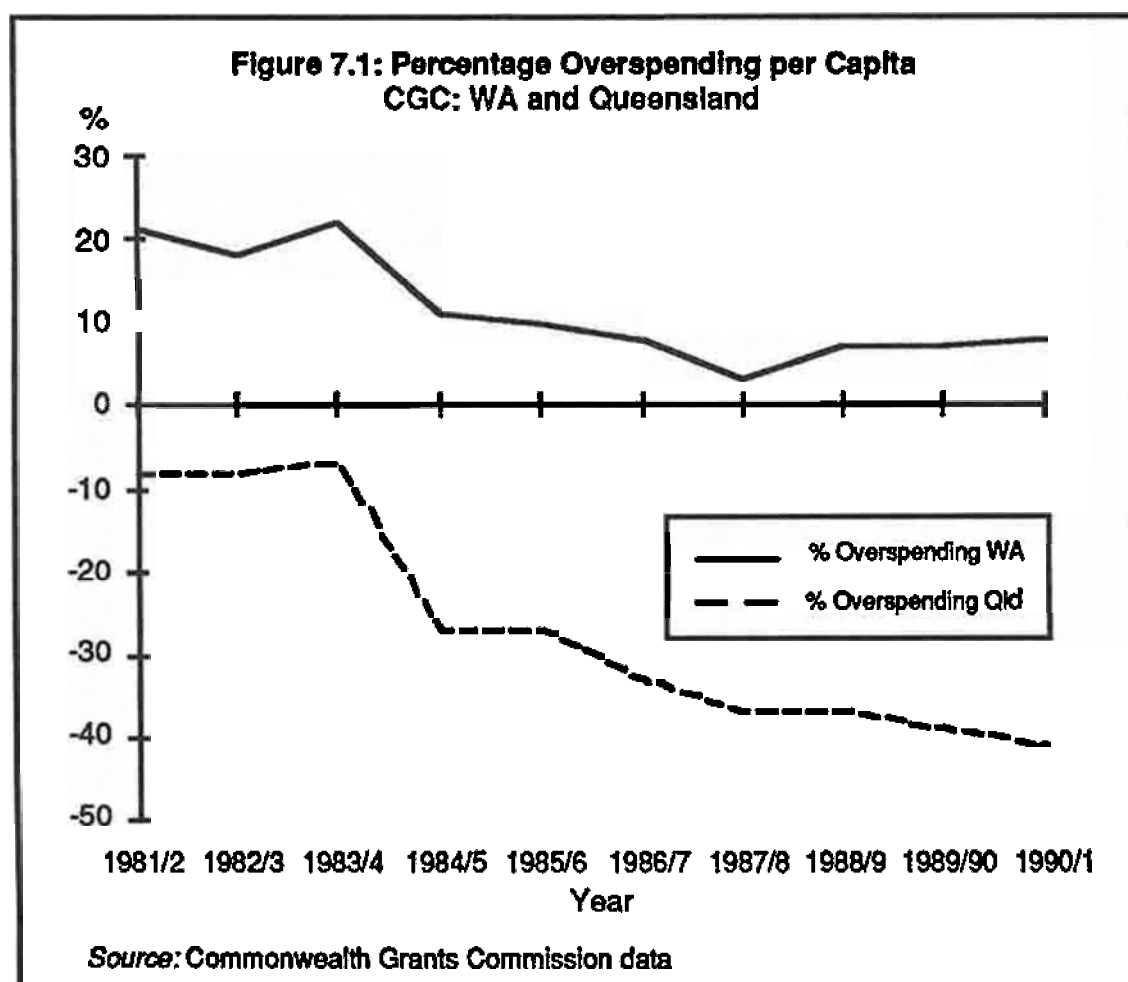
Table 7.2: Commonwealth Grants Commission: QLD (1984-5 prices)

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Standardised	306	308	310	406	414	432	459	458	458	465
Actual	282	284	290	320	325	325	334	333	328	330
% under-spend	8%	6%	7%	27%	27%	33%	37%	37%	39%	41%

Source: CGC data

Note: Years refer to fiscal years (e.g., '1982' refers to 1981/82)

The data for the two States can be brought together and expressed graphically:



A few other figures relating to the public hospital sector in Western Australia and Queensland will reinforce the comparison. In 1989–90, the cost per occupied bed day in Queensland was \$429, the cost per separation \$2449; the same costs in Western Australia were \$515 and \$3026 respectively.

