

Acute health sector reform: an analysis of the Australian Senate's proposals

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On reforming health systems

The sun rose yesterday and with it came a reformed health system. Someone was hired as a policymaker and introduced a fresh idea. A heavily lobbied health Minister changed his mind and gave a new instruction to his permanent head. A government committee altered its stance, and as a consequence, a different policy initiative emerged. New research showed that one type of managerial system was better than another, and several hospital managers took note. Some managers redirected funds from one program to another. Numerous people tweaked the service they offered to patients. A few groups of clinicians, and even more individual clinicians, changed their practice to become more evidence-based. A number of patients, newly signed with a health fund, received private care in advance of the publicly insured.

Obviously, these kinds of occurrences happen every day. The system is always undergoing change, the nature of which is usually small-scale and iterative, and sometimes cyclical.

We can contrast this micro-level, emergent reform with the big bang alternative. Some attempts have led to major changes on the ground: the introduction of the USA's Medicare and Medicaid programs by the Johnson administration in 1965 (which gave millions of poor people reasonable access to health care for the first time); the change to a socialist market economy in China in 1982 (which contributed to the destruction of primary care and a fivefold increase in drug expenditures); the introduction of prospective payment of hospitals in 1983 in the United States of America (Coulam and Gaumer 1992); the birth of the National Health Service in 1948 in the United Kingdom (Doyal 1979); and the inception of Medicare in 1984 Australia (Leeder 1999).

Other attempts at major reform have ended up being smoke and mirrors: Thatcher's 1989 proposal to split the purchaser from the provider (Department of Health 1989); the Jamison inquiry in 1979-1980 into Australian health care (Commission of Inquiry into the Efficiency and Administration of Hospitals 1980); and New Zealand's core services committee in the early 1990s. Each of these ended up with less effect than their rhetoric heralded.

The Australian Senate's inquiry into public hospitals

The Australian Senate's Community Affairs References Committee held a prolonged series of hearings on public hospital funding from November 1999 to April 2000, and subsequently issued a draft report (Hindle 2000; Senate Community Affairs References Committee 2000a). This was followed by a series of 'Roundtable' consultations with various health care professionals, and the Senate's final report was published late last year (Senate Community Affairs References Committee 2000b).

It could eventually be categorised as a catalyst for a successful big bang. On the other hand, it could end up being viewed as inconsequential as many other proto-reforms, and be destined to be stillborn, not even making the second group. We do not yet know which. As Chou En-lai, the former Chinese Premier, once said when answering a question about the importance of the French Revolution: “it is too early to tell”.

It is not too early to start to digest the Senate’s report, however. Hansard transcripts of the public hearings are available at www.aph.gov.au/hansard, and the final report can be obtained from The Senate, Parliament House, Canberra.

In the remainder of this Editorial, we first provide brief information about the public health sector and discuss the Inquiry that led to the report. We cover the main part of the final report, and then comment on the views of a minority of the Committee members.

In the process, we assess its potential. Then we discuss some pertinent issues about implementation, should this come about in the way the Senate’s forty-two recommendations suggest.

Before proceeding further, we declare an interest. One of us presented at the Committee hearings and the other participated in the Roundtable deliberations. We have been committed all our respective careers to improving the health system. Some of our views and past-published work may have influenced the report that we seek to critique.

Public hospitals and the report’s ideas for reform

The public hospital sector consumes a little more than a quarter of health spending, or some \$14 billion annually. In 1998-99 there were 755 public hospitals, 54,000 beds and 3.8 million patients treated in them.

Whoever and wherever it consulted, the Committee found strong support for public hospitals, along with considerable concern for their wellbeing. The report declared that the system was not in crisis, as the Australian mass media seem to hold, but rather ‘suffering severe strain’. Putting aside the linguistic niceties, the persuasive conclusion is that something needs to be done in the short term, because the Committee has determined that \$450 million extra should be found by the Commonwealth over the next two years to bolster services, and this amount should be matched by the States and Territories. Quite suddenly we are talking about an infusion of real money into acute health care. It is not clear what component of this amount is an ambit claim.

