Funding Melbourne's hospitals: Some historical moments

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Abstract

In 1993 the Victorian Government introduced casemix funding as part of its restructure of the public hospital system. Casemix funding provides a new basis for government funding according to outcomes. At the same time, restructure of hospitals allows for a reconsideration of who is eligible to use them. Historical research into the growth of the public hospital system in Melbourne shows that attempts to reform the hospital system are as old as the system itself. This paper argues that the views of hospitals in funding crises and the solutions that are recommended have more to do with the politics of the day than the economics of running hospitals.

When the Liberal Government took over in Victoria in March 1992, one of the first jobs that Marie Tehan undertook as Minister for Health was the restructuring of hospital funding. Public hospitals, she claimed, were uncompetitive, the private hospital sector was underutilised in delivering health services, and more efficient (*Age*, 1 June 1993). The introduction of casemix funding in July 1993 was the centre-piece of this reform, and meant that hospitals were no longer funded according to historical rationales but on an outcomes basis.

> *The aim of casemix funding is to fund hospitals according to the services they provide and to encourage increases in productivity and efficiency* (Department of Health and Community Services 1994, 2).

Jackson (1995, p 106) argues that the historic form of funding hospitals was based on each hospital's argument that what it did was unique and required more funding to care for a particular set of patients. Governments had no way of comparing what hospitals did. The effect of this was that those hospitals which employed management most effective in the art of bargaining with government received the most money. This led to enormous inequalities in the hospital system as well as great inefficiency. Casemix, she argues, provides the means to

resolve such systemic problems by providing the basis to describe the product of hospitals in terms of outcomes and comparing efficiency across institutions.

I would like to suggest that the potential for casemix to solve problems of hospital funding and waiting lists, or to make hospitals more economic and efficient, may not be met. The basis for this assertion is that the causes of these problems are complex and may lie outside the control of the hospital system, for example, the abandonment by consumers of private health insurance (Latham 1994, p 34; Scotton 1995, p 83). Moreover, hospital financing is, in fact, the battlefield on which governments and hospital management fight one another to achieve their own goals. Such goals often have their origins in broad social values, rather than in terms of hospital output. At the same time, the mix of the imposition of a policy, hospital management's response to the policy, and other external factors may bring about some unintended consequences.

Let me place all of this in an historical perspective. Casemix is the most recent attempt by a government to gain greater control over the direction of public hospitals through control of funding. The relative power that the Minister of Health has over hospitals these days has been won in a series of battles that have taken place since the Melbourne Hospital was first established in the 1840s.

The big issues that dominated the relations between hospital committees of management and governments in the nineteenth century were: Who should be eligible for treatment in a charitable institution? Who should pay to maintain these institutions? Solutions were proposed along ideological lines which, until well into this century, were not tied to party political policies. Hospitals argued that governments should contribute to their maintenance accounts when donations were not sufficient to meet hospital expenses and that governments should be responsible for those patients the hospitals did not want to take. Governments were not entitled to be very critical since this was private charity and socially superior to the English system of caring for the sick poor through the Poor Laws (Victoria, Parliamentary Papers 1871). Governments observed with alarm the proliferation of charities they were expected to support and offered solutions that would save them money, for example, limiting patients to only the poorest or expanding eligibility to those who could pay. Some of these solutions would have unintended consequences, as we will see, but none of the solutions solved the problems, either from the point of view of government saving money or from the point of view of hospitals having enough money to conduct their affairs as they wished. In these battles of competing interests, the elderly and people with chronic and incurable illnesses were bargaining points; hospitals could threaten to stop caring for them or governments could insist that

hospitals force relatives to pay for their care instead of demanding larger grants (Victoria, Parliamentary Debates 1883).

By the end of the nineteenth century, the emergence of educated people in full-time employment gave rise to another category of patient, which became a bargaining point. These were the patients who were earning enough to pay something towards their care but not the full cost of private medical care. Governments sometimes insisted that these patients were not eligible for care in a charitable institution, that is, that their care belonged to the private system, while other governments at other times seemed to encourage hospitals to take them.