There is no reason to believe that Queensland's public health services are in any way worse either than those of most States or those of Western Australia. (One fairly coarse measure of adequacy can be found in State-by-State levels of private health insurance: Queensland has the lowest level of private insurance in Australia.⁸⁸) If Queensland can maintain this unexceptionable level of service by spending less than its standardised figure and less—far less—than Western Australia, then it is virtually impossible to escape the conclusion that Western Australia overspends and spends in a way which, *prima facie*, appears to be very inefficient. The first table also shows that per capita spending on public health (not hospitals as such) has been rising steadily.

(A note of caution does need to be sounded here. While interstate comparisons are useful in many respects, not least in uncovering areas of gross discrepancy, they are not to be taken as policy prescriptions *per se*. The limitation here is not simply one of comparing very different institutional structures, with their own history and rationale; but rather that whatever usefulness cost comparisons may have is severely limited by the absence of quality comparisons.)

In the case of most States, a detailed analysis of the sources of inefficiency would not be easily possible; lack of data would prevent it. That would be the case, too, in Western Australia, if it were not for the existence of the Metropolitan Health Services Review (hereafter, MHSR).⁸⁹ The recommendations of the Review are for the most part ineffectual (reflecting political constraints); the statistical appendix, however, contains a good deal of raw data which can be made to show where some of the acute problems lie.

Three explanations are usually brought forward to explain cost pressures on our public health systems:

- excessive demand;

⁸⁸ Queensland *does* have a different history of public health provision from Western Australia. But here, as elsewhere, the discrepancy between the two levels of expenditure suggests that quality is less important a determinant than efficiency. See the comments on CGC data in Chapter 5.

⁸⁹ Metropolitan Health Services Review, Final Report to the Government of Western Australia by Deloitte Ross Tohmatsu, Perth, December 1991.

- increases in capital costs; and
- increases in equipment and drug costs.

It is worth looking at each of these in turn.

In the absence of a freely-operating market, *demand* is somewhat difficult to measure; indeed with an apparent price of zero, demand is perhaps meaningless. More or less reasonable substitute measures have to be found elsewhere. We can look at the throughput of hospitals, as found in the number of patients discharged—'separations'. We can look at the intensity of treatment, at the pressure a patient places on hospital resources—bed days. On the basis of the MHSR data we can say that between 1986–87 and 1990–91, separations in teaching hospitals rose by 17.3 per cent, or 3.5 per cent per year, and bed days in teaching and non-teaching hospitals rose by only 1.5 per cent. Neither figure reveals any strong indication of excessive demand. It might be further noted that over the same period admissions increased by 14.7 per cent, or 2.9 per cent per year, another indicator of weak demand.

The argument for *capital costs* as a contributing factor is even weaker. Data from State Budgets show that real capital costs per bed day have fallen by 64 per cent between 1986–87 and 1990–91.

The two other components of costs mentioned—*equipment and drugs*—did increase. In teaching hospitals, equipment costs per bed day rose by 44.4 per cent over the period studied, and accounted for 17.8 per cent of the total rise in real costs per bed day. Equipment costs in non-teaching hospitals rose by 64.8 per cent by the same bed day measure, accounting for 8.3 per cent of the total rise in real costs. (The difference between the respective contributions to total cost increases reflects the fact that teaching hospitals are more costly to equip and operate). The real costs of drug supplies in teaching hospitals rose by 29.3 per cent by the same measure over the period, accounting for 11.4 per cent of the total cost increase. These factors therefore contributed noticeably to cost increases, but are far from being major factors.

The principal factor is one which is not much mentioned in the public debate: *labour costs*, particularly of nurses, doctors and administrators. The omission is surprising, since health is essentially a service industry, heavily dependent on labour costs.