The Committee was presented with expert advice - we hesitate to say ‘evidence’ because so little data are available and most are contested - that the stress may be unsustainable, the cost shifting behaviour is endemic and the system is fragmented. These fundamental problems need to be fixed. The answer for the medium term is to pool funding at State level. Thus, Commonwealth-funded programs such as general practice and the Pharmaceutical Benefits Scheme (PBS) would be rolled into a single fund along with State-managed programs like public hospitals and community health services. The problems experienced because of multi-level responsibilities, due mainly to the accident of history we call Federation, would be alleviated by a more unified and better coordinated system.

Within the scope of this core idea various options are possible. For example, the pooled fund could be managed by regions. These go by various names in Australia (which of course reinforces the point that lack of coordination is rife) including area health services, networks, districts and regions. Another option is to introduce capitation payments whereby doctors ration services under capped budgets, similar to the United Kingdom. Yet another is to allocate funding on a population basis across regions. A mix of these could be adopted. However, although each has merits, none received wholehearted endorsement by the Committee because each might adversely interfere with the principles of Medicare or the integration of services at State level.

Notwithstanding the concerns about feasibility, the Committee was very interested in a trial of a regional model, perhaps in one or more large geographical areas. In a brief supplementary report the Australian Democrats, who were supportive of the Inquiry’s findings and recommendations, identified the Australian Capital Territory and the Hunter Valley Region of New South Wales as suitable sites. The aim of any trial would be to minimise unforeseen consequences. Big bang may be the preferred mode, but sensibly, the Committee supports practising before we unleash it.

The recommended date for adoption of the model is July 2003. Those of us who have been involved in earlier large-scale reform processes know that, *a priori*, two and-a-half years seems a long time. Yet to commit to the design, execution and evaluation of far-reaching trials within this kind of time frame would be, in Sir Humphrey's words, 'courageous'. It may be that the Senate is trying to force the Government's hand by introducing a deadline, but as the Government has not yet absorbed the report, that date sounds more like a suggestion than an insistence and even less an accurate forecast.

In the process of responding to its terms of reference the Committee examined numerous closely related matters. It concluded that, despite the Government's earlier pronouncements, the links between private health insurance and demand for public hospital services are unclear, possibly tenuous and likely to be non-existent. Whichever is the case, the links are highly complicated. The evidence for privatisation of hospitals was thought to be mixed, and until better research findings are available, further privatisation should be forestalled. The Committee found the lack of high quality data about hospital performance and the dearth of research evidence about clinical, management and delivery matters 'staggering'. More work to resource and enhance IT and target key research questions is thus essential.

There are many other flaws in the present system that need to be tackled, according to the Committee. A national health policy should be pursued. More resources are needed for increased home care, emergency departments and to address nursing shortages. Strategies for better teaching and research are lacking. Major initiatives to improve quality and safety are still required, including strengthening the Australian Council for Safety and Quality in Health Care. More work should be done on undertaking projects and reporting on quality, involving consumers, adopting clinical guidelines and promoting evidence-based decision-making.

The cynics might respond by saying that none of this is new, and that not only the health sector, but the education, industrial relations, law enforcement and energy distribution sectors (to name only a few) all suffer debilitating coordination problems for various reasons but mainly due to federalism. We argue that this is too harsh a view and, in any case, all political systems have strengths and weaknesses. Nevertheless, there is a point to be made here. Despite the governance arrangements of Australia, many people would agree it is high time we resolved the politico-structural impediments to providing health care in an integrated way.

Enter stage right: the Government reformers

Leaving the story at that point would be doing an injustice to what the Senate thinks, however, because there was a minority report from the Government members of the Committee which finesses the recommendations of the majority. That their views were in the minority may say nothing about health care strategies and only remind everyone about the party structure in the Senate: all government Senators from the Coalition took the minority view, but they were outnumbered by the opposition parties - predominantly Labor and Australian Democrats.

As is usual in reports of this nature, the minority views appear at the end, from pages 185 to 207. They also make interesting reading. As much as any document in recent times, the total report exposes the political divide over health care.

