

Hospital overhaul is our only hope

The Prime Minister used the recent release of the third Intergenerational Report to declare 2010 the year of major health reform. Kevin Rudd said action must be taken to avert the looming demographic crisis or else the cost of health care for the elderly will overwhelm the budget by 2050.

The long-term perspective of the IGR obscures as much as it reveals about the challenges facing the health system

We already spend 10 per cent of GDP on health and the bureaucratic, inefficient and overcrowded public hospital system consumes \$30 billion a year while failing to provide an acceptable quantity or quality of basic services

The PM has been heavily criticised for delaying hospital reform until some time in the first half of this year. But his government's round of Australia-wide consultation meetings in public hospitals in the past six months has drawn attention to the key issues.

Doctors and nurses have told how frustrated they are working for unresponsive state departments such as NSW Health and Queensland Health.

In these states in particular, frontline staff are sick of patient care remaining under-resourced while money is squandered on the salaries and perks of an army of managers warehoused in the area health services.

The Opposition Leader is now focusing on how public hospitals are financed and administered, daring Rudd to fulfil his election pledge to take the system over. Almost everyone agrees that ending the dual funding of the health system by the feds and the states is a good idea.

Federal control of hospital funding represents a big step towards ensuring care is delivered in the most appropriate and cost-effective way.

However, centralising hospital funding in Canberra is no silver bullet. In fact, the hopes invested in this policy seriously underestimate the challenges involved in public hospital reform.

The challenge is how to make public hospitals accountable for the funding they receive once the commonwealth takes over.

There is some support for creating regional health authorities. Proponents of this model argue local hospital boards are an anachronism because services need to be organised on a regional basis to avoid special pleading and duplication. We're told that making each hospital accountable to a regional bureaucracy will ensure proper planning and avoid waste.

This is a bad joke. Regional health authorities would replicate the dysfunctional area health system that has proved a disaster, especially in NSW and Queensland.

Despite steadily increasing budget allocations -- state and territory health budgets have increased by over 10 per cent during the past five years -- the area health bureaucracies preside over hospital systems crippled by state-wide bed shortages and severe cuts to basic services.

Nevertheless, the regional model continues to guide health policy. The NSW opposition, for example, is committed to establishing smaller health district services, albeit under the control of appointed management boards.

Trying to improve hospital performance by tinkering with administrative arrangements is a dead end.

Policymakers must realise that the problems in public hospitals are systemic, and similar to those that routinely afflict bureaucratically run public services.

If, as seem likely, the NSW opposition forms the next state government, the health district boards will quickly ask the premier and health minister for an enormous amount of capital, plus recurrent funding, to reverse years of neglect. If Rudd or Tony Abbott takes over public hospital funding, they'll inherit the same problems and be expected to stump up the cash to rebuild hospitals across the nation.

Before the federal government will even contemplate reinvesting in the public system, it will need to believe it can get more bang -- increased and better services -- for its buck.

Public hospitals will therefore need to be transformed into what they presently are not: cost-conscious service providers.

This is achievable, and the burden of financing the rebuilding of the system can even be lifted from the federal budget if public hospitals are made financially, rather than bureaucratically, accountable. The first step is to replace block funding of hospitals with a national activity-based payment system.

If the commonwealth only pays hospitals for each occasion of patient care provided, and if the price is calculated at the average cost of these services across the system, all hospitals will have an incentive to discover the most efficient way of delivering care. The second step is to re-establish independent local hospital boards throughout Australia.

Each board should have full managerial and financial authority, and be entirely responsible for planning the future of its facilities.

Under the proposed structure, planning decisions will be disciplined by the knowledge that annual budgets will be determined by the number and kind of patients treated. A business case will have to exist before decisions are taken to invest in extra services.

A guaranteed stream of activity-based payments that included the cost of capital would let local boards confidently make long-term investment decisions.

This would also enable public hospitals to secure private financing, instead of having to go cap-in-hand to government to fund desperately needed new beds and buildings.

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