Table 7.3: Real cost per bedday (\$): WA Teaching Hospitals

	1986/87	1987/88	1988/89	1989/90	1990/91	% increase	% of total increase
Nursing	110	113	112	116	120	8.8%	21.5%
Medical	62	63	62	72	76	22.9%	31.6%
Admin	37	39	38	39	41	9.9%	8.2%
Total	322	324	319	338	349	8.6%	61.6%
Equip	18	18	17	21	26	44.4%	17.7%
Drugs	17	18	20	21	23	29.2%	11.3%
Total operating	79	80	83	85	89	12.7%	22.2%
Grand Total	444	447	444	470	489	10.1%	100%

Source: Metropolitan Health Services Review (MHSR)

Once again we can make a revealing (if limited) comparison between Western Australia and Queensland:

Table 7.4: Average Salaries 1989–90 Total Public: QLD v WA

	QLD	WA	% Difference
Nursing	\$28,466	\$34,052	19.6%
Medical	\$71,192	\$75,167	5.5%
Admin	\$22,566	\$25,503	13.1%
Hotel	\$21,792	\$22,438	2.9%
Med Supp	\$28,342	\$35,292	24.5%
Total	\$29,423	\$33,067	12.4%

Source: Australian Institute of Health (AIH), Hospital Utilisation and Costs study, 1989–90, preliminary data

The MHSR data show that between 1986–87 and 1990–91, the nursing salary component in teaching hospitals, in terms of real cost per bed day, rose by 8.8 per cent, and accounted for 21.6 per cent of the total cost increase in teaching hospitals. It should be noted that over the same period nursing numbers fell; so the rise is entirely due to salary increases. It should be noted that this was largely imposed by circumstances outside the State government's control: in particular the Commonwealth's support for a new national nurse wage structure. In the same terms, doctors' real wages in teaching hospitals rose by 23 per cent, accounting for 31.6 per cent of the total cost increase. In terms again of real wage per bed day in teaching hospitals, administrative salaries rose by 10 per cent; numbers increased by

13.5 per cent. We might also note that labour costs accounted for 62 per cent of the total rise in real cost per bed day in teaching hospitals, and for 72 per cent in non-teaching hospitals.

Wage costs are only a part of any full picture: in the end, of course, productivity is the most important part. As far as the data allow us to judge, there have been some minor improvements in productivity—particularly of nurses—but such benefits as have occurred have been captured by the hospital personnel rather than the taxpayer. In trying to understand productivity issues it may be useful to look at the changes in staffing over recent years:

Table 7.5: Staffing Levels per Occupied Bed: Teaching Hospitals

	1986/87	1987/88	1988/89	1989/90	1990/91	% Increase
Nursing	1.94	1.88	1.82	1.83	1.86	-4.0%
Admin	0.74	0.78	0.79	0.81	0.82	11.3%
Hotel	0.97	0.94	0.93	0.95	0.91	-5.4%
Med Supp	0.69	0.70	0.70	0.71	0.73	5.4%
Maintnce	0.24	0.23	0.22	0.22	0.22	-9.7%
Medical	0.43	0.44	0.45	0.52	0.55	28.5%
Total	5.0	4.98	4.92	5.03	5.09	1.8%

Source: MHSR

And the comparison with Queensland would seem to show that Western Australia has lower productivity in the areas of administration, domestic and medical officers:

**Table 7.6: Staffing levels per Occupied bed 1989–90, QLD v WA
(Total Public)**

	QLD	W.A.
Nursing	1.97	1.70
Admin	0.35	0.60
Hotel	0.56	1.05
Med Supp	0.76	0.47
Medical	0.22	0.28
Other	0.14	0.20
Total	4.00	4.30

Source: AIH preliminary data (HUCS)

Reform and Recovery

Looking at staffing, behind these statistics, reveals a number of problems which have been allowed to develop without any serious regard for the financial implications. One significant problem is the switch from hospital-based to tertiary education-based training for nurses. This has been the immediate cause of a particular cost factor, in that relatively poorly paid trainee nurses are no longer available for a wide range of routine hospital duties. The benefits of the switch are not clear; there are reasons for believing that the professional skills of new nurses are not as good under the new system as under the old, and the disappearance of the trainee class has left nurses without anyone to whom those routine duties can be delegated.

Another significant problem for Western Australia is the number of teaching hospitals. It is not simply that we have five teaching hospitals, which seems rather a lot to service one faculty of medicine. Expenditure on teaching hospitals in Western Australia is a higher proportion of total hospital expenditure than in any other State. At about 60 per cent of the total, it is very considerably higher than in Queensland, for instance, at about 45 per cent; and with about 40 per cent of total public beds in teaching hospitals, it is very considerably higher than Queensland's 25 per cent.