Here are some examples of the way different governments politicised, then attempted to solve, the big issues of how to fund the charitable institutions and who should be eligible to use them. In 1880 the radical Berry Government appointed an inspector of charities whose brief it was to conduct an annual inspection of each charitable institution and report on its efficiency. This included, in the case of hospitals, the ability to treat and discharge as many patients as possible at as cheap a rate as possible. Hospitals would now be rewarded for their efficiency and the government grant would be directly tied to the inspector's report (Mitchell 1977, p 8). This appointment was widely supported by both radical and conservative members of parliament. Along with efficiency, the concept of fees being charged to patients was considered as a means to raise revenue for hospitals in the 1880s (Mitchell 1977, p 78). The inspector recommended it, even though it did not have wide acceptance. The medical profession was against it; if patients could afford to pay for medical care, they should not do so in a charitable institution but seek a private medical practitioner (*Australasian Medical Gazette* 1893). Subscribers to charities objected on the basis that their donations were meant to support the deserving poor and not provide facilities for those who could well afford to pay for themselves. Some parliamentarians objected on the same grounds.

But the committee of management of the Alfred Hospital in 1884 saw this as a means of raising revenue, and as a means of providing accommodation for those who could afford to pay and whose homes were not suitable for them to be nursed in. They decided to build separate wards to accommodate private and semi-private patients. Before doing so they checked with the treasurer that this would not jeopardise their grant and took encouragement from his lack of objection (Mitchell 1977, p 68). The treasurer at this time was James Service, who was also president of the committee of management of the Alfred Hospital. In one year the hospital netted £1200 from these wards, a serious amount at the time since the government grant for maintenance was £4000.

The Children's Hospital had also established private beds in 1887 by setting aside 10 per cent of all beds as pay beds. This was not so much a revenue-raising procedure, but more likely reflected the hospital's concern to be seen to be cooperating with the recommendations of the inspector of charities.

In 1891 the Alfred Hospital was told by the new inspector of charities to close down its pay wards (Mitchell 1977, p 68) as they were in contravention of government policy. Hospitals receiving the government grant were to be available only to the indigent, who must prove themselves as being deserving of charity. There was a new government in power with a whole new ideology. This ideology claimed that the unscientific application of charity sapped the moral fibre of society and caused the recipients to become spongers on their betters (Kennedy 1985, p 120). No-one should now receive charity who could work. Work was always available to those who really wanted it. Hospitals were seen as some of the most guilty institutions since they provided care for the sick without inquiring into their circumstances. Even worse, they kept the chronically ill and elderly people at the expense of the government grant and the charitably minded when they should force relatives to take them home.

The force behind this new ideology was the Charity Organisation Society. One of its most ardent supporters was the premier, James Munro, while the speaker of the house, Sir Matthew Davies, was vice-president of the society. Under this new regime, a Royal Commission was held that recommended a poor law be introduced into Victoria and that hospitals be put under the scrutiny of charitable boards (Kennedy 1985, p 125). In the meantime, the Charity Organisation Society demanded that it become the organisation to interrogate all patients requesting medical treatment in a public hospital (Kennedy 1985, p 102). Only by the greatest vigilance could the State and charitable citizens be saved money. As the depression of the 1890s deepened, the Charity Organisation Society devoted its time to harassing the unemployed rather than the sick. But government funds were cut to hospitals. In order to raise revenue, the Alfred Hospital actually extended the number of beds for which it charged patients. The hospital got around the new government policy by calling the charge a contribution and lowering the rate (Alfred Hospital 1893). Contributions were considered favourably by the Charity Organisation Society and the government as a way of making the poor realise that they could not get handouts.

During the 1890s the Melbourne Hospital had its government grant reduced from £15 000 to £12 000 (Melbourne Hospital Annual Report 1896). By 1903 the grant was further reduced to £9840 (Melbourne Hospital Annual Report 1903). The hospital was chronically in debt, even though it practised the most stringent economies by reducing wages and salaries of all staff, reusing bandages

and continually monitoring diets. Yet the hospital continued to expand its services. Between 1894 and 1906 the annual reports began to recommend specialisation in women's diseases and diseases of the ear and throat for outpatients. The latest Roentgen ray equipment was installed in the hospital, with an honorary skyagraphist to operate it, and honorary anaesthetists were appointed. By 1898 the hospital reported its first waiting list for surgery and recommended two operating theatres and more surgical beds. By 1901 there was a waiting list for female surgical patients, since the hospital had given accident cases precedence over these. By 1906 the annual number of outpatients exceeded 20 000 for the first time and this was attributed to the opening of a new operating theatre. During the same period the annual reports told a story of patients being turned away due to a chronic bed shortage. This was caused, the medical superintendent of the period considered, when many beds were taken up by the destitute, who could not find beds in the benevolent homes, and by fever patients, for whom a special fever hospital ought to be provided.