The Government did not want the Inquiry in the first place (Minister for Health and Aged Care 1999) and its Senate members do not like the ideas in the main report, and do not support them. They believe that health should not be so 'blatantly politicised'. It is argued the Labor Opposition has been posturing by using its dominant position on the Committee (in concert with the Australian Democrats) to formulate and advance its health policies, probably in preparation for the next Federal election.

The Government minority Senators go further: the opportunity to have a genuine look at public hospitals was missed. The report intrudes into State and Territory responsibilities. The terms of reference were ill conceived and in any case were not adhered to, illustrating the Opposition's political motivations. Instead of the report's recommendations, the key features of the present system should be strengthened: for instance, continuously improving the current systems based on extant policies, and enhancing access to private and public services based on the principle of freedom of choice.

The Government side asserts that moves toward integration are already in train, because of Commonwealth leadership in providing strong cooperative mechanisms between governments at different levels, hospitals and doctors. The National Demonstration Hospital Program, Coordinated Care Trials and (GP) Division-Hospital Integration program are cited as important initiatives to show that this is working.

According to the minority report the Commonwealth Government has increased its quantum to public hospitals by \$5.6 billion in real terms from 1993 to 1998, a 25% rise. In the same period the States and Territories have decreased their share by 17%. The funding consequences of increased private health insurance mean that the States and Territories are much better off than before, and pressure on the public system should go into remission by 2003 because of the forecast shift to the private sector. Thus the \$450 million extra funding sought by the Committee should come from the States and Territories and does not need to be matched by the Commonwealth.

Further, much of the cost shifting is by public hospitals - who are pushing costs to patients and the Commonwealth - and this should be investigated further. Why did the majority on the Committee not recommend this?

In regard to other majority report recommendations, the Government critics assert that data and quality of care issues are being addressed already. In an amusing aside the Government members argue that, although the majority report suggests that a national advisory council be established to advise on Commonwealth-State funding, this would add more duplication and bureaucracy. In any case they would hard be pressed to find an unused acronym or do work that is not done already by AHMAC, ACCC, ACSQHC, ADEC, AIHW, AMWAC, ANCAHRD, ANCD, APAC, ATAGI, CCDI, CDNANZ, CMEC, MSAC, NATSIHC, NDPSC, NHIMG, NHIMAC, NHPC, NHDC, NHMRC, NICS, NPAAC, NPHPG, PBAC, RHSET and TDEC.

In sum, the minority report expresses disappointment at the opportunity that was missed to recommend sensible change. This would be more likely to occur if cooperation between Governments were enhanced and existing initiatives expanded. The radical recommendation for pooled funding is merely a political ploy to advance Opposition policy. In any case, the majority report does not represent an adequate evaluation of this idea.

According to the Government minority, the main report is neither original nor balanced, ignores established facts, fails to consider how the present system is amenable to improvement and thus is not particularly useful. Present reform initiatives 'will allow Australians to benefit from a world class public hospital system'.

The future of the report

It seems to us that the present Commonwealth Government, or a future Commonwealth Government, might accept or reject the Senate report's majority recommendations, based, *inter alia*, on five possibilities.

First, perhaps there is nothing broken and so there is nothing to fix. This is the minority Government members' position. The rationale is that current measures to help public hospitals are already in train, and incremental reform will do the job. If there are some funding shortfalls, it is not the Commonwealth's fault, and the solution rests with the States and Territories.

Second, there is ideology. If the underlying ideology is that public sector institutions should merely tread water while private sector institutions expand, then the majority's report is bound to fail.

Third, there is political achievability. If the current or any future government thinks that this reform idea is too hard or will not be electorally palatable, it will also fail.

Fourth, there is the issue of merit. If merit is the main decision criterion, the majority proposals may succeed in some form, because there seem strong arguments for pooled funding and doing more to improve service coordination than running small-scale and prolonged trials.

Finally, a change in Government may be the crucial determinant. It appears to us and any number of individuals and groups appearing before the Committee that it is an unassailably obvious point that something must be done about public hospitals. If the core idea of pooled funding is in reality Opposition policy enshrined

in a majority Senate report, it is likely to be adopted by a future Labor Government, assuming that it is elected sooner rather than later. Otherwise, the momentum might be lost.