A further obvious area for examination is the staffing mix of hospitals. In 1989-90, across both teaching and non-teaching hospitals, nurses accounted for 40 per cent of staff, doctors for 7 per cent, administrators for 15 per cent, domestic staff for 24 per cent, medical support for 11 per cent and other staff for 3 per cent. Once again, it is interesting to compare this situation with Queensland's: nurses accounted for 49 per cent, doctors for 5.5 per cent, administrators for 8.9 per cent, domestic staff for 14.1 per cent, medical support for 18.9 per cent and other staff for 3.6 per cent:

Table 7.7: Staffing Mix 1989-90 (Total Public)

	QLD	WA
Nursing	49%	40%
Medical	5%	7%
Admin		15%
Hotel	14%	24%
Med Supp	19%	11%
Other	4%	3%

Source: AIH preliminary data (HUCS)

There would seem to be a good initial case for believing, first, that our hospitals are administratively top-heavy, and, second, that too large a proportion of hospital staffs are engaged in non-health care areas that might be handled better in other ways.

The comparison with the statistical profile of Queensland reveals another useful observation: Western Australia has, proportionately, more large hospitals and fewer middle-sized hospitals. This is in itself a source of cost and management problems. As the National Health Strategy has pointed out, '...large hospitals exhibit decreasing returns to scale. All other things being equal, 300–500 bed hospitals are considered the most cost efficient with diseconomies of scale occurring over 500 beds ... Studies of large hospitals in the U.S. and Australia ... have proposed the establishment of self-contained units of 100–150 beds as a means of counteracting diseconomies of scale.'⁹⁰

In two important areas, this short overview is deficient.

It has not been possible to say anything very useful about the quality of care. This is simply because we have found no recent independent data which would enable us to make any sensible comparisons. We will, therefore, take quality as given, and independent of State expenditure patterns. In a very broad sense, this is justifiable: international comparisons between developed countries show a very weak connexion between overall health expenditures and obvious indicators such as life expectancy. And rationally we would expect that: while the returns on the provision of the fundamentals of public health, such as clean water, good sewerage, and immunisation are high, returns diminish rapidly at the other end of the health spectrum, in the provision of very expensive, technologically intensive individual treatment.

Nor has it been possible to make any systematic criticism of work practices in our public hospitals, and for much the same reasons. While there is now a wealth of evidence on work practices on, for instance, our waterfront, all the recent published studies of public hospitals shy away from explicit discussion of the relationship between the industrial relations context and efficiency. In the course of this study, however, ample anecdotal evidence has emerged to make it perfectly clear that counterproductive work practices (including demarcation) are sufficiently rigid to induce severe constraints on

90 National Health Strategy, Issues Paper No 2, *Hospital Services in Australia, Access and Financing*, Canberra, September 1991, page 43. It should perhaps be noted here that the particular figures cited are not beyond dispute, and that the argument may need to be adapted to local circumstances.

Reform and Recovery

efficiency. Evidence now emerging in Victoria since the change of government offers further corroboration.

Some First Steps to Reform

Given the constraints mentioned earlier, comprehensive reform of Western Australia's public hospital system is not possible without a fundamental policy change at the Federal level. Such a change need not be radical: anything which allowed the States freedom of experiment in maximising efficiency, without compromising the Federal government's proper need for accountability, would help. Even with that freedom, the very nature of health care provision is such that perfect solutions are unattainable; so here we are looking at third- or fourth-best solutions. That need not worry us greatly: the size of the sector is such that even marginal improvements in efficiency will be more than welcome.

(The Queensland comparison is instructive here. Using the Commonwealth Grants Commission data, it is possible to show that if Western Australia's public health spending—defined as 'general medical expenditure'—were managed in precisely the same way as Queensland's, we would save, in real terms, roughly \$215 million per year. This is not, as we have said before, a simple prescription for reform.)

The brief preceding sketch, however, provokes some immediate commonsense recommendations for reform. We offer six simple proposals to begin.