At this stage the expansion of surgery was not to the detriment of other patients, but between 1898 and 1906 surgical patients certainly began to take precedence over other patients. One of the reasons for the expansion of surgical activity was that hospitals could be paid for this surgery. Since patient contributions had become a legitimate source of income, surgical patients presented as a lucrative source. And the Melbourne Hospital needed a source of income since it had an accumulated debt of £26 500 in 1899. A surgical patient could remain in hospital for as little as 10 to 20 days, 10 days being seen as the recovery time and a further 10 as convalescence. This was in contrast to destitute and chronically ill patients whose stay was indefinite. A surgical patient could also be expected to pay a reasonable contribution since most were not indigent, but many could not afford private medical fees and private hospital fees. Thus by 1900 the annual report could claim that patient contributions had played an important part in increasing ordinary revenue for the year. As all Melbourne hospitals turned enthusiastically to surgery, the endemic problems of what to do with elderly, chronically ill and incurable patients and how to fund the hospitals remained unaddressed. In fact, hospitals contributed to criticisms by being seen to encourage imposition in encouraging surgical patients to attend a charitable institution rather than a private hospital. By 1908 the Melbourne Hospital reported in its annual report to contributors that it would only admit consumptives under protest and called for public support to persuade the government to provide accommodation for them.

A final example is treasurer McPherson's 1922 Hospital and Charities Amendment legislation (Victoria, Parliamentary Debates 1922, p 454). This was

an attempt by a government to impose its will on the committees of management of charities through legislation. The debate is interesting as it shows the growth of party political policy. McPherson argued for cost-saving measures by limiting those who were eligible to use the public hospital system, while the deputy opposition leader argued for nationalisation of hospitals and their funding through taxation and insurance. Importantly, McPherson recognised that if limiting the use of public hospitals was to work, then hospital care for those who could pay a little was needed. He proposed a whole new system of intermediate hospitals to be built by the government and managed by honorary committees for this purpose. This provision of his Bill was amended by ministers and members of his own party in the Legislative Council. The effect of this was that intermediate patients continued to use the public hospital system in a haphazard way until such usage became legitimised some decades later by the imposition of Labor Party policy.

From time to time this issue is revived by governments. For example, Minister Tehan and the Secretary of the Department of Health and Community Services suggested that public hospitals should not be available to those whose income was above a certain limit, since they were limiting the access of the poor to these services (*Age,* 8 October 1993).

Conclusion

Previously I suggested that the potential for casemix to reduce waiting lists, reduce the cost of public hospitals and make them more efficient may not be met. The reason I suggest this is because of some of the above historical evidence. Casemix has operated in a climate of budget cuts, an external factor which has affected all sections of the community in Victoria. When public hospitals are starved of funds, they may concentrate on the most lucrative patients, as was the case with the Alfred Hospital, or they are forced to concentrate on the most lucrative form of treatment, as was the case with the development of surgery at the Melbourne Hospital. In the latter case it has meant the escalation of that form of treatment in terms of patient numbers and amounts of money spent on it. Waiting lists are a by-product of the successful development of a new form of medical or surgical specialist intervention and hence grow as the number of specialist interventions increases. As surgery has become increasingly sophisticated, it has become increasingly expensive, especially if the peripheral technology such as is needed for diagnosis and monitoring is taken into account. Oncology services provide an example of this. Casemix will advance the tendency to advocate the most technologically advanced treatments in hospitals at the

expense of 'untechnological' care, which also has beneficial outcomes. In cancer treatment, major hospitals are now carrying out bone marrow transplants as well as surgical interventions, while smaller hospitals are opening up day treatment wards to administer chemotherapy to patients. At the same time, allied health services such as physiotherapy and social work are being cut back.

Casemix itself has no way of preventing soaring costs due to the implementation of high cost technologies. In institutions where 80 per cent of the costs are estimated to be generated by the medical practitioners (Jackson 1995, p 108), administrators do not have full control. Indeed, they may welcome the introduction of new technologies as a response to budget restrictions.

Casemix funding has not done away with the ideological battlefield on which government and hospitals confront one another. To some extent, the emphasis on hospital autonomy means that individual hospitals have been given another means to argue for enhanced funding on the basis that they are 'special cases', for example, carrying a higher proportion of patients needing complex, long-term or specialist care. A further argument is that external factors need to be taken into account, for example, the neediness of the population the hospital serves.

Finally, an historical perspective suggests that the wider ideological debate about what public hospitals are for and who they should serve has by no means concluded. Powerful arguments are still put forward that they are part of the infrastructure of citizenship. Only time will tell if proponents of this argument will rekindle the debate.

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