Two problems with implementation

Politicians do not like to answer hypothetical questions, but we are under no such self-imposed constraints. Legitimate concerns lie with the implementation phase of the majority reform proposal if it does proceed at some stage in the future, as distinct from the question of the need for it. Implementation, that symbiotic partner of reform proposals, is a vexatious and troublesome spouse. Senate Reference Committees can make out logical, attractive, and well-designed cases (depending, in this instance, upon one's perspective), but the devil is in the adoption, not just the policy detail. It is tricky to try to predict what the main challenges might be. However, should the pooled funding proposal see the light of day, two major implementation issues loom large. These centre on structure and decision-making about resource allocation.

At bottom, the Committee majority proposes structural reform. The Commonwealth Government's major extant policy platform for public hospitals - taking the pressure off by bolstering the private sector through accelerating private health insurance participation - is also a structural response. Yet structural change is a necessary but not sufficient precondition of deep-seated, sustained change.

Everywhere you look there has been restructuring activity in health care. Departments of health across the country have been reorganised almost continuously over the past two decades. In the 1990s general practice was restructured into divisions (Commonwealth Department of Health and Aged Care 2000) and teaching hospital services into clinical directorates (Braithwaite 1993).

What benefits have been achieved through this activity? The research evidence appears to be: not many. The organisational behaviour literature suggests strongly that the opportunity for large gains in performance, service delivery and effectiveness come not so much from restructuring as from changing organisational culture in positive ways. Culture is about shared values, philosophy, beliefs and attitudes of people. It is manifested in behaviour. Ethnographers can observe culture by looking at how people talk and behave - what they do when they work together for common purpose.

Culture, then, is centrally about 'the way we work together to do things around here'. Contrast this with the longstanding view, ever since Sax (1984), that the Australian health system is best characterised as a 'strife of interests'. There is no unifying culture, but division. Ironically the Senate's report, split into two, is itself a case in point.

The evidence seems to be saying that changing the structure of the financial and delivery aspects of a health system may be a precondition to viable change, but of far more importance is the need to find, promote and nurture shared values and practices. This means coming to grips with new ways for the parties to deal with and relate to each other. It involves building relationships, working collaboratively, cooperating over the care of patients and negotiating constructively when differences arise. This may sound unrealistic to health sector stakeholders who expect a discordant plurality of positions, and even stranger to politicians who are used to antagonism and combat.

But if you change the structure for the better you may find you have simply skated over the surface of reform. If you change the culture for the better then you may find you have really changed the healthcare system.

Lest the cynics think we are being unduly optimistic, we assert that there are several examples of whole countries, sectors of the economy and large complex organisations that have achieved this kind of cultural change. This does not mean that everyone within the transformed institution now agrees with everyone else. However, we are more likely to find negotiated values, approaches and beliefs and a shared vision for the future. One fundamental feature of the kind of institution we are talking about here is that there may be differences amongst the players, but there is general agreement - and behaviour to match - that the common good overrides the divisions.

Cultural change of this type is dramatic. Think of Japan from the 1950s to the 1980s (from poor quality to excellence), the IT industry from its beginnings to now (from a technical- to people-orientation) and Nokia

Corporation in Finland from the 1970s to present (a slumbering, diffuse mix of businesses centred on timber logging to a major multi-national corporation). Each has gone through a cultural transmutation, and has benefited in major ways. And so, more pertinently, have their customers. Perhaps the time has almost arrived when we start to ask how this extent of cultural change can be effected in the health sector.

A second troublesome implementation point concerns resource allocation. The Committee majority says that pooling funds would enable resource allocation decisions to be made within and between programs. This means, for example, that if decision-makers thought it appropriate, GPs could be paid more. This is what the Australian Medical Association wants as one of its claims. It is not clear how this directly relates to patient care, but it may be an issue that needs to be addressed. But if a rise in GP's remuneration levels were shown to be necessary, where would the money be found? Would it come from reductions in specialists' incomes, pathology or radiology services, cleaning services in public hospitals, or through the 'downsizing' (to use another organisational structural term) of public health units?