- It is important that government let the managers manage, within specified and publicly accountable guidelines. This means appointing managers who understand the financial constraints of hospitals, rather than doctors (and, increasingly, nurses) who gravitate into management. It means more businesslike boards. It means increasing the distance between management and bureaucracy. It means, also, better information on inputs and outputs: an annual report along business lines is a great discipline.
- In terms of costs and efficiency, the most important single area of management is industrial relations. Perhaps the highest of all reform priorities is the immediate introduction of enterprise-based bargaining into public hospitals. This will not, in a sense, be easy: patients are not conveniently ill between 9 and 5, and hospitals are not factories. Better industrial agreements will involve greater flexibility than is common in enterprise-based

bargaining, and that flexibility will come at a cost, some of which will be the cost of cashing out complex and inefficient penalties and special conditions. Any reasonable settlement will be worth the cost. It is important that the 'enterprise' be the smallest possible unit: at the very least, the hospital itself; in very large hospitals such smaller and separable management units as can be naturally created. Different negotiated packages between hospitals will encourage competition for resources, and that competition will create further efficiencies. It is, of course, essential that negotiations proceed without interference from third parties, most especially the government.

- Hospitals and their management should attempt to manage only health care. All other functions—including, for example, data management, catering, maintenance, gardening, cleaning and transport—should be contracted out by competitive tender.
- The Department should investigate the possibility of buying beds from the private hospital sector where appropriate and where possible within the Medicare guidelines. The experience of New South Wales in this area will repay examination (not least in designing contracts, which should perhaps specify DRG-determined services rather than 'beds').⁹¹
- The number of teaching hospitals should be reduced. If the specialty obstetrics and paediatrics hospitals are to be retained as such, then it may be difficult to reduce the overall number to less than four; three would be preferable. The all-State average of teaching to non-teaching beds should be a useful guide in effecting the reduction, and should be achievable within a term of government. It will be important in this that the government have a very clear idea of the precise mixture of costs involved in running teaching hospitals: existing data are inadequate, but it seems more than likely that there is some cross-subsidy between the teaching and medical functions which is at the moment far from determinable.
- The arguments about diseconomies of scale should be thoroughly absorbed into future planning. Current policy should examine whether some of the existing giants can be broken up; whether, for instance, Shenton Park can be split off from Royal Perth. An important part of the arguments about scale relates to continuing developments in day-care surgical procedures for ambulatory

91 DRG: Diagnostic Related Groups

patients. It is likely that major new hospital investment can be deferred for some time by concentrating on smaller day-care centres. Planning should also aim to bring Western Australia's bed/population ratio closer to the national average. As of 1989–90, this State's bed/population ratio was 5.18 beds per 1000 population, and the Australian average 4.9 beds per 1000.⁹² Current policy plans for 4.3 beds per 1000 by the year 2001. As other States are adopting similar plans for reducing their own ratios, the 2001 goal will still leave Western Australia above the then national average. A stricter goal and a shorter timetable are necessary. Western Australia has the luxury (not available to, say, Victoria) that a more sensible ratio can be achieved without massive bed closures.

Effective Reform: a Structural Approach

These recommendations are all well within the bounds of political possibility; their counterparts can be found in various public sector activities across Australia. If implemented they would bring Western Australia's public hospital costs to more acceptable levels, and lay a more rational foundation for the inevitable future growth in the system. The last few words are important: whatever reforms are put in place have to cope not only with present problems but with the facts that Western Australia is a growing State, that the demand for health care will rise, and that another bout of major capital investment will be due some time in the next decade.

They do not, however, directly address the central policy problem identified earlier: the fact that the inefficiencies are inherent in the structure of the system. They arise, almost inevitably, from the fact that the purchaser of the service and the provider of the service are effectively identical.

In the world of commerce, such services would be bought by negotiation between supplier and buyer, at a mutually acceptable price which encompassed quality and quantity. The public health system admits of no point at which such an arm's-length transaction can take place: there is a continuum from the Minister through the bureaucracy to the hospitals. Bureaucratic negotiation takes the place of market transaction. This introduces all sorts of non-market difficulties, especially political and interest-group pressure. It is doubtful

92 *Ibid.*, pages 40–41.

that anyone in the process knows the real price of any relevant service, and, indeed, the system operates to suppress such considerations. At best, negotiations on an annual basis will be conducted on the simple basis of last year's allocation plus a bit extra for inflation or expansion. At worst, the process may be intensely political.

The problem then can be stated in this form: how do we maintain a hospital system funded by the taxpayer, which satisfies the Medicare constraint, in which provider and purchaser operate at arm's length?

We offer two models, which the new government can refine. The essence of both is that they provide a break in the continuum between Minister and hospital: the government is clearly identified and established as purchaser, the hospital as provider.

The first step in both models is to establish the hospitals as independent, publicly-owned entities. This is simply done by legislative means. The legislation should specify that

each hospital has a clear charter to carry out its operations in an efficient, commercial manner;

- each hospital has a fully commercial board, whose members are predominantly non-medical and can be replaced if they do not perform;
- while answering to the board, the management of each hospital would be fully autonomous, especially in relation to assets, staffing, work practices, contracting-out, investment decisions, and commercial relations with other suppliers;
- board and management alike in each hospital be independent of political influence, further specifying that ministerial intervention of whatever kind be by public correspondence, so that ministerial intervention, and disagreements between hospital managers and the Minister, be tabled in Parliament and reported in annual reports;
- non-commercial undertakings requested by the government (which may include difficult medical resource allocation areas such as emergency and outpatient services, or more broad 'community obligation' areas) be funded by transparent subsidy from the Budget; and that

hospitals operate in a truly neutral competitive environment, most particularly with regard to payment of all relevant taxes and charges, to servicing of deemed debt, and to payment of dividends.

This new corporate structure for providers is common to both models; the differences lie in the method of purchasing.

One way of handling purchasing—call it Model A—is to direct admissions away from hospitals. The government would set up an allocation bureau as an offshoot of the Department. Such a bureau would maintain a constantly-revised list of prices for beds and procedures, probably based on DRGs. The admitting physician would ask for an allocation through the bureau, and the bureau would provide the physician with the range of going prices. In the case of fully public patients (that is, those without private insurance for whom Medicare picks up the whole bill), the physician would have no choice but to send the patient to the cheapest provider. Other patients would have the choice of selecting the price and quality desired, and paying the difference.

This case-by-case allocation method could be refined to a level of some sophistication. It has the advantage of making prices very much more transparent to physician and patient than at present. Consumer information is essential for effective competition. (It is doubtful, however, that it can be achieved in any significant way under the Medicare arrangements. Ideally, consumers of health should share at least part of the cost of service if the information is to be sought and used appropriately.) Continuous pressures on efficiency are also an advantage. The obvious disadvantages are the constraints it would place on rational forward planning, and the possibility of bureaucratic inefficiencies, though both could be largely overcome through appropriate design.

The alternative purchasing method—call it Model B—is closer to already-established systems of tendering for provision of services to government. Quite simply, the Department, or some more independent bureau, would seek offers from the hospitals for the provision of so many beds over the coming year. The tender would specify not only the number of beds, but the kinds of services attached to the beds, again by DRG or some similar classification. Importantly, the contract or tender specifications would include quality standards, both medical and non-medical, and, to the extent possible, duration. And where the treatment of Medicare patients is not the prime concern, it should be possible to include private hospitals in the tender process.

Again, the basic principle, here stated very simply, can be refined in execution. In the process of refinement, the government should look closely at the new New Zealand system, basically identical in

principle, now effectively in operation, and already yielding very good results. There seem to be no obvious disadvantages attaching to this model, which has a considerable virtue in that it can operate well under either the present Commonwealth policy regime or under any more rational regime that changes of government may bring.

There remain questions of relatively minor importance that cannot easily be answered here for various good reasons. Model B, our preferred model, is, for instance, clearly suitable to operation in the metropolitan area. Does it apply elsewhere? The answer to that is not easy to give. Certainly even the smallest country hospital would benefit from the principle of autonomous management; and we think it likely that the tender system would uncover potential efficiencies (for example, through specialisation within regions) not achievable under the present system.

Again, the question would need to be posed separately for other major functions, such as psychiatric care; but, again, we believe that there are no reasons in principle why the model should not apply. Even outside the complete hospitals system there is no reason why the separation of purchaser and provider should not be widely extended. It is easy, for instance, to see how it could be applied to other major programmes such as the Continuing Care Programme. In the case of drug and alcohol programmes, the applicability is again clear, and offers a good method of financing care through non-profit (volunteer, community and religious) organisations.

We have not in this chapter covered all the many functions currently carried out by the Department of Health. The focus has been very clearly on reforming the major public hospitals, which account for the lion's share of expenditure and have obvious first priority in reform. The government should, however, consider all aspects of the Department's programmes. Particular attention should be given to health promotion and education programmes. There is, in the first place, a need to ensure that the effectiveness of the programmes is measured by some impartial observer. Second, those programmes which involve offence to commonly-accepted standards of morals should be debated, in and out of the Parliament.