In one sense an advantage of the current system is that it makes such decisions less explicit and thus less contested than they may well be under a pooled funding arrangement. This is not a plea in favour of the current system, but an observation. If the Commonwealth agrees to pay more to GPs today, or spend more on the PBS at the moment, it does not lead to an obvious conclusion drawn by most other people in the system that there will be less for them. We might say that the decision-making and its negative effects are, for the decision-maker, fortuitously distal. But if GPs and the PBS gain while the health budget overall is relatively stable, all other things being equal, there will undoubtedly be less for public hospitals. Few stakeholders under current arrangements make that explicit connection. Instead, when they have them, GPs and supporters of the PBS will celebrate their successes, and other players will tend to keep their noses to the grindstone.

As an aside, few people have noted the downside of lifetime community rating. It has been successful thus far in attracting more low users and will deter high users in time, and therefore will improve the risk profile of private insurers. There is one directly equal loss: every improvement in the risk profile of private health insurance has a counterbalancing negative consequence for the public insurance scheme. The Prime Minister is quite right in saying that lifetime community rating is a big success - as long as he is also right in saying that the health of private insurance is more important than that of public health insurance.

Under an integrated pool arrangement as proposed by the Senate's majority, rationing and trade-offs will be much more explicit. If you work within a State or region with a pooled but capped budget and GPs successfully argue for a pay increase, or a decision is made to increase resources to the PPS, other programs will immediately see that they will be directly worse off. Thus the reactions of stakeholders, but not necessarily the stakes themselves, will intensify, because the nexus between decision and its negative effects are now proximal, not distal.

Thus we ask: what is the mechanism by which resource decisions like this will be made? How will funds be re-allocated from one program to another? By what criteria will economic choices like this be decided? This is where highly technical concepts such as opportunity costs and marginal analysis come in, but few understand them and fewer still are trained in their use.

Indeed, the majority recommendation of the Committee to spend \$900 million more on public hospitals over the next two years (or \$450 million by the minority's reckoning) is itself a case that illustrates our point. What is the source of this additional funding? Is it to be taken from elsewhere in the health system, other government programs outside of health or increased taxes? Those in the public hospital system may cheer at the news, for it is not every day that a group of Senators argues your case for a lot more funding. But far fewer will be chastened by it, because it is not clear where the money is to come from and it will not be for some time. If past behaviour is any guide, non-public hospital stakeholders will not spend a lot of time thinking that they will be making the compensatory savings. But someone will have to receive fewer resources, or someone else will have to pay more.

Make such a decision within a smaller, pooled fund and you will soon hear the voices of the proponents of every other program. Considerable work will be needed to reach agreement on the criteria for decision-making about resource allocation under pooled funding, and how to manage complex negotiations across stakeholder groups.

Conclusion

On balance, there is merit in the majority's report. However, more information is needed on how to fund it, both in regard to short term relief for public hospitals, and longer term change.

We are sufficiently convinced by the arguments for pooled funding (we prefer at regional rather than State level) and would like to see a fully-fledged trial proceed. Before it does, it is essential to flesh out how economic trade-offs across program types will be negotiated.

The minority report also makes some good points about the continuing progress being made. In total, both the majority and the minority reports fail to acknowledge there is reason on both sides on which ideas for a better future need to be constructed. The culture of the Senate (and Australian politics in general) made this outcome predictable. It may even be a healthy sign in the political context, but it is seriously damaging to reform of health care.

This leads us to ask whether it is likely that politicians and bureaucrats will ever begin to focus on cultural rather than structural reform. We are reminded of CP Snow's aphorism in *The Two Cultures*: "when scientists are faced with an expression of the traditional culture it tends ... to make their feet ache". We report that our four feet are quite sore.

Whatever the fate of the Senate's report, the health reform journey, always interesting, is likely to be particularly fascinating as this saga unfolds. Will the next phase in the reform process be more of the same - that is, continuously emergent, iterative reform, or big bang? We do not know, but then again, neither does the Australian Senate. We have one recommendation: stay tuned.

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